

INPATIENT MENTAL HEALTH SERVICES

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook describes the requirements for the provision of inpatient mental health care within the Department of Veterans Affairs (VA) VHA Mental Health Services (MHS). **AUTHORITY:** 38 U.S.C. §§ 1706 and 1710, and 38 CFR 17.38(a).
- 2. MAJOR CHANGES.** This is a new VHA Handbook.
- 3. RELATED DIRECTIVES.** VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, and VHA Handbook 1163.01, Psychosocial Rehabilitation and Recovery Services.
- 4. RESPONSIBLE OFFICE.** MHS (10P4M) in the Office of Patient Care Services (10P4) is responsible for the contents of this Handbook. The Office of Mental Health Operations (10NC) is responsible for the implementation of this Handbook. Questions regarding the content of this Handbook may be addressed at 202-461-4120. Questions related to implementing this Handbook should be directed to 202-461-5992.
- 5. RECISSIONS.** VHA Manual M-2, Part X, paragraphs 3.02 through 3.05 are rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled to be recertified on or before the last working day of September 2018.

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INPATIENT MENTAL HEALTH SERVICES

1. PURPOSE

Veterans Affairs (VA) must provide capacity for mental health services for Veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting, to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient mental health settings also must provide a healing, recovery-oriented environment. This Veterans Health Administration (VHA) Handbook provides the expectations, procedures, and reporting requirements for the provision of inpatient mental health care for eligible Veterans with mental health conditions requiring that level of care. It is intended to complement VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Facilities and Clinics, by describing the inpatient mental health services referred to in that document.

2. BACKGROUND

a. In 2003 the President's New Freedom Commission on Mental Health filed its report, [Achieving the Promise: Transforming Mental Health Care in America](http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf), (<http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf>.) The report begins, "We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community." This report was the catalyst for the *VA Action Agenda, Achieving the Promise: Transforming Mental Health Care in VA*, (2004), and the Mental Health Strategic Plan (MHSP) derived from it and approved by the Secretary of Veterans Affairs in the fall of 2004. The overall intent of the MHSP was to ensure that all Veterans have prompt access to state-of-the-art general and specialized mental health services, consistent with the vision of the President's New Freedom Commission report.

b. In fiscal year (FY) 2008, MHS published VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Facilities and Clinics, which incorporated many of the requirements of the MHSP. The Handbook specifies the range of mental health services, including inpatient care that must be made available to all eligible Veterans. The Inpatient Mental Health Services Handbook describes in more detail the inpatient mental health care and services that are required to be made available without delay to all eligible Veterans, who require this level of care.

c. A major objective of the transformation of mental health care in VA is the transition to a patient-centered, psychosocial rehabilitation and recovery model with the goal of incorporating recovery into every level and type of mental health care. The most salient premise of this model is that people with mental disorders, including those with serious mental illness, can be active participants in their treatment and can improve and recover; that is, gain or regain the capacity to

live a meaningful, self-determined life, and thrive in their communities. These guiding principles are consistent with VHA initiatives to ensure that care is personalized, with proactive patient involvement, and they are applicable to the inpatient mental health setting.

d. Inpatient mental health care represents a level of care that some Veterans may require for stabilization and treatment of acute symptoms of their mental health condition. Every Veteran, regardless of his or her history of hospitalizations or severity of their mental health condition, can recover to “live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.” Veterans, even during the course of an inpatient hospitalization, can be engaged in the process of defining, pursuing, and achieving personally defined goals that support their recovery, result in improved health and well-being, and promote full participation in the communities of their choice. Inpatient mental health services constitute part of the recovery journey and thus reflect and incorporate the principles of recovery in the provision of services, as well as the environment of care. A warm, homelike, healing, and safe environment with compassionate staff that support and nurture individual recovery are therefore cornerstones of inpatient mental health care.

e. While recovery concepts and services have been incorporated into a range of outpatient and residential programs, it has been more challenging to initiate in the inpatient setting. Due to the severity of the patient’s symptoms on admission, inpatient units typically function primarily as stabilization units, focusing primarily on psycho-pharmaceutical interventions and safety. As a result, inpatient units often lack the resources, staffing and staff training to provide comprehensive psychosocial rehabilitation and recovery services. This Handbook is designed to address those issues.

f. A philosophy of care in the inpatient setting that embraces the concepts of personalized, proactive, patient-centered care and mental health recovery, presents the opportunity to provide state-of-the-art care in one of the most intensive settings in mental health. This approach represents a culture shift for some staff from a traditional approach to one of collaboration, engaging in a joint effort with the Veteran in his or her journey to recovery. This culture shift is inherent to all recovery-oriented care and is imperative to achieving the transformation called for by the President’s New Freedom Commission.

g. In order to fully integrate the psychosocial rehabilitation and recovery model, this Handbook outlines the requirements for each inpatient unit to implement recovery-oriented services. Programming must be consistent with the recovery model used in other mental health programs in the facility. In keeping with the concept that recovery is an ongoing process experienced by the Veteran, the Veteran’s recovery plan must continue seamlessly through admission, discharge, and follow-up residential and outpatient care. For new patients, a recovery plan must be initiated during the hospitalization and continue seamlessly into discharge and follow up residential and outpatient care settings.

h. VHA Inpatient Mental Health Services must provide evidence-based, recovery-oriented care in a safe, healing environment to eligible Veterans who need that level of care due to severe, acute mental health symptoms. As an element of the continuum of care, inpatient mental health services include treatment of mental health and substance use disorders, as well as chronic or non-acute medical conditions that require attention during a patient’s hospitalization and can be

safely managed in that setting. Services are provided in partnership with Veterans and their families, and address the goals of recovery, rehabilitation, improved quality of life, and community integration.

i. Our data show that women Veterans utilize inpatient mental health services at a higher rate than do male Veterans. Current utilization is at 6 percent and this number is projected to double within 5 years. Each facility must ensure adequate access to meet the demand as it increases. Inpatient mental health units must have rooms for women Veterans that are safe and private, with locking bedrooms and bathrooms. Because of the rapid growth in the number of women in the military and the Veteran population, inpatient mental health services must plan for women to access at least 10 percent of current inpatient mental health beds. Remodeling and new construction must accommodate 15-20 percent female bedrooms.

j. Significant improvements have been made to the continuum of care available for persons with mental health conditions, including an extensive network of Mental Health Residential Rehabilitation Treatment Programs (MH-RRTP), Psychosocial Rehabilitation and Recovery Centers (PRRC) Mental Health Intensive Case Management (MHICM) Programs, and Community Living Centers (CLC) to care for patients whose mental health condition is stable but who cannot manage activities of daily living or who continue to require a high degree of support and structure. Further developments in treatment modalities have also been widely incorporated including a number of evidence-based psychotherapies, newer psychotropic medications, and the national implementation of Primary Care Mental Health Integration (PCMHI), to name a few. The availability of this broad continuum of care has resulted in a reduction in overall admissions and lengths of stay per thousand enrolled Veterans, and has reduced the need for longer term inpatient mental health care.

k. New recovery-oriented models of care and enhancements in the continuum of care have demonstrated that Veterans with serious mental illness can thrive in their communities and residential care settings. Based on these advances, VA has begun phasing out long term stay mental health programs, such as the Sustained Treatment and Rehabilitation (STAR) Programs.

l. Similarly, Psychiatric Intensive Care Units (PICU) were established at a time when inpatient mental health units were larger, lengths of stay were longer, and the current continuum of care was not available. Short stays combined with improvements in the environment of care and a broad range of improvements in clinical care have provided the foundation for phasing out the PICU level of care.

3. DEFINITIONS

a. **Acute Mental Health Care.** Acute mental health care refers to high-intensity mental health services for Veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and provide the type and intensity of clinical intervention necessary to treat the patient.

b. **Commitment and Involuntary Mental Health Treatment.** Commitment and involuntary mental health treatment refer to the totality of applicable state laws governing

involuntary mental health evaluation and treatment, including time limited holds for evaluation, involuntary outpatient treatment, and forced administration of psychotropic medication. It is understood that “commitment” in this document generally refers to civil commitment and not to criminal commitment, as criminally committed Veterans while in custody of a state or federal agency are not eligible for VA health care services when such institution has a duty under law to provide care.

c. **Decision-Making Capacity.** Decision-Making capacity is a clinical determination made by a practitioner that assesses whether a patient has the requisite capacities to make health care decisions. There are four major components to decision making capacity: understanding, appreciating, formulating and communicating. The first two components represent the patient’s ability to comprehend and appreciate the nature and expected consequences of each health care decision, including the benefits and risks of each option. The latter two components represent the ability to develop a judgment and convey a clear decision concerning health care. Decision-making capacity is distinct from competency, which is a judicial determination made by a court of law.

d. **Hazardous Items.** Hazardous items, previously referred to as contraband, refers to items that constitute a threat to the safety of patients and staff and/or the security of the unit. Since the term “contraband” is actually defined as trafficking or smuggling of illegal goods, it is being replaced with “hazardous items” to clearly reflect the concern for safety and to reduce the stigmatization associated with “contraband.” Examples of hazardous items include weapons, lighters, matches and smoking materials, alcohol and illegal substances, and certain clothing items such as belts that have shown high lethality; when used in suicide attempts, and other items that staff may identify as harmful to the patient.

e. **Mental Health Advance Directive.** A mental health advance directive is for patients whose future decision-making capacity may be at risk due to mental illness. In this type of directive, the individual indicates preferences about future mental health care (e.g., hospitalization, medications, restraints, and/or electroconvulsive therapy).

f. **Mental Health Care.** Mental health care includes services for the evaluation, diagnosis, treatment, rehabilitation, and prevention of mental health and substance use disorders.

g. **Patient-Centered Care.** Patient-centered care is an approach to health care that prioritizes Veterans and their values, and partners with them to create a personalized strategy to optimize their health, healing, and well-being.

h. **Psychosocial Rehabilitation.** Psychosocial rehabilitation is the term used within VHA that is analogous to psychiatric rehabilitation, which the United States Psychiatric Rehabilitation Association (USPRA) defines as, “promoting recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives.” USPRA notes that rehabilitation services must be collaborative, person directed, individualized, evidence-based, and an essential element of any health care system. The USPRA definition may be found at:

<https://netforum.avectra.com/eWeb/DynamicPage.aspx?Site=USPRA&WebCode=about>

i. **Recovery.** Recovery is identified as, “the single most important goal for the mental health service system in *Transforming Mental Health Care in America, Federal Action Agenda: First Steps.*” The Substance Abuse and Mental Health Services Administration (SAMHSA) national consensus statement on recovery defines recovery from mental disorders and/or substance use disorders as, “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” **NOTE:** *This definition can be found at <http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/>.*

j. **Sexual Assault.** Sexual Assault refers to any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors. Falling under this definition of sexual assault are sexual activities such as: forced sexual intercourse, sodomy, oral penetration, or penetration using an object, molestation, fondling, and attempted rape. Victims of sexual assault can be male or female. This does not include cases involving indecent exposure, exhibitionism, or sexual harassment in the absence of a sexual assault as defined in this paragraph.

k. **Sexual Harassment.** Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

l. **Specialty Mental Health Services for Women Veterans.** Specialty Mental Health Services for women Veterans includes addressing topics such as, mental health disorders during pregnancy and effects of psychoactive medications on women’s health across the lifecycle (i.e., sexual dysfunction, potential teratogenicity, and menopausal symptoms).

4. SCOPE

This Handbook is limited to descriptions of hospital-based inpatient mental health settings. It excludes MH-RRTPs and community based bed settings that are described in separate Handbooks. Inpatient specialized substance use disorder and post-traumatic stress disorder treatment settings are also described in separate VHA policies (VHA Handbooks 1160.03, Programs for Veterans with Post-Traumatic Stress Disorder (PTSD) and 1160.04, VHA Programs for Veterans with Substance Use Disorders (SUD), respectively). Inpatient settings described in this Handbook are not required at all VA medical facilities, but are options that are available depending on local circumstances and demands. Timely access for patients requiring acute inpatient mental health care is; however, required at all VA health care settings.

5. RESPONSIBILITIES OF THE DIRECTOR OF INPATIENT AND OUTPATIENT POLICY

The Director of Inpatient and Outpatient Policy is responsible for:

a. Developing national policy and procedures for inpatient mental health care based on relevant laws, regulations, and VHA’s mission, goals, and objectives.

b. Providing consultation and guidance to Veterans Integrated Service Networks (VISN) and VA medical facilities for the development of inpatient mental health units.

- c. Reviewing all medical facility inpatient bed and program change proposals and providing comments to the Deputy Under Secretary for Health for Operations and Management (10N).
- d. Providing timely reports to the Office of Patient Care Services as requested.

6. RESPONSIBILITIES OF THE OFFICE OF MENTAL HEALTH OPERATIONS (OMHO)

The Office of Mental Health Operations (OMHO) is responsible for:

- a. Monitoring inpatient mental health services for timely access to all eligible Veterans. Services may be provided by VA, and when additional capacity is needed, contracted sites, or referrals to a community resource must be utilized to the extent the Veteran is eligible.
- b. Monitoring VA medical facilities' implementation of VHA Handbooks, including *VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics* regarding inpatient mental health care elements and the content of this Handbook.
- c. Providing VA central office, VISNs, and the VA medical facilities with current data reports regarding their implementation of inpatient mental health care requirements.
- d. Providing technical assistance and consultation to VISNs and VA medical facilities regarding inpatient mental health care, which may include conducting site visits as requested.
- e. Reviewing, forwarding, and tracking medical facility inpatient mental health beds and program change requests to MHS for review.
- f. Providing final recommendations on the requests to the Deputy Under Secretary for Health for Operations and Management (10N).

7. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICES NETWORK (VISN) DIRECTOR

Each VISN Director is responsible for:

- a. Ensuring that inpatient mental health services are accessible without delay to all eligible Veterans in the VISN.
- b. Ensuring that inpatient mental health programs in the VISN are operated in compliance with relevant law, regulation, policy, and procedures.
- c. Ensuring that VHA policies and procedures for inpatient program and bed changes are followed by VISN facilities.
- d. Ensuring that inpatient mental health beds are managed as a VISN resource, so that all mental health beds are available to all patients within the VISN.

e. Ensuring adequate capacity within the VISN to accommodate inter-and intra-facility transfers in a timely manner.

f. Ensuring that policies or agreements for inter-facility transfers are established among VISN hospitals. Those policies or agreements must include:

(1) A clearly defined and transparent inter-facility transfer process;

(a) In most instances, if a bed is available at another VA, that VA medical facility may not refuse admission based solely on holding one or more beds for local use.

(b) In situations where this might cause significant hardship for the receiving facility, such as facilities in remote areas or otherwise with limited access to community beds, policies or agreements must clearly delineate the decision-making process, ensuring access to VA beds when at all possible.

(2) Timeliness expectations for processing inter-facility transfers.

(3) A clearly defined process for communication of the Veteran's mental health and medical condition and clinical care needs. Provider-to-provider communication is required and must be documented in the Computerized Patient Record System (CPRS). This communication must be timely and must not result in a delay in transfer.

(4) That the receiving facility is to rely on a review of CPRS records. Faxed documents may only be required when they are not available in CPRS or other electronic form (such as Vista Imaging).

(5) That the transferring of involuntary patients across state lines is available for patients when this is authorized by relevant federal and state law. *NOTE: Regional Counsel should be consulted prior to initiating transfer.*

8. RESPONSIBILITIES OF THE MEDICAL FACILITY DIRECTOR

Each Medical Facility Director is responsible for:

a. Providing and maintaining inpatient mental health program oversight to ensure access, quality services, and compliance with VHA policy and procedures.

b. Providing safe, well-maintained, and appropriately-furnished facilities that are healing environments that support and enhance the recovery process for all Veterans.

c. Ensuring that the standards of the Mental Health Facilities Design Guide (December 2010) are met for new units and those units undergoing renovation, and that existing units meet the intent of the Design Guide to create a warm, homelike, healing environment. This document is available at <http://www.cfm.va.gov/til/dGuide/dgMH.pdf>.

- d. Ensuring that the guidelines delineated in the Mental Health Environment of Care Checklist are met.
- e. Ensuring the timely completion of all reporting, monitoring, and accreditation requirements mandated by VA.
- f. Ensuring that involuntarily hospitalized patients are treated compassionately and ethically with dignity and respect and in compliance with requirements in this Handbook, VA regulations (38 CFR 17.33) and applicable state law.
- g. Ensuring that resources are available to promote access to acute mental health services by making certain:
 - (1) The availability of mental health admission, triage, and outreach services to provide crisis or other appropriate intervention while eligibility is being confirmed; and
 - (2) That Emergency Departments (ED) have dedicated 23-hour observation capacity and capability to serve mental health patients. The purpose of this is to allow a limited period of time to stabilize a patient while a more thorough assessment is completed. The space must meet the safety requirements of the Mental Health Environment of Care Checklist for Suicidal Patients. One-on-one observation must be maintained when clinically indicated. Appropriate and timely follow-up must be arranged for Veterans discharged from the ED.
- h. Ensuring that timely and appropriate medical care is provided to patients receiving mental health care on an inpatient mental health unit.
- i. Ensuring the continuation of mental health services to the extent possible when a patient needs to be transferred from inpatient mental health to other services.
- j. Ensuring Veterans are treated in the least-restrictive environment necessary to maintain the safety of the Veteran and the general public.

9. RESPONSIBILITIES OF THE FACILITY MENTAL HEALTH LEAD

Each facility Mental Health Lead (Mental Health Service Line Director, discipline Service Chief, etc.) is responsible for:

- a. Ensuring that the full range of mental health services is available to all patients on an inpatient mental health unit as appropriate to their clinical needs. Services must include medication management, recovery-oriented services, family services, and evidence-based psychotherapies, as well as homeless services and evaluation for Therapeutic and Supported Employment Services (TSES) and Mental Health Intensive Case Management (MHICM). Programming on the unit must include individual, group therapy, psychosocial nursing education, as well as other services to meet individual patient care needs.
- b. Ensuring that recovery principles are incorporated into all activities in the inpatient mental health unit.

c. Ensuring that recovery-oriented clinical programming appropriate to the inpatient setting is provided to patients on the inpatient unit.

d. Designating an Inpatient Program Coordinator to coordinate and promote consistent, sustained, high quality therapeutic programming for all patients on an inpatient mental health unit. The coordinator must work in collaboration with the Nurse Manager to ensure that programming is coordinated and effectively integrated into the inpatient setting. The Inpatient Program Coordinator may be from any mental health discipline and may be selected from the staff assigned to the unit.

e. Providing oversight of care and treatment within their areas of responsibility.

f. Ensuring interdisciplinary collaboration in the development and implementation of treatment plans, clinical services and programs, and discharge plans.

g. Ensuring that every patient on an inpatient unit has an identified interdisciplinary treatment team responsible for the coordination of needed services. This includes coordination with the patient's Mental Health Treatment Coordinator, whether at the same facility or a referring facility.

h. Ensuring that follow-up within 7 days of discharge is coordinated with the patient's active participation. It is preferable for the patient to meet the outpatient provider prior to discharge. The contact must be face-to-face, preferably either in person or via telemental health, though by phone is acceptable. While the pre-discharge encounter would not replace the outpatient follow-up required within 7 days of discharge, the direct contact is intended to provide a linkage with outpatient care, and actively involve the patient in planning the follow-up appointment in order to support the patient to engage in continued care after discharge.

i. Ensuring that medical needs of patients are addressed in a timely fashion and that follow-up medical care is coordinated upon discharge.

j. Ensuring the timely completion of all mandated reporting, monitoring, and accreditation requirements.

k. Ensuring all facility and VHA documentation requirements for each clinical discipline are completed timely and accurately in the electronic medical record for patients receiving inpatient care. Encounters must be completed according to VHA Directive 2009-002, Patient Care Data Capture at http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1821. **NOTE:** *This is an internal Web site and is not available to the public.*

10. PRINCIPLES FOR PROVIDING INPATIENT MENTAL HEALTH CARE

The guiding principles for inpatient mental health care incorporate a patient-centered, recovery-oriented approach in the least-restrictive setting. This includes providing timely access to treatment in a safe, therapeutic, and healing environment; monitoring and evaluating patients;

prompt treatment and discharge planning; adequate staffing; privacy and gender sensitivity; and adherence to the principles of psychosocial rehabilitation with an expectation of recovery.

a. **Safety and the Environment of Care**

(1) The environment on an inpatient mental health unit is an element of treatment and must engender an experience of hopefulness, healing, and recovery while maintaining safety. The setting must be comfortable, reflecting a healing, home-like therapeutic setting. While new facilities can more easily incorporate warm and inviting design elements into the environment, there are many design elements that can be introduced into existing units that would create such an environment. *NOTE: For more information see The Mental Health Facilities Design Guide at <http://www.cfm.va.gov/til/dGuide/dgMH.pdf> and Mental Health Environment of Care Checklist (MHEOCC) at <http://vaww.ncps.med.va.gov/guidelines.html#mhc>. This is an internal Web site and is not available to the public.*

(a) The inpatient unit must be configured to promote interaction among staff and patients to facilitate the establishment of therapeutic relationships, trust, and patient engagement. In addition to the healing elements of a trusting relationship, this will allow staff to observe such issues as patient agitation or a change in behavior, providing an opportunity for early intervention.

(b) The unit work area (previously referred to as the Nursing Station) must be open and promote staff-patient interaction to facilitate ongoing observation, interaction, and early intervention. Medical items needed by the staff that could present hazards to patients must be kept in a safe and secure location out of reach of patients.

(2) Inpatient staff must provide assessment and ongoing reassessment of suicide and safety risk. Suicide prevention and precaution procedures must be followed to mitigate risk for Veterans on the unit who are at risk for suicide. Recovery-oriented programming must include safety planning and suicide prevention care.

(3) Safety features, particularly those included on the Mental Health Environment of Care Checklist (MHEOCC) must be implemented to promote safety. The MHEOCC provides relevant information on resources and products, as well as recommendations for design elements that create a therapeutic, healing environment. The Checklist must be completed biannually by an interdisciplinary team. Deficiencies are to be corrected within the required time frame. Deficiencies that are not able to be resolved due to building layout or other unchangeable factors must have a mitigation plan to provide a safe environment.

(4) Inpatient units need to be staffed at a level that ensures that all patients are safe in the environment of care and to facilitate staff observation of those patients needing monitoring due to agitation, aggression or behavioral concerns. One-on-one (1:1) care may be necessary for patients during such times (see VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel).

(5) All staff who interact with patients on the inpatient mental health unit, including staff who provide services intermittently, such as phlebotomists, dieticians, speech therapists, chaplains, engineering and maintenance staff, and others, must receive annual training on the

environment of care, the management of disruptive behavior and gender-sensitive care. Training must be appropriate to the staff's role and level of interaction such that intermittent staff may receive an overview while staff assigned to the unit or who provide direct care on the unit have more extensive training. Any observed changes in behavior or mental status and environment of care concerns must be reported to the Inpatient Coordinator or designated staff identified by the facility. The SharePoint site for the Prevention and Management of Disruptive Behavior (PMDB) is a resource for training and education material and can be found at <https://vaww.portal.va.gov/sites/PMDB/Pages/PMDB-Directives.aspx>. *NOTE: This is an internal Web site and is not available to the public.*

(6) Staff assigned to the unit must be sufficiently trained to recognize warning signs of self-destructive and dangerous behaviors, including risk of suicide and violence. When such symptoms or warning signs are observed, the care team, or any staff person who observes the behavior, must act immediately to optimize safety. The interdisciplinary team must have a plan in place to manage potentially violent behavior that includes a variety of scenarios and staffing levels on all tours of duty. Inpatient staff have the responsibility to assume the lead in managing potentially violent behavior for mental health patients admitted to inpatient care. If the immediate situation is judged to be too risky, or if the staff person does not have training and skills for safe intervention, the staff person must seek immediate assistance.

(7) Facilities must have a policy and processes in place to check for hazardous items (formerly referred to as contraband) as clinically appropriate for patient safety.

(a) Checks for hazardous items must be performed at time of admission and as clinically appropriate when patients return from off-unit activities and when patients have been with visitors. The process must be respectful and sensitive to patient dignity while ensuring that items that may create a safety risk are not brought onto the unit. Such checks must be conducted in a private and secure area. If a bodily search is conducted, such as the use of a wand, the search must be conducted by a staff the same gender as the patient. Staff must have documented training in how such searches must be conducted.

(b) Scheduled and random room checks must be performed. Patients must be present in their rooms during the check.

(c) Family and visitors must be educated regarding safety on the unit for the Veteran and others and the need to ensure that hazardous items are not given to the Veteran or brought into the unit. As family and visitors may bring hazardous items with them to the visiting area, such as cigarette lighters or pocket knives, they must be encouraged to allow staff to place those items in a secured location during the visit.

(d) If hazardous items are found in a patient's possession or room, the patient's clinical status must be reassessed and appropriate clinical action taken, such as patient education regarding safety, more frequent checks, placing the patient on 1:1 observation status, or other clinically appropriate intervention.

(e) If weapons or suspected illegal substances are discovered during a search for hazardous items or at any time, VA Medical facility police must be notified. The Medical facility must

seek the advice of the VA Regional Counsel concerning the applicability of federal, state, or local laws regarding weapon possession by a mental health patient. Such advice must become a part of the facility's established policy and procedures.

(8) Units must provide a safe and clinically appropriate setting for geriatric patients. Frail, elderly, or patients with disruptive behavior secondary to dementia must be kept safe from patients demonstrating agitated behavior to prevent inadvertent injury. Larger facilities may establish a separate wing or unit for geriatric patients with treatment programs designed to meet their needs.

(9) As the majority of Veterans are male, safe and secure locked sleeping and bathroom arrangements must be available for female patients on mixed gender units.

(10) Transgender and intersex patients must be treated with dignity, respect, and sensitivity. Patients must be addressed and referred-to based on their self-identified gender, and care must be provided as clinically appropriate and in accordance with VHA Directive 2013-003, Providing Health Care for Transgender and Intersex Veterans. Private rooms may be the best option even if this would result in temporary unavailability of a bed or beds in rooms with more than one bed. Where there are questions or concerns related to room assignments, an ethics consultation may be requested.

b. Sexual Assault and Harassment Prevention and Response

(1) Patients on an inpatient mental health unit are hospitalized due to serious mental health symptoms that may include or result in vulnerability to sexual harassment or assault. In order to maintain a safe and healing environment and with a focus on recovery, the mental health unit must provide safety from sexual assault and sexual harassment in accordance with VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in VHA medical facilities. Sexual interactions between patients must be prohibited as a preventive measure, as well as to support the patient's focus on recovery.

(2) VHA medical facilities must have policies and procedures related to sexual conduct, including guidelines for the prevention of sexual assault and harassment and response to observed or reported sexual behavior, assault or harassment on inpatient mental health units.

(3) Patients must be informed of the unit policies regarding sexual behavior during their orientation to the unit. They must be educated and encouraged to report sexual harassment or assault to staff, and educated as to the potential consequences of engaging in sexual assault or harassment or engaging in consensual sex.

(4) Staff on the unit must be familiar with the policies and knowledgeable in how to recognize and respond to observed or reported incidents of sexual behavior, assault or harassment.

(5) Suspected or observed incidents of sexual assault or harassment and incidents reported by patients must be reviewed by the Treatment Team and addressed in a manner that is sensitive and culturally appropriate.

(6) Response to alleged victims of sexual assault or harassment must be supportive, and empathic to reduce the potential for blaming the victim or retraumatization. The VA Police must be notified immediately of any alleged sexual assault. Patients who have decision-making capacity and are able to communicate decisions concerning their health care may give informed consent to such issues as medical care, forensic examination and collection, and disclosure. For patients who lack decision-making capacity or are declared incompetent, informed consent for such decisions must be obtained from the patient's surrogate.

(7) The alleged victim and alleged perpetrator must be separated. The alleged perpetrator must be isolated from other patients and potential victims. If a transfer is necessary, this must be done based on a thorough review of the clinical needs of each patient.

(8) Alleged perpetrators of sexual assault or harassment must be treated respectfully throughout the course of assessment and any ensuing investigation. Mental health treatment must continue to be provided to the extent the Veteran is eligible.

(9) When an incident of sexual harassment or assault is reported or observed, guidelines for the assessment, management, and reporting of the incident must be followed in accordance with VHA Directive 2010-014, Assessment and Management of Veterans Who Have Been Victims of Acute Sexual Assault.

(10) As mental health conditions may render individuals to be more easily victimized, all reports of sexual assault must be taken seriously and investigated and should never be summarily dismissed because of psychosis, delusions, or other symptoms of their mental health condition.

c. **Seclusion and Restraint**

(1) As patients have the right to treatment in the least-restrictive environment necessary to maintain safety, seclusion and restraint are interventions of last resort only for patients whose behavior presents an imminent risk to self or others and non-restrictive interventions have not mitigated the risk. Joint Commission standards and Federal regulations (38 CFR 17.33(d)) regarding seclusion and restraint must be followed at all times. **NOTE:** *For more information see the [Joint Commission Manual via E-dition](#),*

<http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointCommissionEDitionAcknldg.aspx>.

NOTE: *This is an internal Web site and is not available to the public.*

(2) Inpatient units must continually explore ways to prevent, reduce, and eliminate seclusion and restraint.

(3) Clinical programming, staffing levels, activities and staff engagement with patients must facilitate a staff's ability to identify issues and intervene preemptively, before a patient reaches a level of agitation or safety risk that requires seclusion or restraint.

(4) Staff must be trained and competent to provide de-escalation and interventions to prevent a patient from reaching a level of agitation or risk that requires seclusion or restraint. The PMDB SharePoint provides training and education resources and can be found at

<https://vaww.portal.va.gov/sites/PMDB/default.aspx>. *NOTE: This is an internal Web site and is not available to the public.*

(5) Staff must be trained and competent in the utilization of seclusion and restraint. They must be competent in the use of the specific device or devices used for restraint in their setting.

(6) Every inpatient unit must have at least one room designed and designated for seclusion and restraint. The room must be structured to prevent patient self-injury while retaining a therapeutic ambiance through color, lighting, noise control, and an appropriate restraint-safe bed.

(7) Use of seclusion or restraint may continue for a period of time that does not exceed current community and/or accreditation standards, and must be terminated as soon as it is safe to do so. Assurance of staff safety must be a consideration whenever seclusion and restraint is complete.

d. Recovery-Oriented Clinical Care

(1) A safe environment of care is necessary but not sufficient to ensure safety and promote mental health recovery. Recovery-oriented clinical care that encompasses staff engagement, patient engagement and empowerment, and instilling a sense of hope must be provided in an environment that, by design, is healing and therapeutic.

(2) In recovery-oriented care, patients must be actively engaged in the process of defining personal goals based on their self-chosen values, interests, roles, and aspirations. Their treatment plan must reflect clinical interventions designed to facilitate the patient's achievement of those goals. This approach to care requires a dialogue with patients to understand what is important to them, and collaboration with patients and their families, to the extent the patient desires, to develop and implement a plan that supports them in their self-determined journey of recovery. Instances in which a patient may have cognitive impairment and may be unable to participate in the treatment planning process or may have a surrogate who may not align with recommended treatment goals may require specialized consideration when planning care.

(3) Patients must be allowed to dress in personal clothes during the day. Personal clothing or personal items of clothing may not be withheld except in circumstances in which those items are deemed to pose a safety risk. Clothes are not to be withheld as a method of controlling behavior or identifying Veterans in some specific way, such as the newly admitted, those with suicidal risk, those with wandering risk, etc. Clothing and undergarments must be made available to patients who do not have access to these items.

(4) Patients and family members involved in the patient's care must receive orientation to the mental health unit, to include a review of recovery principles, clinical programming, and unit rules. As safety is essential to establishing a therapeutic environment for recovery, safety features of the unit must be included in the orientation and reviewed as needed throughout the patient's stay.

(5) Family and visitors are important supports for Veterans and must be involved in the Veteran's care to the extent appropriate and desired by the Veteran. Orientation must be

provided to family and visitors with particular attention to mental health recovery, as well as safety on the unit for the Veteran and others.

(6) The outdoors can provide a therapeutic experience for patients. Staffing must be adequate enough to provide access to the outdoors when feasible, given weather conditions and safety considerations.

11. PROGRAM ELEMENTS

a. Admission to Inpatient Mental Health Care

(1) Admission to inpatient mental health care must be available to all eligible Veterans who require hospital level care for a mental health condition, either in the VHA medical facility where they are being treated, a nearby VA facility, or by non-VA care. When acute mental health care is determined to be needed, immediate admission is optimal. When this is not possible, there must be no delay in taking action to ensure safety and initiation of treatment for the Veteran.

(2) Active duty military personnel may receive services according to VA statutory and regulatory authority.

(3) Eligible justice-involved Veterans who are not incarcerated must have access to services on an equal basis with other eligible Veterans.

(4) Veterans who are inmates in an institution of another government agency are not eligible for VA care if that agency has a duty to provide health care and services (See 38 U.S.C. 1710(h); 38 CFR 17.38(c)(5)).

(5) In accordance with the requirements of VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, independently licensed mental health providers must be available in Urgent Care Centers (UCC) and Emergency Departments (ED), either on duty or on call, to assist in the evaluation and management of mental health emergencies. Level 1a facilities must have on-site coverage from 7:00AM to 11:00PM, 7 days a week.

(6) Licensed independent mental health providers who are authorized by their license to admit patients and have admitting privileges at the VHA medical facility may authorize admission to that VA facility. If the patient or responsible accompanying party requests a mental health admission but the patient does not meet criteria for admission, the admission may be denied by any provider licensed to do so and privileged by that facility. This decision must be based on a thorough evaluation and clearly documented justification. When the admitting provider is not a medical provider, medical consultation is recommended to ensure that potentially relevant medical issues are addressed.

(7) If appropriate treatment facilities are not available at the site the patient is receiving the evaluation, facilities must have a plan in place to ensure Veterans have access to the needed level of care.

(8) Mental health admissions must be addressed with the same urgency as medical or surgical admissions. Assessment and care must be provided in a timely manner. For each patient seeking inpatient mental health care, the following issues must be addressed:

(a) Eligibility determination. No patient who presents verbal or physical aggression, or expresses suicidal or homicidal thoughts or intent, and is considered to be a danger to self or others shall be turned away due to ineligibility regardless of point of entry (e.g., CBOC, Business Office, Emergency Department). The patient will be maintained in a safe environment while staff pursue appropriate alternate arrangements, such as transfer to a community mental health facility or to a local emergency department (ED) for appropriate disposition. Once identified as a danger to self or others by VA providers, it is the facility's responsibility to ensure safe transfer to another facility. Veterans themselves or family members should not be instructed to go to the local ED on their own.

(b) The severity of the Veteran's symptoms; and

(c) The potential for danger to self or others, which includes:

1. Patients who present for admission for suicidal ideation must be assessed for suicide risk and placement of a Patient Record Flag indicating that the patient is a high risk for suicide must be considered. Records of patients who present for admission for a suicide attempt are to be flagged in accordance with VHA Directive 2010-053, Patient Record Flags. This must occur whether or not the patient is admitted.

2. Patients who present for admission for withdrawal from alcohol or drugs. Although alcohol and drug withdrawal can often be safely and effectively managed on an outpatient basis, medically supervised inpatient withdrawal management must be available, as needed, for patients evaluated to be at risk for moderate to severe withdrawal from alcohol, sedative/hypnotics or opioids. Withdrawal management may be conducted on an inpatient mental health unit, medical unit, or Medical Intensive Care Unit, as clinically appropriate and consistent with local policies.

(9) Assessment of voluntary or involuntary status must be completed. **NOTE:** *Involuntary admissions must be managed according to state law. A consultation with Regional Counsel is recommended due to the wide variation in state laws and procedures governing involuntary hospitalization.*

(a) VA records and available non-VA records, including Department of Defense (DoD) records for Veterans recently discharged from military service, must be reviewed. Information from family or referring agencies must be elicited to the extent the Veteran or, in the event that the Veteran does not have decision making capacity, the Veteran's surrogate, consents.

(b) Thorough medical and biopsychosocial assessment. Medical conditions must be addressed to facilitate ongoing care while the patient is on the inpatient mental health unit.

(c) Access to treatment when clinically indicated, either on site or transfer to another VA or community facility must be provided to the extent the Veteran is eligible.

(d) If a bed is available at another VA, in general, that VA medical facility may not refuse admission based solely on holding one or more beds for local use.

(e) Provider to provider communication is required and must be documented in the patient's medical record.

(f) When a patient needs to be transferred to another facility, the referring provider is responsible for determining if the patient requires hospitalization and to the extent possible, for ensuring that the patient's medical and mental health status are stable enough for transfer. Acceptance or non-acceptance of the Veteran by the receiving facility must be based on the patient's clinical needs as assessed by the sending facility, and the receiving facility's ability to meet those clinical needs.

(g) Procedures must be in place for reviewing the patient's mental health and medical status with a transferring facility's clinical staff to ensure that the patient's mental health problems are clearly understood and within the capabilities of the receiving facility to manage. Providers are encouraged to discuss the patient's condition, the most appropriate placement for the patient (e.g., medical bed vs. mental health bed) and need for concurrent medical care.

(h) This process is to be timely to facilitate transfer as quickly as possible and to ensure that staff have the necessary information documented in the case of shift changes during the transfer process.

(i) To ensure appropriate hand-off communication is complete and accurate, nursing communication must be included in the transfer process and documented in the clinical record.

b. Discharge from Inpatient Settings

(1) Discharge planning must begin promptly after admission to an inpatient setting. The Treatment Team must strive to support the patient in being discharged to the setting they prefer, working toward a discharge plan that will facilitate mental health recovery.

(2) Discharge is to be coordinated with the patient's Mental Health Treatment Coordinator and others as appropriate, such as a Case Manager when transfer is to a MH-RRTP or PRRC.

(3) The inpatient program is responsible for initiating and coordinating the discharge plan and arranging appropriate follow-up care.

(4) The program or facility to which the Veteran is being discharged must be actively involved in the process to facilitate patient engagement and timely follow-up.

(5) Discharge planning must include:

(a) The Veteran or the Veteran's authorized surrogate and, with the Veteran's consent, family members and other individuals requested by the Veteran to participate (significant others,

household members, close friends, spiritual guides, etc.). Availability of others to participate (except surrogates) must not unduly delay the discharge.

(b) Participation of the inpatient Treatment Team.

(c) Representation from the Outpatient Treatment Team. For patients referred from another VA, the treatment team from their home facility should be included via tele- or videoconference.

(d) Provider-to-provider direct communication to facilitate transition to follow-up care.

(e) Direct communication between the patient and the outpatient provider, preferably face-to-face either in person or by telemental health, though via phone is acceptable.

(f) Communication and coordination with primary care and other specialty care when indicated.

(g) Linkage with the appropriate outpatient care resources, such as, but not limited to, Mental Health Intensive Case Management (MHICM) programs or utilization of other recovery-oriented resources, such as a PRRC, Intensive Outpatient Treatment for Substance Use Disorders or other VA and/or community treatment resources.

(h) Homeless Veterans must be discharged to stable housing, residential rehabilitation, or transitional housing. Homeless Veterans who prefer other options must be informed of programs available for homeless Veterans and engaged in services to the extent the Veteran desires.

(6) Discharges to residential care must be seamless and under most circumstances, must be directly from the inpatient setting. Consistent with VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), when there is a delay in admission to the residential treatment program, outpatient clinical services must be provided as appropriate.

(7) As part of the discharge planning process, all patients admitted to an inpatient unit for evaluation of suicide risk must be re-evaluated and flagged for high risk for suicide if necessary and not already done. The purpose of flagging is to ensure enhanced care and follow-up post discharge. Veterans who were admitted due to reports of suicidal ideation or attempt, but on further thorough evaluation are determined not to be suicidal, do not need to be flagged or placed on the High Risk for Suicide list.

(8) Discharge instructions must include a description of any changes to the patient's treatment made during the hospitalization and a list of all medications (and what they are for) to be taken after discharge; information regarding follow-up appointments including the provider name, dates, times, and location. Instructions for patient self-management and for family/caregiver support, when indicated, including "red flags" for when the patient/caregiver must call for help (and numbers to call) or return to the hospital.

(9) The patient must be given a written copy of the discharge instructions at the time of discharge. Patients whose treatment included a Suicide Prevention Safety Plan must be given a copy of the Plan at discharge.

(10) When a patient is discharged to the community, outpatient follow-up must be timely and occur within 7 days or sooner when clinically indicated.

c. **Clinical Care on Inpatient Mental Health Units**

(1) Inpatient mental health units must be safely and adequately staffed to offer comprehensive mental health evaluation, diagnosis, and treatment in a recovery-focused, safe, healing environment for patients experiencing mental health problems that cannot be assessed and/or treated at a lower level of care.

(2) The primary objective of inpatient mental health care is to provide the level of intensive treatment necessary for safety and stabilization with a shift to a less intensive level of care as soon as clinically appropriate and feasible based on available resources. Since patients are admitted due to the severity of their symptoms, all mental health units must be secured (i.e., locked) in order to accommodate involuntary patients and patients who are temporarily severely agitated or at risk of harming themselves or others, as well as to provide safety and privacy by controlling access to the unit by others.

(3) Inpatient mental health units must have the capability of providing care to patients who may have severe mental health and behavioral problems, including high suicide risk, uncontrolled assaultive behavior, severe agitation, disorganized behavior secondary to psychosis, confusion, or other severe mental health condition.

(4) Inpatient mental health units must have the capability of providing care to pregnant women Veterans.

(a) Care must be coordinated with the Veteran's providers, including mental health providers, and the non-VA maternity care provider.

(b) Women Veterans need to be evaluated to determine the most appropriate locations for care. Decisions to refer or transfer the care of the patient from one inpatient setting to another need to be made based on consideration of the stage of pregnancy, the patient's health status, and the local resources available and needed to meet all of the patient's medical and mental health needs.

(5) Larger inpatient mental health programs may include separate inpatient units, areas or specified beds for the range of programs and services they provide. In smaller programs, an inpatient mental health unit may include beds and programming addressing multiple functions and inpatient services.

(6) Intensive mental health care must be multi-dimensional including, but not limited to, evidence-based medication management, psychosocial rehabilitation, evidence-based psychotherapy, patient education, medical care, spiritual counseling, occupational therapy, recreational and creative arts therapy, kinesiotherapy, appropriate involvement of family and significant others, and interventions when desired by the Veteran. Telemental health to the inpatient setting may be considered to provide expertise not available on site. Every element of care must be delivered using patient-centered, recovery-oriented principles and approaches.

(7) An interdisciplinary team approach is essential to providing comprehensive, coordinated, holistic care. Interdisciplinary teams are characterized by a high degree of collaboration, communication, and interdependence to ensure that the patient's needs are met. Each patient on an inpatient mental health unit must be assigned an Interdisciplinary Treatment Team responsible for collaborating with the patient, and family with the patient's permission, in developing and implementing a recovery-oriented treatment plan. The interdisciplinary team must:

(a) Develop a comprehensive treatment plan that includes patient-driven goals with an ongoing emphasis on recovery that maximizes each patient's functional independence.

(b) Provide clinical services and referrals for services that support the Veteran in achieving his or her recovery goals to the extent the Veteran is eligible. Such services may include peer support, Supported Employment, MHICM, PRRC, engagement in community programs, and other services to meet the Veteran's needs.

(c) Evaluate the patient's response to the services provided and revise the treatment approach as appropriate.

(d) Ensure that any patient considered to be at risk for suicide has a Suicide Prevention Safety Plan, developed in collaboration with the patient.

(e) Refer for assessment and intervention as indicated to ensure housing availability and stability.

(f) Involve the patient's family, and other caregivers in shared decision-making as appropriate and with the patient's consent.

(8) Every patient on the unit should have a personal Recovery Plan.

(a) For patients new to recovery services and programs, the Recovery Plan must be initiated during the inpatient stay and, as a living document, must guide their outpatient treatment and be revised as necessary through their recovery process. Patients must be given a copy of their plan to work on during their hospital stay and upon discharge (see Handbook 1163.03, Psychosocial Rehabilitation and Recovery Centers, http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2428 for a discussion of recovery plans). **NOTE:** *This is an internal VA Web site and is not available to the public.*

(b) For patients already engaged in an outpatient recovery program such as a PRRC, their Recovery Plan must be updated to address the goals for the inpatient hospitalization and discharge.

(9) The following Services must be available to Veterans hospitalized on inpatient mental health units when these services are necessary for the Veteran's treatment to optimize the therapeutic benefit of the inpatient stay. Regardless of how they are organized, services and the approach to care must be patient-centered and recovery-oriented.

1. Evidence-based medication management of both mental health and medical conditions requiring treatment.

2. Medication management must be a collaborative effort among the patient, the inpatient prescriber, and outpatient prescribers, including Primary Care providers to ensure continuity of care.

3. Clinical Practice Guidelines (CPG) for evidence-based pharmacological interventions for treatment of bipolar disorder, major depressive disorder, PTSD and Substance Use Disorder must be consulted and utilized along with clinical judgment in the pharmacologic treatment of disorders for which CPGs are available. This requirement will apply to CPGs added as they are developed for the treatment of other disorders (see <http://www.healthquality.va.gov/>). Deviations from the CPG must be well documented in the patient's medical record.

4. Except where it is medically contraindicated, all Veterans diagnosed with schizophrenia or schizoaffective disorders with severe residual suffering, symptoms, or impairments must be offered clozapine after two trials of other antipsychotic medications, with an explanation of its potential risks and its potential benefits, consistent with procedures for informed consent as outlined in VHA Handbook 1160.02, Clozapine Patient Management Protocol. The patient's informed consent for clozapine treatment, their informed refusal of clozapine, or a psychiatrist's documentation of contraindications must be documented in the medical record.

5. Electroconvulsive therapy is well-established as an effective treatment for a variety of mental health conditions, most commonly depression and mania, as well as other conditions when more conservative treatments have been unsuccessful or when otherwise clinically indicated. Veterans who may be able to benefit from electroconvulsive therapy must be evaluated for this treatment when they have not responded adequately to adequate trials of medication and psychotherapy for depression or bipolar disorder.

d. Recovery-oriented Programming

(1) An orientation to recovery group must be available to every patient at admission and repeated throughout the stay as necessary to ensure understanding of recovery concepts. Recovery groups and unit programming must be developed in close collaboration with the facility's Local Recovery Coordinator, the unit Nurse Manager, and PRRC for facilities that have a PRRC. The purpose of this is to ensure consistency in recovery programming and to support seamless transition across levels of care.

(2) Inpatient units must provide interdisciplinary recovery-oriented programming every day including weekends and holidays. While 5 to 6 hours of programming is optimal, a minimum of 4 hours is required. Typically, programming must be in a group format with each group consisting of an independent module or session. This format allows patients to enter into the program at any point in the rotation of sessions, which is most compatible with short inpatient stays. Patients' participation must be individualized to their specific recovery goals.

(3) Psychosocial rehabilitation and recovery programming must use evidence-based models, such as Social Skills Training, Illness Management and Recovery (IMR), Wellness Recovery

Action Plans (WRAP) or other recovery-oriented models. These tools can be adapted to the inpatient unit with staff education and support.

(4) Programming must be consistent with the recovery-oriented programming in other settings at the facility, such as Residential Rehabilitation Treatment Programs (RRTPs) and Psychosocial Rehabilitation and Recovery Centers (PRRCs). The purpose of this is to ensure consistency and continuity of care across programs and levels of care. The facility's Local Recovery Coordinator (LRC) is a valuable liaison and resource to inpatient staff in designing and implementing recovery-oriented programming.

e. **Evidence-based Psychotherapy**

(1) A broad range of evidence-based psychotherapies (EBP) have been developed for patients with depression, PTSD, serious mental illness and other conditions and are an essential part of treatment. These can be found on the EBP Intranet site, <http://vaww.mentalhealth.va.gov/ebp/index.asp>. *NOTE: This is an internal VA Web site and is not available to the public.* Evidence-based psychotherapies include, but are not limited to, Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT) for depression, Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE) for PTSD, Social Skills Training (SST) for serious mental illness, and Motivational Interviewing. *NOTE: This intranet site is updated as new EBPs are added. Updates and additions would supersede this list.*

(2) The following services must be made available to patients on an inpatient unit:

(a) Evidence-based psychotherapies (EBP) and treatments are applicable to the full range of treatment settings and must be available to patients on an inpatient unit. Treatment may be provided on or off the unit, based on the way the facility organizes care, availability of staff, and as appropriate to the patient's needs and condition. Providers must have required training and certification for the EBP they are providing.

(b) Brief "pre-treatment" or introductory courses on mental health evidence-based psychological services must be available, with timely initiation or continuation of those services on an outpatient basis after discharge from the unit when clinically indicated. The purpose of this intervention is to assist with the transition to evidence-based outpatient psychotherapy.

(c) Specialized treatment of Veterans returning from recent combat arenas, such as Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), and others that may arise in the future.

(d) Patient and family education relevant to the Veteran's condition such as medication management, safety, community adjustment, self-management, healthy living, and other topics that support successful discharge and recovery.

(e) Specialty mental health services for women Veterans, including such topics as mental health conditions during pregnancy and the effects of psychoactive medication on women's health across the life span as clinically indicated.

- (f) Psychosocial and behaviorally-based interventions for geriatric patients, frail elderly, or patients with challenging behavior secondary to dementia or SMI.
- (g) Spiritual assessment and, when the Veteran desires, spiritual counseling.
- (h) All patients on the inpatient unit must have access to necessary medical care.
- (i) Veterans on inpatient mental health units must receive a physical examination in accordance with facility policy. Timely general and specialty medical care should be provided to meet the Veteran's needs.
- (j) Veterans whose medical conditions require treatment on or transfer to a medical or surgical unit must concurrently be provided the mental health care they need as appropriate based on their medical condition. This must be done in close collaboration and communication between the medical and mental health providers to ensure that the Veteran's overall health care needs are met in the most appropriate setting, and that transfer between units is well-coordinated.
- (k) All facilities must make medically-supervised withdrawal management available as needed, based on an assessment of the symptoms and risks of serious adverse consequences related to the withdrawal process from alcohol, sedatives or hypnotics, or opioids.
1. Although withdrawal management can often be accomplished on an ambulatory basis, facilities must make inpatient withdrawal management available for those who require it. Services can be provided at the facility, by referral to another VA facility, or by non-VA care to the extent that the Veteran is eligible.
2. Withdrawal management alone does not constitute treatment for dependence and must be linked with further treatment for SUD. Evidence-based harm reduction therapy must be made available when necessary to stabilize the patient, especially when previous attempts at sobriety-based therapies have failed. This therapy may be initiated on the inpatient unit and completed in outpatient or residential settings. Appointments for follow-up treatment must be provided within 1 week of completion of medically-supervised withdrawal management.

f. **Alternatives to Long-Term Inpatient Mental Health Care**

- (1) With the introduction of the Recovery Model and evidence-based recovery practices, new treatment options in the inpatient setting are now possible to avoid prolonged inpatient admissions. Patients who generally have responded poorly or incompletely to standard treatments may respond positively to settings that foster the hope and inspiration of recovery. Recovery practices provide many Veterans with the skills and resources they need to function more effectively in a lower level of care. This may be especially relevant to our younger generations of Veterans in the earlier stages of illness and life-stages.
- (2) Intermediate beds were previously designated for lengths of stay of up to 90 days and Community Reentry Sustained Treatment and Rehabilitation (STAR) Programs were for longer term care. These levels of care were established prior to the introduction of a broad outpatient

continuum of care and residential programs, including MHICM, PRRCs and MH-RRTPs, and other evidence-based practices, as well as the availability of a broad array of newer, more effective medications. This has resulted in a substantial reduction in lengths of stay and significantly reduced need for this level of care.

(3) Patients currently in intermediate bed programs and STAR programs must be considered to have potential for recovery and for discharge to residential or community-based outpatient programs. Recovery-oriented programming and services as described throughout this Handbook must be implemented for these Veterans in support of this goal.

(4) Intermediate and STAR programs are to be phased out. During this process, beds must remain open and staffing levels must be maintained to provide the level of intensity of recovery care necessary to facilitate discharge to a lower level. As programs are phased out, facilities must consider converting the intermediate beds to acute or residential beds, Community Residential Care, Foster Care Homes, or CLC beds under long term care standards, consistent with the needs of the patient population.

(5) Patients must not be referred or transferred to residential programs or CLCs solely for short term discharge planning purposes. Discharge planning should be done in the inpatient setting. MH RRTPs and CLCs are designed for continued treatment and rehabilitation to aid Veterans in developing the skills to return to the community.

(6) It is recognized that even with the broad array of treatment options, there are still Veterans who may need longer care to achieve stabilization and discharge. The clinical needs of the patient must determine length of stay, and patients who require continued inpatient treatment must receive that level of care.

(7) Patients whose mental health condition is stable but who cannot manage activities of daily living without help may be eligible for long-term care in VA Community Living Centers (CLC-formerly VA Nursing Home Care Units or NHCUs). For patients who are stable but whose behavioral difficulties have thus far interfered with successful discharge, CLCs may wish to admit these Veterans into a CLC Mental Health Recovery program for evidence-based psychological and psychopharmacological services in a CLC based recovery milieu (for more information see VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers at http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2783. *NOTE: This is an internal VA Web site and is not available to the public.* Psychologists are now required in each CLC, pursuant to VHA Handbook 1160.01, which is partly designed to promote the capacity of CLCs to care for individuals with challenging behaviors, to reduce excessive reliance on psychotropic medications and prevent behavioral exacerbations or psychological emergencies. Evidence-based psychosocial approaches to behavior management have been developed that can effectively reduce behavioral disturbance. Furthermore, the household model and consistent assignment of staff can facilitate healing and health in the CLC.

g. **Acute Care Programs**

(1) All inpatient mental health programs must be considered acute and all beds must be designated as acute care beds.

(2) Psychiatric Intensive Care Units (PICU) are highly restrictive settings that were originally established to provide a safer environment than was available on an acute mental health unit, for patients with the most severe behavioral problems, such as high suicide risk, severe agitation and assaultive behavior.

(3) The implementation of the MHEOCC has resulted in acute inpatient units meeting high standards of safety in a less restrictive environment than PICUs. Additionally, owing to advances in evidence-based medication management and psychotherapies and the expansion of the continuum of mental health care, only patients with the most severe mental health conditions require inpatient hospitalization.

(4) Since acute inpatient units provide a safe environment in which to provide care to patients with the most severe behavioral problems, the PICU level of care should be phased out. Mental health bed capacity must be available to meet the needs of the patient population so as PICUs are phased out, facilities must consider converting the unit to acute beds with required recovery services, or residential beds, consistent with the needs of the patient population.

h. **Bed Section**

(1) As PICU and STAR units are phased out, facilities must request program changes in accordance with VHA Directive 2009-001, Restructuring of VHA Clinical Programs, http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1819 and VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, http://vaww1.va.gov/vhapublications/admin/ViewPublication.asp?Pub_ID=2355 *NOTE: These are internal VA Web sites and are not available to the public.*

(2) Once program and bed changes are approved through all levels and program and bed changes are implemented, Treating Specialty Code 93 must be used for recording workload and costs for all inpatient mental health bed programs.

12. INVOLUNTARY MENTAL HEALTH TREATMENT

a. As the Federal government does not have civil commitment laws, state civil commitment laws must be followed including state laws regarding the frequency of any required formal administrative reviews. It is VA policy that facility-level reviews must occur at least monthly. If the state requires a shorter time frame, the more restrictive timeframe must be followed. *NOTE: A consultation with Regional Counsel is highly recommended because of the wide variation in state laws and procedures governing involuntary commitment timeframes and those with intrastate variation.*

b. VA must accept patients committed under the appropriate state law contingent upon the patient's meeting VA eligibility criteria, availability of clinically appropriate facilities for the treatment of such patients, and a clinical assessment of the patient's need for treatment.

c. Each VA facility must develop clear guidelines for involuntary hospitalization across state lines when authorized pursuant to state and Federal law. When appropriate, Memoranda of Understanding must be developed between receiving and referring facilities to formalize the relationship. Consultation with Regional Counsel is necessary in these cases because more often than not, the law does not authorize such interstate transfer.

d. Commitment must be initiated to provide treatment to a patient who refuses treatment or demands discharge, and who meets state-defined legal requirements for involuntary commitment.

e. Patients admitted on an involuntary basis must be evaluated on an ongoing basis for treatment purposes, consistent with the evaluation and treatment process for patients admitted on a voluntary basis. Each evaluation must include assessment of the need to continue the involuntary status so as to recommend removal of this status as soon as clinically appropriate. Each VA health care facility must ensure that each patient committed to its facility must not be involuntarily retained when the reasons for the commitment cease to exist.

f. When a patient has been admitted on a voluntary basis, treatment must continue to be provided on that basis unless there is a change in the patient's clinical condition which would meet criteria for commitment of the patient under state laws. Patients admitted voluntarily must have decision-making capacity. They must be apprised of the potential consequences of a voluntary admission, such as the possible conversion to involuntary status, and loss of liberty to leave at will, and the possible use of seclusion or restraints.

g. Forced Administration of Psychotropic Medication: Practitioners may seek to override the decision of an involuntarily committed patient (or, if appropriate, the decision of his or her authorized surrogate) to refuse the administration of psychotropic medications. This is a very specific exception to VHA's general rule regarding patient decisional autonomy and it applies only to patients who have been involuntarily committed. The prescribed process established in 38 C.F.R. 17.32(g)(2), along with procedures set forth in VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures, must be followed in order to ensure patients the minimum in procedural due process afforded to patients by Federal Courts. Some states mandate more extensive procedural due process and VA personnel need to contact Regional Counsel to determine if further protections are mandatory in their state.

13. INFORMED CONSENT

a. Patients have the right to accept or refuse any medical treatment or procedure recommended to them. Except as otherwise provided in 38 C.F.R. 17.32 and VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures all treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, his or her authorized surrogate. Documentation requirements for the informed consent process are described in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures as well. **NOTE:** *For additional information see VHA Handbook 1200.05, Requirements for the Protection of Human Subjects in Research, for research related consent issues.*

b. All elements of the informed consent process apply to patients who are suspected of criminal wrongdoing or who are the victims of an alleged crime(s). **NOTE:** *For more information see VHA Handbooks 1004.01, Informed Consent for Clinical Treatments and Procedures and 1605.1, Privacy and Release of Information.*

14. MENTAL HEALTH ADVANCE DIRECTIVES (MHAD)

Mental Health Advance Directives are discussed in detail in VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives. MHADs are prepared in advance by patients who may be at risk for losing decision-making capacity in the future due the severity of symptoms of their mental condition. While it is preferable for patients to develop advance directives prior to a hospitalization, development of an MHAD must be offered to a patient with decision making capacity during their hospital admission. Patients may address such issues as restrictions or preferences on medications or treatments that may be used, or other patient concerns. Advance Directives must be implemented and honored in accordance with VHA Handbook 1004.02.

15. STAFFING

a. Interdisciplinary staffing is essential to quality inpatient care and must be sufficient to provide high quality treatment to the diverse inpatient mental health population. Staffing must be adequate in type and number to maintain a safe and therapeutic, recovery-oriented environment. While specific inpatient staffing guidelines are not currently defined, staffing must reflect the range of services that must be provided in the inpatient mental health setting. Staff providing services on the inpatient mental health unit must have dedicated time to provide those services and participate in interdisciplinary treatment team meetings. The following considerations and requirements may also assist in guiding staffing decisions.

b. The Interdisciplinary Team must be comprised of staff from diverse professional backgrounds and with at least four disciplines to ensure a breadth of clinical expertise. Core staff providing services to the patient, including those staff providing medical care, medication management, individual or group psychotherapy and education, case management, and nursing care should be included on the Team. Thus, an Interdisciplinary Team would usually be comprised of staff from at least nursing, social work, psychiatry and psychology, with flexibility at the local level to recognize patient needs, provider expertise, and staffing resources, as long as all functions are covered. Other staff involved in the patient's treatment must be included, for instance, staff providing peer support services, vocational rehabilitation, occupational therapy, recreation and creative arts therapy, kinesiotherapy, nutrition services, or chaplain services.

c. Each unit must be staffed adequately to provide a safe and therapeutic environment. This includes the provision of the broad range of mental health services described in this Handbook. Those services include, but are not limited to, comprehensive assessment and evaluation, medication management, mental health nursing services, psychosocial services, individual and group psychotherapy and psychoeducation, recovery programming, and peer support.

d. Recovery-oriented care requires the coordinated efforts of a broad range of clinicians to provide a full range of health care and psychosocial interventions. Therefore, staffing must

include clinicians to provide pharmacy consultation and services, occupational therapy, recreational and creative arts therapy, kinesiotherapy, vocational counseling, preventive and wellness education, addiction counseling, marriage and family therapy, and other services as appropriate to enhance the care on the unit and meet the needs of individual patients.

16. WORKLOAD AND PRODUCTIVITY

a. Inpatient workload is to be captured in accordance with VHA Directive 2009-002, Patient Care Data Capture. The Directive specifically requires that inpatient mental health services provided by psychiatrists, psychologists, physician assistants, nurse practitioners, clinical nurse specialists and social workers is captured. Workload by other providers who provide care on the inpatient unit, such as pharmacists, occupational therapists and others, should be captured using the same mechanism as other providers.

b. Productivity standards must be established for all providers assigned to the inpatient unit and monitored regularly.

c. As discussed throughout this Handbook, recovery-oriented services must be provided to patients on an inpatient mental health unit. Regardless of where the services are provided, workload must be captured using the inpatient workload method.

d. Similarly, evidence-based psychotherapies provided to patients on an inpatient unit must be captured using the inpatient workload method regardless of where the services are provided.

17. REFERENCES

a. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.

b. Joint Commission Manual E-dition,
<http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointCommissionEDitionAcknldg.aspx>
NOTE: This is an internal VA Web site and is not available to the public.

c. Purser K; Magnar E, Madison J; Competency and Capacity: The legal and medical interface; Journal of Law and Medicine; 2009: 16(5):789-802.

d. U.S. Psychiatric Rehabilitation Association (USPRA) at:
<https://netforum.avectra.com/eWeb/StartPage.aspx?Site=USPRA>.