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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Overview of Involuntary Mental Health Holds at VHA Facilities

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Executive Summary

The VA Office of Inspector General (OIG) conducted a national review of Veterans Health Administration (VHA) processes for managing involuntary mental health holds after findings from four OIG reports identified various concerns relating to involuntary mental health hold processes within VHA. Publication of the OIG reports, over the last two years, also garnered congressional interest in VHA's processes related to involuntary mental health holds across the enterprise; specifically, staff knowledge and training associated with applicable state laws as well as data collection. The national review was conducted from February 2025 to March 2026.

State laws govern involuntary mental health holds, with legal requirements and criteria varying across states.[1] VHA Directive 1160.06(1), *Inpatient Mental Health Services*, assigns responsibility to the VA medical center (facility) director to ensure facility guidelines are in place to address the involuntary commitment process and its alignment with state and local requirements.[2] During the review, the team determined which facilities operate locked mental health acute inpatient units, whether VHA clinicians are authorized to initiate involuntary mental health holds, and whether facilities without locked mental health acute inpatient units have agreements for involuntary admissions in the community. The OIG also evaluated the designation of facility coordinators, existence of local policies, data-tracking practices, and staff training requirements.

Major Findings

Involuntary Mental Health Holds and Admissions

Eighty percent of facilities reported operating a locked mental health acute inpatient unit. Of those, the majority report their clinicians initiate involuntary holds. Per VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* VA facilities without a locked mental health acute inpatient unit must arrange the transfer of patients requiring involuntary admission to other facilities.[3] The other 20 percent of facilities reported not operating locked mental health acute inpatient units; however, only three of those facilities reported having the required formal agreements for such care, increasing care coordination risks.

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[1] SAMHSA, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, last updated October 11, 2024, https://www.samhsa.gov/sites/default/files/civil-commitment-mental-health-care-continuum.pdf; VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023; Nathaniel P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization," *Psychiatric Services* 74, no. 4 (April 2023): 431–33, https://doi.org/10.1176/appi.ps.20220296.

[2] VHA Directive 1160.06(1). *Inpatient Mental Health Services*, September 27, 2023, amended December 27, 2024.

[3] VHA Directive 1160.01.

Local Policies, Point of Contacts, and Data Collection

VHA Directive 1160.06(1), *Inpatient Mental Health Services*, assigns responsibility to the VA medical center director to ensure facility guidelines are in place to address involuntary mental health holds and recommends consulting with Office of General Counsel District Counsel in the development of facility guidelines.[4] Fourteen percent of facilities lacked the guidance on involuntary mental health holds and only 34 percent of facilities reported that their policies were reviewed by Office of General Counsel District Counsel. Thirty-six percent of the 133 facilities that were asked reported tracking involuntary hold data, often through manual methods, and tracking practices varied widely.

Training on Involuntary Mental Health Holds

While VHA Directive 1160.06(1), *Inpatient Mental Health Services*, requires inpatient mental health staff to be trained on relevant regulations, it does not mandate training specific to involuntary mental health hold procedures.[5] Training for staff in the different clinical areas in which involuntary mental health holds are initiated varied by facility.

Impact on Veterans

Involuntary mental health holds and admissions result in a patient being confined against their will. Placing a person on an involuntary mental health hold requires specific knowledge of the laws, criteria, and procedures for the state where the patient is located. The findings in this report identify areas to improve communication of expected practices, coordination of care for patients who urgently need to be admitted for hospitalization, collection and analysis of patient-specific data to help healthcare leaders make decisions, and training that covers facility policy and the applicable city, county, and state law.

Key Recommendations

The OIG made seven recommendations to the Under Secretary for Health related to involuntary mental health hold agreements; documentation expectations; facility-designated points of contact; staff training; changing policy to require consultation with Office of General Counsel District Counsel on local guidance; and implementation of the legal status data field in the electronic health record.[6]

[4] VHA Directive 1160.06(1).

[5] VHA Directive 1160.06(1).

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

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.

VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendations and provided an acceptable action plan (see appendix A). Based on information provided, the OIG considers recommendations 4, 5, and 6 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted a national review to assess Veterans Health Administration's (VHA's) processes for involuntary mental health holds across the enterprise. Specifically, the team examined whether VHA clinical staff are authorized to initiate involuntary mental health holds, identified which facilities operate locked mental health acute inpatient units, and assessed whether facilities without locked mental health acute inpatient units had established coordination of care agreements for care outside of VHA. The OIG also evaluated administrative elements related to involuntary mental health holds, including designation of facility coordinators, establishment of relevant policies, tracking of involuntary mental health holds and admissions, as well as staff training. The review was initiated in February 2025 and concluded in March 2026.

Background

Mental health services in the United States are most often provided to individuals on a voluntary basis.[7] However, when a person is a danger to themselves or others, that individual may be placed on an involuntary mental health hold for a thorough mental health assessment and possible prolonged civil commitment.[8] As both interventions affect an individual's right to freedom and autonomy, standards and procedures for involuntary mental health holds and civil commitment are governed by state law (state specific to location of individual).[9] The federal government does not have laws specific to civil commitment.[10]

VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, requires that mental health services are provided to eligible veterans and that

[7] SAMHSA, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, last updated October 11, 2024, https://www.samhsa.gov/sites/default/files/civil-commitment-mental-health-care-continuum.pdf.

[8] L.C. Hedman et al, "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services* 67, no. 5 (May 2016): 529–35, https://doi.org/10.1176/appi.ps.201500205. An involuntary hold is also called, among other things, a 72-hour hold, pick-up, emergency hold, emergency commitment, psychiatric hold, temporary detention order, or emergency petition; Nathanial P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization," *Psychiatric Services* 74, no. 4 (April 2023): 431–33, https://doi.org/10.1176/appi.ps.20220296; "Civil Commitment Examples: Types, Rights, and Consequences," LegalClarity, accessed June 25, 2026, https://legalclarity.org/civil-commitment-examples-key-cases-and-legal-scenarios-explained/.

[9] SAMHSA, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*; VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023; Nathanial P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization."

[10] VHA Directive 1160.06(1), *Inpatient Mental Health Services*, September 27, 2023, amended December 27, 2024.

> VA medical facilities with locked mental health acute inpatient units must be prepared, when it is feasible and consistent with state laws, to accept involuntary admissions resulting from civil commitments for those Veterans for whom VHA provides health care services. VA medical facilities without locked mental health acute inpatient units must have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when clinically necessary.[11]

An involuntary mental health hold is a brief period of detention intended to connect individuals in crisis with mental health services.[12] The purpose of the involuntary mental health hold is to provide clinicians with the opportunity to perform a comprehensive assessment to determine if the individual meets state criteria for a civil commitment for treatment.[13]

Civil commitment "is a 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 [involuntarily] confined in a psychiatric hospital or receive supervised outpatient treatment for some period of time."[14]

The civil commitment process begins with an involuntary mental health hold.[15] Legal requirements and criteria for involuntary mental health holds may vary by state; however, the most common shared criterion under which an individual may be placed under an involuntary mental health hold is that they have been determined to pose a danger to themselves or others. The length of the hold can vary by state, ranging from 23 hours (in North Dakota) to 10 days (in New Hampshire and Rhode Island). The most common period of an involuntary mental health hold is 72 hours.[16]

Concerns for Review

Findings from several OIG reports identified various concerns related to involuntary mental health hold processes within VHA. For example, Mental Health Inspection Program review teams at Martinsburg and Augusta found a need to align local policies with applicable state laws.[17] Additionally, healthcare inspections at the Augusta, North Florida/South Georgia, and

[11] VHA Directive 1160.01.

[12] Hedman et al, "State Laws on Emergency Holds for Mental Health Stabilization."

[13] Hedman et al, "State Laws on Emergency Holds for Mental Health Stabilization"; Nathanial P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization."

[14] SAMHSA, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*.

[15] Hedman et al, "State Laws on Emergency Holds for Mental Health Stabilization"; Nathanial P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization."

[16] Hedman et al, "State Laws on Emergency Holds for Mental Health Stabilization."

[17] VA OIG, *Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia*, Report No. 24-03520-20, December 18, 2025; VA OIG, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, September 26, 2024; VHA Directive 1160.06(1).

Southern Nevada facilities reported inadequate oversight of the involuntary mental health hold process to ensure compliance with applicable state laws.

- VA OIG report, *Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia*, Report No. 24-03520-20, was published on December 18, 2025, and included 16 recommendations with 3 related to development and implementation of an involuntary mental health hold process that aligns with state law. As of October 19, 2026, 9 recommendations were open, including the 2 specific to the involuntary mental health hold process.
- VA OIG report, *Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida*, Report No. 23-03677-237, was published on August 28, 2024, and included 8 recommendations related to the facility's involuntary mental health examination and admission process. As of October 19, 2026, all recommendations were closed.
- VA OIG report, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, was published on September 26, 2024, and included 3 recommendations related to involuntary admission and hospitalization, policy alignment with state laws, and documentation of legal status. As of March 25, 2026, all recommendations were closed.
- VA OIG report, *Deficiencies in Informed Consent for Admission and Against Medical Advice Discharge Processes for a Patient at the VA Southern Nevada Healthcare System in Las Vegas*, Report No. 24-00160-212, was published on August 1, 2024, and included 4 recommendations related to consent and voluntary admissions to the locked mental health unit. As of March 5, 2025, all recommendations were closed.

Based on these concerns, the OIG initiated a national review to assess VHA's processes related to involuntary mental health holds.

Publication of the OIG reports also garnered congressional interest in VHA's process related to involuntary mental health holds across the enterprise; specifically, staff knowledge and training associated with applicable state laws. Furthermore, the OIG learned from VHA that the Senate Veterans' Affairs Committee noted inconsistencies in involuntary mental health admissions data collection throughout the enterprise and requested that VHA's Office of Mental Health improve its national data capture of involuntary mental health admissions.

Scope and Methodology

The OIG initiated this national review on February 26, 2025. The OIG conducted an entrance brief with VHA staff from the Office of Mental Health, Office of the Chief Operating Officer,

and Government Accountability Office Liaison on February 26, 2025, to notify them of the project, the purpose of the review, and planned steps in the process.

The OIG reviewed relevant VHA documents, policies and procedures, and literature related to involuntary mental health holds. The OIG did not review, or assess facility compliance with, applicable state laws.

On April 4, 2025, the OIG distributed an initial questionnaire to individuals who had substantial knowledge of mental health services at each of the 139 VHA facilities as identified by Veterans Integrated Service Network Mental Health Officers.[18] The purpose of the questionnaire was to gather information about available services and local policies and procedures pertaining to involuntary mental health holds. Questions included whether the facility had an acute inpatient mental health unit, emergency department, and urgent care clinic; staff at the facility could place patients on involuntary mental health holds; and, if applicable, patients on involuntary mental health holds could be admitted to their acute inpatient unit.

Using responses received from the first questionnaire, the OIG sorted facilities based on whether VHA clinicians place patients on involuntary mental health holds, the facility has a locked mental health acute inpatient unit, and the facility admits patients on an involuntary mental health hold. On August 4, 2025, a second questionnaire inquiring about specific services provided at each facility was sent to each of the 139 VHA facilities. There was a response rate of 100 percent for both questionnaires. Questionnaire results were analyzed through March 16, 2026. The results presented in this report represent different subsets of facilities based on the specific services they provide.

The information collected from the questionnaires represents point-in-time, self-reported information, and reflects conditions as of the date the questionnaire was received. Responses may have differed if obtained at another time and may be subject to individual interpretation. Although the OIG sought clarification on duplicate or conflicting information, not all respondents provided follow-up.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews

[18] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/; For this review, the Canandaigua and Bath VA Medical Centers were aggregated together under the VA Finger Lakes Healthcare System.

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

The 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.[19]

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 Inspections teams do not use AI as the 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 Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[20]

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

Inspection Results

The OIG analyzed the questionnaires to gain a high-level understanding of the use of involuntary mental health holds across VA's healthcare system. The responses show the degree with which VHA staff are placing patients on involuntary mental health holds, admitting patients for further evaluation, or partnering with the community to provide involuntary mental health services. The results also describe the written guidance available to VHA staff regarding their local involuntary mental health hold process, the identification of designated subject matter resources, data collection, and staff training.

Overview of Involuntary Mental Health Holds and Admissions

Across VHA, two factors affect processes associated with involuntary mental health holds: whether a facility has a locked mental health acute inpatient unit and whether VHA clinical staff are authorized under state law to initiate an involuntary mental health hold.

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

[20] Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-25-21: § 4(a), April 3, 2025.

Patients experiencing a mental health crisis may present in a VHA emergency department, urgent care center, or outpatient clinic. Regardless of the location, after an initial screening, a VHA clinician or authorized non-VA entity may initiate an involuntary mental health hold, in accordance with state law. Once an involuntary mental health hold is in place, the patient is either admitted to the facility's locked mental health acute inpatient unit, transferred to a community emergency department or designated evaluation facility for further evaluation, or discharged.

Facilities with a Locked Mental Health Acute Inpatient Unit

In response to the questionnaire, 80 percent (111 of 139) of VHA facilities reported having a locked mental health acute inpatient unit.

Of those

- VHA clinicians at 101 facilities with a locked mental health acute inpatient unit initiate the process to place patients experiencing a mental health crisis on an involuntary mental health hold;
- VHA clinicians at 97 of the facilities with a locked mental health acute inpatient unit who initiate the process to place patients on involuntary mental health holds also admit patients on involuntary mental health holds to their locked mental health acute inpatient unit for further evaluation.

Due to state or local laws, a small number of facilities stated they limit the services they offer:

- Four facilities place patients on involuntary mental health holds but do not admit those patients to their locked acute mental health inpatient unit.
- Ten facilities that do not place patients on involuntary mental health holds described state-specific statutes that designate certain non-VHA entities with the authority to initiate involuntary mental health holds including staff from law enforcement, judicial courts, or county agencies. Six of these facilities admit patients to their facility's locked mental health acute inpatient unit after a non-VHA entity places a patient on an involuntary mental health hold.

Facilities Without a Locked Mental Health Acute Inpatient Unit

Twenty percent of VHA facilities (28 of 139) do not have a locked mental health acute inpatient unit, resulting in a need to coordinate care elsewhere for patients requiring admission as a result of an involuntary mental health hold. "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.[21] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[22]

VHA clinicians at 22 of the 28 facilities (78.6 percent) without locked mental health acute inpatient units initiate involuntary mental health holds for patients in mental health crisis. Staff at the remaining 6 facilities do not initiate involuntary mental health holds.

Without a locked mental health acute inpatient unit, VA facilities must arrange the transfer of patients in mental health crisis who need inpatient care to another facility.[23] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, requires facilities without locked mental health inpatient units to establish agreements for involuntary admission and hospitalization elsewhere.[24] However, only 3 of the 28 facilities (11percent) without a locked mental health acute inpatient unit reported having agreements to provide access to involuntary mental health admission and care outside of VHA. While not having a formal agreement in place, the remaining facilities reported the steps they take to initiate assessment and care of patients through community resources. Without these required agreements in place, facilities risk delays and poor coordination of care for patients who urgently need to be admitted for hospitalization.

Involuntary Mental Health Care Local Policies, Coordinators, and Data Collection

Involuntary Mental Health Care Policies

Documented policies and procedures serve multiple purposes in healthcare settings, including communicating to staff what is expected to promote safe, high-quality care, and supporting adherence to applicable laws and regulations. Additionally, they provide operational consistency, regulatory compliance, and risk management. In the absence of these documents, staff may approach care based on out-of-date or incomplete information, potentially leading to lapses in patient safety and failure to follow regulations or laws.

VHA Directive 1160.06(1), *Inpatient Mental Health Services*, September 27, 2023, amended December 27, 2024, states that "the Federal government does not have civil commitment laws." The directive assigns responsibility to the VA medical center director to ensure facility

[21] "Care Coordination," Agency for Healthcare Research and Quality, accessed May 5, 2026, https://www.ahrq.gov/topics/care-coordination.html.

[22] D. 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): 1–10, https://doi.org/10.3389/frhs.2023.1211577.

[23] VHA Directive 1160.01.

[24] VHA Directive 1160.01.

guidelines are in place to address the involuntary commitment process—including involuntary mental health holds, admissions, and hospitalizations—and alignment of the guidelines with state and local requirements.[25]

VHA staff were asked whether their facility has a local policy for managing patients who need involuntary mental health holds and, if so, to submit a copy to the OIG. Eighty-six percent (119 of 139) of facilities reported having such a policy. Of those, 113 (95 percent) said their policy aligned with applicable state laws. Of 47 facilities reporting applicable city or county regulations, 38 (81 percent) reported having policies in alignment with those regulations.

Due to the differences in state and local laws regarding civil commitments, VHA Directive 1160.06(1) recommends consultation with Office of General Counsel District Counsel when developing local guidance; 34 percent (43 of 126) of respondents indicated having done so.[26]

A review of the related documents received by the OIG found variation in the category of documents, clinical care area(s) covered by the documents, and degree of completion. For example, some are standard operating procedures, while others are medical center policies. Some facilities use one document to address involuntary mental health holds for the whole facility while others have separate documents for specific clinical areas, such as the emergency department, inpatient units, or outpatient clinics, resulting in the same topic being addressed in multiple documents. For some facilities, the management of involuntary mental health holds is included within other policies, such as admission policies for mental health units or policies on the management of disruptive behavior. The review also identified documents of varying age, incomplete documents, and documents with the content finalized but unsigned.

VHA does not provide specific requirements regarding what elements must be included in the guidance, nor address oversight or compliance reviews to ensure adherence to the contents within the guidance. Fourteen percent (20 of 139) of facilities acknowledged not having the required guidance in place; the remaining 119 facilities submitted supporting documentation of local guidance. The OIG found approximately 20 percent of the documents submitted to be incomplete, unsigned, or both. Given that involuntary mental health holds and commitments result in a patient being confined against their will, all facilities need current, legally sound and accurate, and complete documents in place for staff to reference. Direction from VHA on document type and elements for inclusion may be warranted to ensure clear communication to staff regarding expected practice for this population of patients.

[25] VHA Directive 1160.06(1).

[26] VHA Directive 1160.06(1).

Involuntary Mental Health Hold Coordinators

State regulations and VHA guidance can change over time. Therefore, it is imperative to have a mechanism to ensure all facilities maintain current knowledge and information about the applicable requirements at the federal and state levels and that facility policy and practice align accordingly.

At the initiation of this project and during development of the second questionnaire, VHA did not require facilities to have a designated subject matter resource or coordinator for involuntary mental health holds. Even so, 40 percent (55 of 139) of facilities reported having someone assigned to serve as a resource, coordinator, or tracker for involuntary mental health holds.

On July 30, 2025, the Acting Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer sent a memorandum to Veterans Integrated Service Network directors requiring that all VA medical facilities identify one person, and an alternate, at each facility to serve as "a local subject matter expert point of contact (POC) for involuntary inpatient mental health commitment to ensure that system policies and practices related to involuntary admissions and ongoing commitment comply with applicable state and federal requirements" by August 11, 2025.[27] The OIG confirmed that, as of April 14, 2026, 57 percent (79 of 139) of VHA facilities had a designated POC and an alternate, 11 percent (15 of 139) had neither, and the remaining were missing either the designated or alternate point of contact.

To assess compliance with this new requirement, VA OIG's Mental Health Inspection Program included identification of a designated point of contact, and an alternate, as an element for review from October 1, 2025, through September 30, 2026.

Involuntary Mental Health Care Data Collection

Collecting and analyzing patient-specific data is important because it provides a picture of the patients served. This helps healthcare leaders make decisions regarding the use of resources, plan targeted interventions, measure outcomes of care, and determine training that staff will need to provide patient population-specific care.[28] Tracking data specific to the involuntary civil commitment process can assist in determining "the frequency and circumstances in which these laws are applied" and inform policy development.[29]

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[27] 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 Service Network Directors (10N1-23), July 30, 2025.

[28] VHA 1082(1), *Patient Care Data Capture and Closeout*, March 9, 2023, amended December 11, 2023; VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, January 18, 2023; Morris and Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization."

[29] Nathaniel P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization."

VHA's *Health Record Documentation Program Guide*, Version 1.3, February 13, 2025, directs VHA staff to include information regarding a patient's involuntary status in electronic health record progress notes. The National Director of Inpatient Mental Health Services informed the OIG that VHA does not have an enterprise-wide method available to identify patients on an involuntary mental health hold for data collection purposes.

Of facilities asked, 36 percent (48 of 133) report tracking data related to involuntary mental health holds. Those facilities use different methods to track the information, often using manual systems where designated staff enter data into spreadsheets or logs. Respondents said they collect data from electronic health record progress notes that use note templates or have standardized titles, as well as from orders, admission and discharge information, and scanned files in the electronic health record.

Locked Mental Health Acute Inpatient Units

For the 103 facilities with locked mental health acute inpatient units that initiate or admit patients on involuntary mental health holds, respondents were asked about tracking changes in a patient's involuntary mental health hold status while hospitalized. Of those,

- thirty-eight (37 percent) track the number of patients who are already on an involuntary mental health hold when admitted to the locked mental health acute inpatient unit;
- twenty-one (20 percent) track the number of admitted patients on an involuntary hold that are discharged from the hospital within the period of the hold.

Of facilities with locked mental health acute inpatient units that initiate and admit patients on involuntary mental holds, 18 of 97 (19 percent) track the number of admitted patients on an involuntary hold that are transferred or converted to a voluntary admission while hospitalized.

Responses varied on where the electronic health record shows that a patient was admitted for hospitalization while on an involuntary mental health hold. Many reported information appears in progress notes and cited their facility's specific note title. Others reported that the status is documented in admission orders or nursing text orders.

Legal Status Identifier

In response to the Senate Veterans' Affairs Committee request to improve enterprise-wide data capture of involuntary mental health admissions, VHA has developed a legal status data field in the electronic health record for use across VHA. This point-in-time metric will identify if a patient is admitted to any VHA locked mental health acute inpatient unit and whether the patient is receiving care voluntarily or involuntarily. An order will be required each time the legal status changes with a focus on the legal status of patients on locked mental health acute inpatient units. A leader in VHA's Office of Mental Health shared that the programming for the legal status data field was sent to VA facilities on June 2, 2026, with installation and implementation expected by

July 1, 2026. On August 14, 2026, another Office of Mental Health leader reported that there are six facilities that are still working on full implementation of the legal status data field.

Training on Involuntary Mental Health Holds

Placing a person on an involuntary mental health hold requires specific knowledge of the laws, criteria, and procedures of the state in which the patient is located. As such, staff managing patients experiencing a mental health crisis need training regarding local policy and expected practice.

VHA Directive 1160.06(1) requires the VA Medical Facility Inpatient Mental Health Program Manager to ensure inpatient mental health staff are trained in relevant regulations.[30] However, the directive does not require training specific to involuntary mental health holds. VHA also does not require staff outside inpatient mental health to be trained in the process of placing a patient on an involuntary mental health hold.[31]

Facilities were asked about their training, the content covered (see figure 1), and which staff received it (see figure 2). Results are shown in the figures and description below.

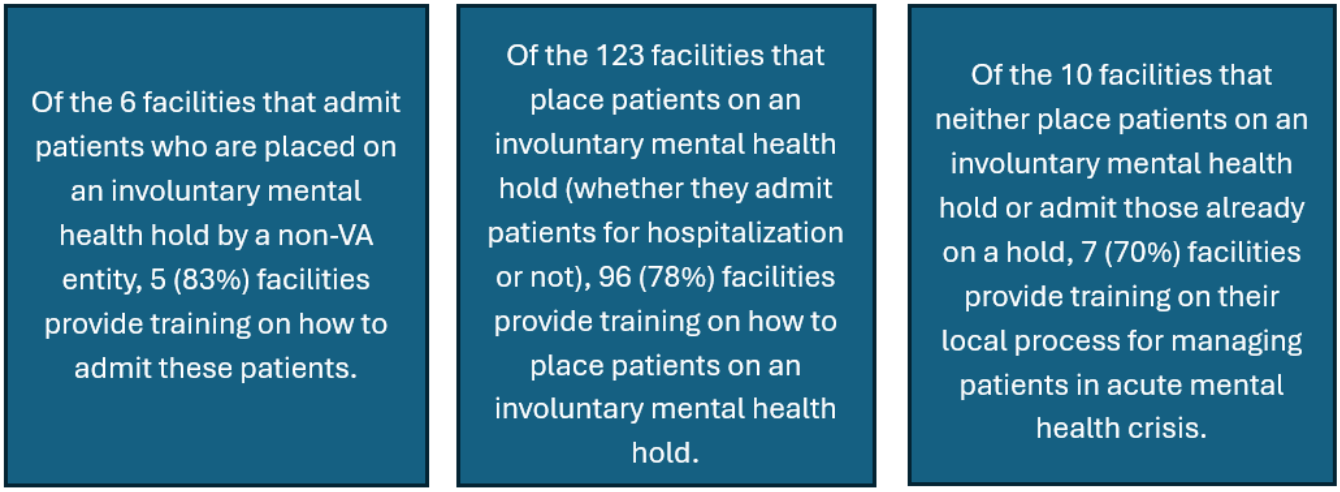


Figure 1. *Training content reported by facility.*
Source: OIG analysis of questionnaire.

Ninety-nine (73 percent) facilities asked reported that training includes content specific to their local policy, 103 (74 percent) include relevant state law, and 63 (61 percent) include city or county law.[32] The OIG assessed training provided to staff on involuntary mental health care processes, based on the location within the facility where steps of the process are completed. Not

[30] VHA Directive 1160.06(1).

[31] VHA Directive 1160.06(1).

[32] Results do not include facilities that indicated city or county laws specific to involuntary mental health holds are not applicable.

all facilities have the same services and departments; for example, not every facility has an emergency department. See figure 2 for details regarding each location.



Figure 2. *Percent of facilities that report training staff on involuntary mental health care processes based on location of care.*
Source: OIG analysis of questionnaire.
Note: Denominators vary as the number of VHA facilities with each of these locations is different.

Overall, the responses show that VHA has an opportunity to ensure all clinical staff involved in the involuntary mental health hold process receive training that covers facility policy and the applicable city, county, and state laws.

Conclusion

In this review, the OIG team evaluated administrative infrastructure rather than patient-level outcomes or the alignment of facility policies with applicable state laws. The OIG found that most VHA facilities operate locked mental health acute inpatient units and allow VHA clinicians to initiate involuntary mental health holds and admit those patients to provide the necessary care. However, staff at some facilities reported they operated within the limits set by state law.

Only a small number of facilities without locked mental health acute inpatient units had formal agreements in place to provide access to involuntary mental health admission and care outside of VHA. Without these required agreements in place, facilities risk poor coordination of care for patients who urgently need to be admitted for hospitalization, which can harm patient outcomes.

The OIG found wide variability in local policies, limited review by Office of General Counsel District Counsel, and inconsistent designation of required facility coordinators. Direction from VHA on document type and elements for inclusion may be warranted to ensure clear communication of expected practice to staff for this population of patients. This is important

given that involuntary mental health holds and commitments result in a patient being confined against their will.

Collecting and analyzing patient-specific data provides a picture of the patients served and helps healthcare leaders make decisions regarding the use of resources, plan targeted interventions, measure outcomes of care, and inform policy development. The OIG found data tracking practices were in place for less than half of the facilities and largely manual. In 2026, VHA developed a standardized electronic health record legal-status field with implementation in the same year.

Placing a person on an involuntary mental health hold requires specific knowledge of the laws, criteria, and procedures of the state in which the patient is located. The OIG identified an opportunity to ensure all clinical staff involved in the involuntary mental health hold process receive training that covers facility policy and the applicable city, county, and state law as training on involuntary mental health hold procedures varied substantially across facilities, with no systemwide requirement for training.

Recommendations 1–7

1. The Under Secretary for Health ensures all Veterans Health Administration medical facilities without a locked mental health acute inpatient unit have the required agreements in place to allow involuntary admissions at appropriate non-VA agencies or hospitals, in accordance with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.

2. The Under Secretary for Health determines if facility guidelines should be required to include processes specific to involuntary mental health holds, admissions, and hospitalizations, in accordance with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.

3. The Under Secretary for Health gives consideration to changing Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services,* to 'require' consultation with Office of General Counsel District Counsel when developing local facility guidelines for involuntary hospitalization to ensure compliance with local civil commitment laws, rather than 'highly recommend' involvement as currently written.

4. The Under Secretary for Health confirms that all Veterans Health Administration facilities have an involuntary inpatient mental health commitment designated point of contact and alternate in accordance with the July 30, 2025, VA Memorandum, *For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts*.

5. The Under Secretary for Health takes steps for full implementation of the legal status data field in the electronic health record and monitors its use in accordance with the June 1, 2026, VA

Memorandum, *For Action: Implementation of a National Standardized Legal Status Orderable Item for Veterans Treated on Inpatient Mental Health Units*.

6. The Under Secretary for Health considers the development of reports using the legal status data field in the electronic health record to inform the Veterans Health Administration of the number of patients across the enterprise receiving care while on an involuntary legal status.

7. The Under Secretary for Health considers whether training specific to involuntary mental health holds, including the relevant law and procedures, should be required for inpatient and outpatient staff involved with the process.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 15, 2026

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

Subj: National Review—Overview of Involuntary Mental Health Holds at VHA Facilities (VIEWS 15275427)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Overview of Involuntary Mental Health Holds at VHA Facilities. The Veterans Health Administration (VHA) concurs with the recommendations made to the Under Secretary for Health and provides an action plan in the attachment.
2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

John Figueroa
Acting Under Secretary for Health

[OIG comment: The OIG received the above memorandum from VHA on October 16, 2026.]

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health ensures all Veterans Health Administration medical facilities without a locked mental health acute inpatient unit have the required agreements in place to allow involuntary admissions at appropriate non-VA agencies or hospitals, in accordance with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service.*

Enter text here

_X__Concur

____Nonconcur

Target date for completion: April 2027

Under Secretary for Health Comments

VHA will distribute a memorandum to all Veterans Health Administration (VHA) medical facilities without a locked mental health acute inpatient unit requiring them to develop agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when clinically necessary, in accordance with VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service. Veterans Integrated Service Network (VISN) Mental Health Leads will ensure the establishment of such agreements at each VHA medical facility and attest that this is completed.

Recommendation 2

The Under Secretary for Health determines if facility guidelines should be required to include processes specific to involuntary mental health holds, admissions, and hospitalizations, in accordance with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.

Enter text here

_X__Concur

____Nonconcur

Target date for completion: April 2027

Under Secretary for Health Comments

VHA will distribute a memorandum emphasizing to facilities that their guidelines must include the administrative and clinical requirements for inpatient mental health services set forth in VHA

Directive 1160.06(1). This includes requirements specific to involuntary mental health holds, admissions, and hospitalization. VISN Mental Health Leads will attest that this is completed.

Recommendation 3

The Under Secretary for Health gives consideration to changing Veterans Health Administration Directive 1160.06(1), to 'require' consultation with Office of General Counsel District Counsel when developing local facility guidelines for involuntary hospitalization to ensure compliance with local civil commitment laws, rather than 'highly recommend' involvement as currently written.

Enter text here

_X__Concur

____Nonconcur

Target date for completion: December 2026

Under Secretary for Health Comments

VHA will consult with the Office of General Counsel (OGC) and evaluate the feasibility of revising VHA Directive 1160.06(1) to require consultation with OGC District Counsel when developing local facility guidelines for involuntary hospitalization.

Recommendation 4

The Under Secretary for Health confirms that all Veterans Health Administration facilities have an involuntary inpatient mental health commitment designated point of contact and alternate in accordance with the July 30, 2025, VA Memorandum, *For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts*.

Enter text here

_X__Concur

____Nonconcur

Target date for completion: Complete

Under Secretary for Health Comments

All legacy VISN Chief Mental Health Officers attested that facilities in their VISN completed this tasker by September 5, 2025.

OIG Comments

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

Recommendation 5

The Under Secretary for Health takes steps for full implementation of the legal status data field in the electronic health record and monitors its use in accordance with the June 1, 2026, VA Memorandum, *For Action: Implementation of a National Standardized Legal Status Orderable Item for Veterans Treated on Inpatient Mental Health Units*.

Enter text here

_X__Concur

____Nonconcur

Target date for completion: Complete

Under Secretary for Health Comments

As of Monday, October 5, 100% of all VHA inpatient mental health units that are admitting patients have implemented the required legal status order. In an effort to monitor its use, the Office of Mental Health (OMH) developed a legal status dashboard, launched on October 1, 2026. The dashboard shows whether every patient admitted to a VHA inpatient mental health unit has a valid and accurate legal status order in their electronic health record.

OIG Comments

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

Recommendation 6

The Under Secretary for Health considers the development of reports using the legal status data field in the electronic health record to inform the Veterans Health Administration of the number of patients across the enterprise receiving care while on an involuntary legal status.

Enter text here

_X__Concur

____Nonconcur

Target date for completion: Complete

Under Secretary for Health Comments

OMH created three reports that are available on the Inpatient Mental Health Dashboard which will allow facilities and VISNs to monitor 1) a point in time metric of whether legal status was recorded during a Veteran's hospitalization, 2) whether that status was voluntary or involuntary, and 3) for those Veterans who were admitted on involuntary status, whether their involuntary status was changed to voluntary during hospitalization.

OIG Comments

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

Recommendation 7

The Under Secretary for Health considers whether training specific to involuntary mental health holds, including the relevant law and procedures, should be required for inpatient and outpatient staff involved with the process.

Enter text here

__X_Concur

____Nonconcur

Target date for completion: November 2026

Under Secretary for Health Comments

The USH will consider the feasibility of an assessment of local staff training needs given that state laws regarding civil commitment vary, and processes and procedures for implementation of involuntary mental health holds and admission also may vary within states.

OIG Contact and Staff Acknowledgments

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