

**UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL  
CENTERS AND CLINICS**

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook specified the Mental Health Services that are to be available to all enrolled veterans.
- 2. SUMMARY OF MAJOR CHANGES.** This is a new VHA Handbook incorporating new standard requirements for VHA Mental Health Services nationwide.
- 3. RELATED DIRECTIVES.** VHA Directive 1160.
- 4. RESPONSIBLE OFFICE.** The Office of Patient Care Services, Office of Mental Health (116) is responsible for the contents of this VHA Handbook. Questions may be referred to 202-461-7309.
- 5. RESCISSION.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working date of June 2013.

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## UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook lays out minimum requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all enrolled veterans, wherever they obtain care, have access to needed mental health services. It also specifies those services that must be accessible through each VA Medical Center and each Community-based Outpatient Clinic (CBOC). By building the requirements for services on specifications of what must be available to each veteran, no matter where in VHA that they receive care, it is designed to focus on the patient's perspective, and on meeting the care needs for each veteran.

### 2. BACKGROUND

a. Release of this Handbook is a reflection of the high priority that VHA places on enhancing mental health services for returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans, as well as for those who served in prior eras. This document and the requirements for mental health services within it are significant steps in the process that began with approval of the VHA Comprehensive Mental Health Strategic Plan in 2004, and the allocation of funding through the Mental Health Enhancement Initiative to support its implementation beginning in 2005. Distribution of this Handbook will be followed by the distribution of the metrics that will be used to ensure the implementation of its requirements. When fully implemented, these requirements will complete the patient care recommendations of the Mental Health Strategic Plan, and its vision of a system providing ready access to comprehensive, evidence-based care.

b. The VHA Comprehensive Mental Health Strategic Plan and the requirements included in this Handbook have been developed to implement the goals of the President's New Freedom Commission on Mental Health, including the principle that mental health care is an essential component of overall health care. This means that services addressing substance use –related conditions must be integrated or coordinated with other components of mental health care, and that mental health services must be integrated or coordinated with other components of overall health care. Although this Handbook focuses specifically on mental health services, it does so within a comprehensive and integrated healthcare system. The interactions between mental Health and other components of health care will be further clarified by the release of a broader Patient Care Services Handbook within the next 12 months; it will incorporate mental health as an integrated component of overall health care.

### 3. SCOPE

*NOTE: Throughout this Handbook, the term mental health services is meant to include services for the evaluation, diagnosis, treatment, and rehabilitation of both substance use disorders and other mental disorders.*

- a. This Handbook defines requirements for the services that must be provided at VA medical centers, CBOCs, and Veterans Integrated Service Networks (VISNs). The services that must be provided in CBOCs differ according to the size of the clinics. In this Handbook, very large CBOCs are those that serve more than 10,000 unique veterans each year; large CBOCs are those that serve 5000-10,000 veterans; mid-sized CBOCs are those that serve 1,500-5,000 veterans; and small CBOCs are those that serve under 1,500 veterans. **NOTE:** *Other services are at times mentioned, with wording indicating such services “may” be delivered, or that facilities are “encouraged” or “strongly encouraged” to provide them. These indicate suggestions, not requirements.*
- b. It is not the purpose of this Handbook to describe all mental health programming that could be appropriate and effective. Sites are strongly encouraged to go beyond these specifications in developing their mental health programming, in accordance with their challenges, resources, and opportunities. As in the past, VISNs and facilities are strongly encouraged to engage in research and clinical innovation to develop new strategies of care. Ongoing improvements in the VHA system depend on these approaches to developing best practices.
- c. Program specifications are not described in detail, allowing opportunities for local choice, within the specifications, and for developing programs that address local variation in presenting problems. For example, some areas of the country have far more homeless veterans than do other areas, and their specific programming can be expected to vary accordingly.
- d. Care must be provided with fidelity to these specifications. Fidelity includes attention to good program design, to delivery of evidence-based psychotherapy in ways that capture those therapy procedures, and to the provision of pharmacotherapy using evidence-based strategies for choosing medications, implementing treatment, monitoring both side effects and therapeutic outcomes, and modifying treatment when appropriate. Details that are not provided in this Handbook can be found in program documents and Clinical Practice Guidelines. **NOTE:** *Contact the VA Central Office, Office of Mental Health Services with questions or requests for technical assistance at: 202-461-7309.*
- e. Care must be delivered by qualified, trained, competent staff. In general, this Handbook does not specify the professions who should provide the services described, but there must be attention to ensuring that care is provided by those at an appropriate level of training and clinical privileging. All professional staff must have the administrative and clinical support(s) they require to allow them to work efficiently.
- f. These specifications of the mental health services that must be available to each veteran and those that must be provided at each type of facility supplement other requirements for timely access and quality of care. Because VHA is responsible for mental health care to a defined population, it has responsibilities for ensuring ready access to care for new patients, as well as for the continuity and quality of care for established ones. At a time when large numbers of veterans are returning from deployment and combat, ensuring access to care for patients in need must be considered VA’s highest priority.

g. In order to ensure full coverage across a spectrum of needs, the specifications are laid out according to particular program areas. Individual veterans typically present with more than one mental health problem, and, typically, they also present with other health problems as well. Services must not be set up in isolation. It is expected that there will be communication and coordination between services. Every program element described in this Handbook must be understood as a component of comprehensive care.

#### 4. RESPONSIBILITIES

a. **Facility and VISN Mental Health Leadership.** Facility and VISN Mental Health Leadership must work in collaboration with overall leadership at each level to ensure:

(1) There is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for mental health conditions and other components of health care for all veterans.

(2) Every veteran seen in mental health services is assigned a principal mental health provider. When veterans are seeing more than one mental health provider and when they are involved in more than one program, the identity of the principal mental health provider must be made clear to the patient and identified in the medical record. The principal mental health provider will be identified on the patient tracking database for those patients who need case management.

b. **The Principal Mental Health Provider**

(1) The principal mental health provider must ensure that:

(a) Regular contact is maintained with the patient as clinically indicated as long as ongoing care is required.

(b) A psychiatrist reviews and reconciles each patient's psychiatric medications on a regular basis.

(2) Each principal mental health provider must collaborate with the Suicide Prevention Coordinator in each facility to support the identification of those who have survived suicide attempts and others at high risk, and to ensure that they are provided with close monitoring and enhanced care.

(3) The principal mental health provider is responsible for:

(a) Coordinating development of the veteran's treatment plan, incorporating input from the veteran (and, when appropriate, the family),

(b) Monitoring progress, and

(c) Coordinating revisions to the treatment plan, when necessary.

(4) The principal mental health provider has the responsibility for communicating with the veteran (and the veteran's family, when appropriate) about the treatment plan, and for addressing any of the veteran's problems or concerns about the veteran's care.

## 5. SPECIFICATIONS

a. These specifications describe both general mental health services and a number of specific programs focusing on conditions or problems, such as: substance use disorders, Post-Traumatic Stress Disorder (PTSD), military sexual trauma, homelessness, and psychosocial rehabilitation. Although facilities differ in the way they organize and administer these services, when facilities have distinct services or programs, they must develop service agreements defining when and how patients are transferred or co-managed between them.

b.. The specifications in this Handbook for enhanced access, evidence-based care, and recovery or rehabilitation must not be interpreted as deemphasizing respect for the needs of those who have been receiving supportive care. No longstanding supportive groups should be discontinued without consideration of patient preference, planning for further treatment, and the need for an adequate process of termination or transfer.

(1) All veterans receiving mental health care need to be enrolled in a VA primary care clinic to receive primary care. When veterans are not already engaged in primary care in VHA, mental health providers need to assist them in arranging a first visit to primary care. Patients who decline primary care involvement must receive all required screening and preventive interventions in the mental health clinic.

(2) Mental health services must be recovery-oriented. According to the National Consensus Statement on Mental Health Recovery (found at: <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>): "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of the person's choice while striving to achieve ... full potential."

(a) The Consensus Statement lists ten fundamental components of recovery:

1. Self-direction,
2. Individualized and person-centered,
3. Empowerment,
4. Holistic,
5. Non-linear,
6. Strengths-based,
7. Peer support,

8. Respect,
9. Responsibility, and
10. Hope.

(b) As implemented in VHA recovery, it also includes:

1. Privacy,
2. Security,
3. Honor, and
4. Support for VA patient rights.

(3) All mental health care must be provided with cultural competence.

(a) All staff must have training and expertise about military and veterans' culture, and must be able to understand the unique experiences and contributions of those who have served their country.

(b) All staff must receive cultural competence training addressing military and veterans' culture, as well as ethnic and minority issues.

(4) There must be a mental health treatment plan for all veterans receiving mental health services.

(a) The treatment plan must include the patient's diagnosis or diagnoses and document consideration of each type of evidence-based intervention for each diagnosis.

(b) The treatment plan needs to include approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.

(c) As appropriate, the plan needs to consider interventions intended to reduce symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.

(d) The plan needs to be recovery oriented, and attentive to the veteran's values and preferences, as well as the evidence-base regarding what constitutes effective and safe treatments.

(e) The treatment plan needs to be developed with input from the patient, and when the veteran consents, appropriate family members.

## 6. IMPLEMENTATION

a. VA Central Office recognizes that local and regional issues may affect the implementation of these requirements. *NOTE: The Office of Mental Health services needs to be kept informed about such difficulties as they arise and evolve.* Potential barriers to implementation can include:

- (1) Space limitations within VA facilities,
- (2) A relative lack of availability in certain regions of mental health clinicians who could be recruited to the VA,
- (3) Difficulties in meeting information technology needs,
- (4) The distances for patient travel,
- (5) Limitations in the availability of community-based providers who could provide services via sharing agreement, contract or non-VA fee basis care, and
- (6) The time that may be required to develop contacts or other arrangements with local provider organizations.

b. Each VISN must request modifications or exceptions for each medical center and CBOC for those requirements that cannot be met in fiscal year (FY) 2008 and FY 2009 with available and projected resources.

c. VISNs must submit requests for modifications and exceptions to these requirements to the Office of Mental Health Services (116) for informational purposes and to the Deputy Under Secretary for Operations and Management (10N) for approval. Any unresolved issues between the program office and operations will be presented to the Principal Deputy Under Secretary for Health for resolution. Requests are to include mark-ups to this document indicating the specifications of the package of services that will be delivered in each facility together with justifications for the modifications or exceptions, and, where relevant, requests for the additional resources that would enable implementation. These may include requests for medical care funds, medical facilities funds, informatics resources, legal support for contracting, or other resources.

d. Requests for modifications and exceptions need to include plans for ensuring the availability of all required services for veterans who need them, and, where relevant, timetables and milestones for implementation of the requirements at relevant facilities.

## 7. STRUCTURE AND GOVERNANCE OF MENTAL HEALTH SERVICES

a. Each VISN must include a mental health professional as a member of its principal decision-making body. Each facility must include such leadership in its governance.

b. Where there are mental health service lines, or equivalents, recruitment of leadership must be compliant with current VHA policy, which specifies that all mental health leadership

positions must be advertised for all of the core mental health professions (Psychiatry, Psychology, Social Work, and Nursing), and that selection must be equitable among candidates. Evaluation of candidates and selection of leadership needs to consider all relevant factors.

c. Mental health programs must not function as isolated entities. Regardless of the structure of mental health services and of their leadership, there must be mechanisms for ensuring that leadership has coordinated input from all of the mental health professions that serve patients in relevant facilities, and from each of the specialized programs. Mental health leadership has the responsibility to build a coherent program, much like the Chief of Medicine coordinates the activities of a diverse group of specialists.

(1) Each of the core mental health professions needs to be represented by a designated leader in that profession who takes responsibility for the professional practice of that discipline and has responsibilities for mentoring and professional development of staff in that profession. This person needs to have responsibilities for, or direct input into, hiring decisions and performance evaluations.

(2) Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center. Facilities are encouraged to include representation from Vet Centers in this Council. The facility Director may decide whether other professions (e.g., Recreation Therapists, Occupational Therapists, Chaplains, and others) should also be represented.

(a) Reporting

1. Where there is a mental health service line or equivalent, the Mental Health Executive Council reports to its leadership.

2. Where the core disciplines function more independently, the Mental Health Executive Council reports to the Chief of Staff.

(b) Responsibilities. The Mental Health Executive Council is responsible for:

1. Proposing strategies to improve care and consulting with management on methods for improvement and innovation in treatment programs.

2. Working to coordinate communication among and between various departments and specialty mental health programs.

3. Reviewing the mental health impact of facility-wide policies that include, but are not limited to:

a. Policies on patient rights, privileges, and responsibilities;

b. Restraints and seclusion;

- c. Management of suicidal behavior; and
- d. Management of mental health emergencies.

d. Leadership of mental health services in medical centers should have professional oversight of the delivery of mental health care in associated CBOCs. However, this oversight cannot diminish or replace formal lines for reporting for staff at the clinic, or for decision-making about allocation of clinic resources. There must be mechanisms for ensuring communication between the leadership of mental health services and that of the associated CBOCs, such that their mental health delivery needs, activities, and evaluation outcomes are appropriately considered in the governance and decision-making processes for those facilities.

*NOTE: This requirement for oversight and communication is intended to ensure the ability of the CBOC to respond to patients' mental health needs, regardless of the processes used to address them. It applies whether or not the CBOC has specific mental health staffing.*

e. Standards for the productivity of mental health providers are currently being developed. Staffing levels, case loads, or panel sizes for each of the programs and services described in this Handbook will have to meet these standards when they are approved.

## 8. COMMUNITY MENTAL HEALTH

a. Each VISN and each medical center must appoint mental health staff responsible for liaison with State, county, and local mental health systems and with community providers, ensuring coordination of VA activities with those of other public mental health and health systems. Such activities include:

- (1) Informing state, county and local mental health providers about VA services.
- (2) Working through or with existing programs providing liaison with State National Guard programs, and with Vet Centers in their outreach to Post Deployment Health Re-Assessment (PDHRA) events.
- (3) Maintaining awareness of community-based public and private mental health assets, particularly with respect to veterans and their families.
- (4) Developing models for coordinating services for eligible and enrolled veterans and families (e.g., sharing agreements, collocation of staff, providing telemental health).
  - (a) Coordination of telemental health programs needs to be overseen by the Office of Care Coordination.
  - (b) Sharing agreements with the Department of Defense (DOD) and the military services must be coordinated through the office designated for that function.
- (5) Addressing issues regarding involuntary mental health treatment that occur under state laws and sometimes across state lines.

b. When responsibilities for care within a state are divided between two or more VISNs, the VISNs need to coordinate their state liaison activities.

c. VISNs must designate a mental health professional, usually one of the facilities' Suicide Prevention Coordinators, to serve on each State's council or workgroup on suicide prevention.

d. Each VISN and each medical center must designate at least one mental health professional to serve as public spokespersons for specific mental health issues. These individuals must work collaboratively with public affairs, communications offices, and leadership at the local, regional, and national levels. *NOTE: Media training is encouraged.*

e. Each facility must designate at least one individual to serve as a liaison with Readjustment Counseling Centers (Vet Centers) in the area (if any), to ensure care coordination and continuity of care for veterans served through both systems.

f. Facilities need to develop processes and procedures for promoting collaborations between mental health providers and VA Chaplains. Mental health services are encouraged to work with Chaplaincy to develop interactions with community clergy, including training to facilitate collaboration, appropriate referral, and coordination of services.

g. VISNs and facilities must collaborate with Vet Centers in outreach to returning veterans. Outreach activities can include presentations at National Guard or Reserve sites, e.g, PDHRA events.

(1) Outreach to OEF and OIF veterans has several goals: informing recently discharged veterans of the nature of VA benefits including, but not limited to health care benefits; screening veterans for signs and symptoms of mental health conditions; and supporting engagement in clinical services as needed (e.g., enrolling veterans in care, preferably within the 5-year period of enhanced enrollment priority status after discharge for returning combat veterans).

(2) Outreach can involve veterans' families, as well as the veterans themselves, consistent with VHA's legislative authority to work with families.

h. Facilities are strongly encouraged to promote a local mental health Consumer-Advocate Liaison Council to facilitate input from stakeholders on the structure and operations of mental health services.

(1) Mental health Consumer-Advocate Liaison Councils are composed of consumers and family members of consumers, and may include other stakeholders including, but not restricted to:

(a) Veteran Service Organizations (VSOs),

(b) Representatives from the National Alliance for the Mentally Ill (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health advocacy groups active within the local community; and

(c) Local community employment and housing representatives;

(2) If a facility has a Mental Health Consumer-Advocate Liaison Council, at least one VA mental health staff member needs to be designated to serve as a liaison to the Council to facilitate communication with the leadership of the facility's mental health program.

## **9. GENDER-SPECIFIC CARE**

a. Mental health services need to be provided in a manner that recognizes that gender specific issues can be important components of care.

(1) When clinically indicated, eligible veterans (women and men) being treated for military sexual trauma must have the option of being assigned a same-sex mental health provider, or opposite-sex provider if the trauma involved a same-sex perpetrator.

(2) It is encouraged that men and women be offered the option of a consultation or treatment from an opposite-sex mental health provider, when clinically appropriate.

(3) Patients treated for other mental health conditions must have the option of a consultation from a same-sex provider regarding gender-specific issues.

(4) For some medical centers and clinics, these requirements and suggestions may require referral to a provider at a nearby VA facility, use of telemedicine, or use of sharing agreements, contract or non-VA fee basis care.

b. All VA facilities must have environments that can accommodate and support women and men with safety, privacy, dignity, and respect.

c. All inpatient and residential care facilities must provide separate and secured sleeping accommodations for women. Mixed gender units must ensure safe and secure sleeping and bathroom arrangements, including, but not limited to door locks and proximity to staff.

## **10. 24 HOUR A DAY, 7 DAYS A WEEK (24/7) CARE**

a. VHA policy requires that all VHA emergency departments have mental health coverage by an independent, licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, or advanced practice nurse) either onsite or oncall, on a 24/7 basis. For "Level 1A" facilities (those facilities that have higher utilization, higher risk patients, specialized intensive care units, and research and educational, as well as clinical missions), mental health coverage must at a minimum be on-site from 7 am to 11 pm. At other times, it may be on-site or on-call. On-call coverage requires a telephone response within 20 minutes and the ability to implement on-site evaluations within a period of time to be established on a facility-by-facility basis. Psychiatric residents and psychology postdoctoral fellows, where available, may provide coverage with appropriate supervision on site or on call.

b. All medical centers with emergency departments must have resources to allow extended observations or evaluations for up to 23 hours when clinically necessary. This may be

accomplished through accommodations such as observation beds in the emergency departments, or, when consistent with State law and accreditation standards, through arrangements with inpatient units. These may be especially important to allow observations and evaluations of patients presenting in states of intoxication.

c. Urgent care centers must have mental health coverage during their times of operation. "Level 1a" complexity sites must have mental health coverage from a licensed independent mental health provider available on-site during their times of operation at least from 7 am to 11 pm with on-call coverage at other times. For other facilities, urgent care centers must have mental health coverage during their times of operation that may be on site or on call.

d. Providers in Emergency Departments (EDs) and Urgent Care Centers, as well those in mental health care setting must be aware of relevant State laws for involuntary hospitalization. Facilities with locked and secure mental health inpatient units must be prepared to accept involuntary admissions. All other facilities must have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when it is appropriate.

e. All telephone triage programs must have the capacity to evaluate mental health problems. They must have:

(1) Staff, training, and protocols to allow responders to screen for mental health conditions and to know when to contact the mental health provider on call for an evaluation of the screening findings.

(2) A mental health provider on call to provide back-up decision-support when needed.

(3) Procedures to facilitate access to the national suicide prevention hotline when appropriate.

f. CBOCs and facilities without EDs or 24/7 urgent care must have predetermined plans for responding to mental health emergencies when they occur during times of operation. They must also identify at least one accessible VA or community-based ED where veterans are directed to seek emergent care when necessary and:

(1) Develop contracts, sharing agreements or other appropriate arrangements with them for sharing information.

(2) Develop financial arrangements for payment for authorized emergency services and necessary subsequent care.

g. Patients in ED or urgent care settings must be evaluated to establish the urgency of care. When indicated, interventions must be initiated immediately, with follow-up as appropriate. Follow-up for mental health conditions determined to be non-urgent must be within 14 days.

## 11. INPATIENT CARE

a. Inpatient care should be available to all eligible or enrolled veterans who require hospital admissions for a mental disorder, either in the VA medical center where they are treated, a nearby facility, or by contract, sharing agreement or fee-basis referral to a community facility.

b. Secured inpatient units must be available for these veterans when symptoms or conditions represent a danger to themselves or others, and for those who require involuntary admission. Medical centers with secured inpatient units need to be prepared to accept involuntary admissions of enrolled veterans when this is consistent with state law and the practice of relevant judicial bodies. Other medical centers must have agreements with relevant agencies or hospitals to allow them to arrange for involuntary hospitalization when it is appropriate.

c. Inpatient units must promote a positive therapeutic and least restrictive environment and strive to be restraint-free.

d. Acute hospitalization must be available without delay for those who require urgent or emergent admissions.

e. Staff on inpatient units must function as care teams with close coordination of their activities to ensure continuity of care, safety, and effective treatment for all patients.

f. All patients on inpatient units must be evaluated on a continuous basis for symptoms and warning signs of self-destructive and dangerous behaviors, including risks of suicide and violence. When such symptoms or warning signs are observed, the care team must act immediately to optimize safety.

g. All inpatient units must be surveyed at least quarterly with the Environment of Care checklist at: <http://vaww.ncps.med.va.gov/Dialogue/pslog/view.asp?eid=280>. *NOTE: This is an internal VA web site not available to the public*). Safety problems need to be remedied prior to the next quarterly review. Exceptions must be approved by the VISN Director and the VA Office of Mental Health Services.

h. Acute inpatient psychiatry wards need to be staffed at a level that ensures that all patients are safe in the environment of care. One on one (1:1) care may be necessary for patients with a high risk for suicide, especially when the environment of care includes problems that have not yet been remedied.

i. Privacy and a safe environment for all patients are required in all mental health programs, as well as access to gender-specific staff when requested.

j. Inpatient, as well as outpatient care, must be guided by principles of psychosocial rehabilitation with an expectation of recovery. Specifically:

(1) The veteran and, with the veteran's approval, family members must be encouraged to participate in inpatient treatment planning and discharge planning to the fullest extent possible.

(2) Staff evaluations of inpatients must include attention to the veteran's goals, activities directed toward improved functioning, involvement in community activities, and other indices of functioning and role performance.

(3) Treatment goals for inpatients need to be congruent with those expectations for functioning, including discharge to a less restrictive level of care.

k. Discharge planning needs to include consideration of referral to Mental Health Intensive Case Management (MHICM) programs or utilization of other recovery-oriented resources, such as Psychosocial Rehabilitation and Recovery Centers (PRRC) (see subpar. 13b). It also needs to include communication and coordination with primary care.

## 12. RESIDENTIAL CARE

*NOTE: This paragraph and others in this Handbook refer to Residential Rehabilitation and Treatment Programs (RRTPs). This term is used to refer both to those facilities currently designated as RRTPs and to Domiciliaries. Although these programs have different histories, policies and practices should be identical in RRTPs and Domiciliaries.*

a. Each eligible veteran must have timely access to residential care facilities as medically necessary to meet their mental health needs. Mental Health residential care facilities provide specialized, intensive treatment and rehabilitation services; in addition, they can provide supported housing and a therapeutic environment allowing veterans living in rural areas to access the full array of needed and medically necessary mental health services.

b. Each medical center must provide access to Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) for eligible veterans who require this type of care. This requirement can be met:

(1) On a local basis through the availability of Residential Rehabilitation Treatment Programs (RRTPs) at the facility,

(2) On a regional basis through service agreements with other VA facilities, or

(3) By sharing agreements, contracting, or non-VA fee basis care in community facilities.

c. Each VISN must have residential care programs able to meet the needs of women veterans and veterans with a Serious Mental Illness (SMI), PTSD, Military Sexual Trauma, Substance Use Disorders (SUD), Homelessness, and Dual Diagnoses either through special programs or specific tracks in general residential care programs. However, the needs for some types of sub-specialty care (e.g., women with PTSD or veterans with PTSD and SUD) may be limited, and regional or national resources may be needed.

d. Mental health services must be provided to female veterans at a level on par with male veterans at each facility. MH RRTP clinicians must possess training and competencies to meet the unique mental health needs of women veterans.

- e. Each MH RRTP must be in full compliance with current VHA policy.
- f. MH RRTPS must be Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited in Behavioral Health Residential Standards.
- g. Facilities must ensure that waits for admission to a MH RRTP do not delay the implementation of care by instituting processes that include:
  - (1) Ongoing monitoring and case management of referred patients.
  - (2) Provision of treatment as needed to ensure stabilization of target conditions and management of comorbidities. *NOTE: This may include inpatient care.*
  - (3) Utilizing waiting periods to provide pre-group preparation to enhance the experience and benefits of group treatment. Pre-group preparation can be provided on an outpatient basis provided veterans are in a safe and secure environment.
- h. Whenever eligible veterans have an urgent need for care, it must be met.
- i. Whenever there is a gap of greater than 2 weeks for any veteran accepted into an MH RRTP or a closed group program, other forms of care must be provided in the interim.
- j. When the referral to the MH RRTP involves a transfer between facilities, the referring facility must maintain responsibility for care until the time of admission, including responsibility for travel arrangements.
- k. The use of cohort-based or closed group modalities, which can enhance the levels of trust and cohesiveness within group members, especially when highly-sensitive topics are discussed. However, they can also introduce delays in admission and the start of treatment. Use of cohort-based or closed groups is authorized in a VHA facility only when the care system within the facility is designed to ensure that they do not lead to any veteran's being turned away from care.
  - (1) When VHA facilities utilize cohort or closed group treatment, the facility must ensure that this does not limit access to needed care. This may require immediate provision of all required treatment that can be provided outside of the closed group in ambulatory, inpatient or other residential care settings as appropriate.
  - (2) Pre-group preparation can be provided on outpatient basis provided veterans are in a safe and secure environment or in open beds in a MH RRTP.
- l. Facilities must ensure that discharge planning, including an aftercare plan, occurs for all veterans leaving an MH RRTP and that these veterans are provided a "package of care" based on clinical needs at time of discharge.
- m. Facilities must ensure full compliance with VHA Self Medication Program.

n. Facilities must ensure safety and security of all MH RRTPs. Facilities must ensure that each MH RRTP is in compliance with VA and accrediting body standards for safety and security.

o. MH RRTPs require 24/7, on site-supervision. At least one staff member must be physically present on the unit at all times that veterans are present on the unit. The only exception to this requirement is in Compensated Work Therapy (CWT)–Transition Residences (TR). Because residents in these facilities are more stable and functional than those in other MH RRTPs, a peer “house manager” may supervise the residence in lieu of staff. However, professional staff must be available on an emergency basis.

p. Each MH RRTP must be staffed by an interdisciplinary clinical team or teams of health care professionals and paraprofessionals. Attention to the veteran’s medical, social, and psychological needs must be ensured through adequate medical staff, social workers and psychologists. Appropriate supporting administrative and clerical staff must be provided to allow for efficient operation.

q. In most MH RRTPs, staffing includes full-time staff assigned directly to the program and part-time staff from other inpatient or outpatient units providing treatment and rehabilitation services.

r. Special attention must be given to meeting the unique needs of women veterans, especially in the areas of SMI, sexual trauma, homelessness, and interpersonal violence.

s. All MH RRTPs must be sensitive to the special needs of veterans, and to the needs of specific populations, including the: homeless, ethnic minority, women, geriatric patient, SUD, PTSD and other psychiatric comorbidities, infectious disease, Spinal Cord Injury (SCI), and Traumatic Brain Injury (TBI).

t. Based on the MH RRTPs mission and patient demographics, MH RRTP staff must have competencies to meet the individual needs of the special populations

u. Evidenced-based psychosocial treatment interventions must be provided in each MH RRTP. MH RRTPs are strongly encouraged to include Seeking Safety, motivational interviewing, motivational incentives for recovery-related behaviors, and supported employment.

v. All MH RRTPs must have staffing with the training and expertise needed to provide interventions, designed to benefit the veteran, that include residents’ families when these are included in the treatment plan.

### 13. AMBULATORY MENTAL HEALTH CARE

*NOTE: Evaluations and treatment for mental health conditions can be provided in mental health care services, through primary care and other medical care settings, or by arrangements with non-VA community services.*

a. All new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days.

(1) The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs, and to trigger hospitalization or the immediate initiation of outpatient care when needed.

(2) The initial 24 hour evaluation can be conducted by primary care, other referring licensed independent providers, or by mental health providers.

b. Waiting times for all services for established patients must be less than 30 days from the desired date of appointment.

c. Telemental Health services require a qualified professional at the facility and support staff at the distal end who can arrange appropriate time and space for the veteran, and provide who can provide technical support as needed. *NOTES: (1) Use of Telemental Health to support the delivery of services is allowed and encouraged as a mechanism for meeting requirements throughout this document. Nevertheless, it is important to recognize that there may be limits to the services that can be provided using this technology. These may include certain highly interactive and “high-touch” evaluations or interventions. (2) Sufficient band width is required for satisfactory communication. The Mental Health Service needs to consult with the medical center and VISN Information Technology Office to determine specific requirements to have satisfactory clinical video conferencing capabilities.*

d. Psychotherapy groups can be closed or cohort-based, or they can continually be open to new members. There are a number of arguments in favor of closed groups. However, waiting for the formation of a new group can lead to delays in the institution of treatment. Accordingly, closed or cohort-based groups are allowable in VHA facilities only when the facility’s care system ensure that they do not lead to the denial of care for any veteran, and that waiting for the start of a new psychotherapy group does not lead to delays in the implementation of care

(1) Whenever care is needed on an urgent basis, it must be provided.

(2) Patients awaiting the start of a therapy group must be monitored on an ongoing basis. Their care needs must be evaluated, and alternative treatments must be implemented when needed, for example:

(a) When patients are a danger to themselves or others,

(b) When they are experiencing increasing degrees of impairment, or

(c) When they are suffering from severe symptoms.

(3) Waiting periods need to be utilized to provide pre-group preparation to enhance the experience and benefits of group treatment. Whenever patients need to wait for the start of a group, they must be offered an appropriate form of interim treatment.

e. VA Medical Centers must provide general and specialty mental health services.

(1) General mental health services include:

(a) Diagnostic and treatment planning evaluations for the full range of mental health problems;

(b) Treatment services using evidence-based pharmacotherapy, or evidence-based psychotherapy for patients with mental health conditions and substance use disorders;

(c) Patient education;

(d) Family education when it is associated with benefits to the veterans;

(e) Referrals as needed to inpatient and residential care programs; and

(f) Consultation about special emphasis problems including PTSD and Military Sexual Trauma.

(2) Specialty mental health services include:

(a) Consultation and treatment services for the full range of mental health conditions.

(b) Evidence-based psychotherapy.

(c) Mental Health Intensive Case Management

(d) Psychosocial Rehabilitation Services, including: Psychosocial Rehabilitation and Recovery Centers, family psychoeducation, family education, skills training, peer support, and compensated work and supported employment;

(e) PTSD teams or specialists;

(f) Military sexual trauma special clinics;

(g) Homeless programs; and

(h) Specialty substance abuse treatment services.

f. Clinics in medical centers must offer a full range of services during evening hours at least 1 day per week. Additional evening, early morning, or weekend hours need to be offered when they are required to meet the needs of the facilities patient population.

(1) Like medical centers, very large CBOCs, those seeing more than 10,000 unique veterans each year must provide mental health services during evening hours at least 1 day per week. Like medical centers, they must offer services during additional evening, early morning, or weekend hours when they are required to meet the needs of the facilities patient population.

(2) Other CBOCs are strongly encouraged to provide mental health services evenings and weekends.

g. Facilities must offer options for needed mental health services to enrolled veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible. *NOTE: Facilities need to consider making services available by sharing agreement, contract or Non-VA fee basis for other enrolled veterans when travel for VA care represents a hardship.*

(1) This may be through providing residential care in a setting that allows access to needed treatment.

(2) It can include provision of telemental health services with secure access available near the veteran's home, or

(3) It can also include making services available via sharing agreement, contract or non-VA fee basis from appropriate community-based providers, when available.

(4) When veterans decline these options because they prefer to receive care from VA providers, this should be documented.

h. Very large CBOCs, those serving 10,000 or more unique veterans each year, are encouraged to provide MHICM teams, Psychosocial Rehabilitation and Recovery Centers, Intensive Outpatient programs for substance use disorders, and Grant and Per Diem programs for homeless veterans. They are required to provide the other ambulatory care services listed in paragraph 10.

i. Large CBOCs, those serving 5,000 or more unique veterans annually must, provide the general and specialty mental health services required for very large CBOCs, using telemental health as needed to meet this requirement. They must provide a substantial component of the mental health services required by their patients on-site or by telemental health, but they may supplement these services by referrals to geographically accessible VA medical centers, or through sharing agreements, contracts or non-VA fee-basis mechanisms.

j. Mid-sized CBOCs, those serving between 1,500 and 5,000 unique veterans annually must provide general mental health services, using telemental health as needed. Other services must be available to those who need them, on-site or by telemental health, by referral to a VA residential care program or a geographically accessible VA medical center, or through sharing agreement, contract or non-VA fee basis.

k. Smaller CBOCs with less than 1,500 unique veterans are:

(1) To provide access to the full range of general and specialty mental health services to those who need them through on-site services, telemental health, referral to a VA residential care program or a geographically accessible VA medical center, or through either contracts or fee-basing with local providers or organizations.

(2) Strongly encouraged to provide evaluation and treatment-planning services, as well as general mental health services on-site or by telemental health.

#### **14. CARE TRANSITIONS**

Facilities must ensure continuity of care during transitions from one level of care to another. When veterans are discharged from inpatient or residential care settings, they must;

- a. Receive information about how they can access mental health care on an emergency basis.
- b. Be given appointments for follow-up at the time of discharge.
- c. Receive follow-up mental health evaluations within 1 week of discharge.

(1) Facilities are strongly encouraged to provide follow-up within 48 hours of discharge.

(2) When necessary because of the distance of the veteran's home from the facility where the veteran receives follow-up care or other relevant factors, the 1-week follow-up may be by telephone.

(3) However, any indications of clinical deterioration, non-adherence with treatment, or danger to the veteran or others must trigger appropriate and timely interventions.

(4) In all cases, veterans must be seen for face-to-face evaluations within 2 weeks of discharge.

d. Receive follow-up medical evaluations within a time frame established through communication and coordination with primary care or another relevant service.

#### **15. SUBSTANCE USE DISORDERS**

##### **a. Patient-Centered Requirements**

(1) Appropriate services addressing the broad spectrum of substance use conditions including tobacco use disorders must be available for all veterans.

(2) Services for tobacco-related disorders need to be provided in a manner that is consistent with the VA-DOD Clinical Practice Guideline for Management of Tobacco Use, which can be found at: [http://www.oqp.med.va.gov/cpg/TUC3/TUC\\_Base.htm](http://www.oqp.med.va.gov/cpg/TUC3/TUC_Base.htm)

(a) During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for tobacco use.

(b) In addition to education and counseling about smoking cessation, evidence-based pharmacotherapy needs to be available for all adult patients using tobacco products. When provided, pharmacotherapy needs to be directly linked to education and counseling.

(3) All interventions for substance use conditions need to be provided in a fashion that is sensitive to the needs of veterans and of specific populations including the homeless, ethnic minorities, women, geriatric patients, and patients with PTSD and other psychiatric conditions, as well as infectious disease (human immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and hepatitis C), TBI, and SCI.

(4) Services addressing substance use conditions can be provided in VA facilities in SUD specialty care, in primary care and other medical care settings (especially in programs that integrate mental health and primary care), through programs integrating treatment for co-occurring mental health and SUD (dual diagnosis) in mental health settings, or in community settings through sharing agreements, contracts, or non-VA fee basis care. Regardless of the setting, the process of care must recognize the principle that SUDs are, in most cases, chronic or episodic and recurrent conditions that require ongoing care.

(5) Consistent with the National Voluntary Consensus Standards for Treatment of Substance Use Conditions endorsed by the National Quality Forum (2007) and the VA-DOD Clinical Practice Guidelines for Management of Patients with SUD in Primary and Specialty Care Settings, the following services must be readily accessible to all veterans when clinically indicated.

(a) During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for alcohol misuse.

(b) Because population screening is not evidence-based for substance use conditions other than alcohol misuse and tobacco use; primary care, medical specialty, and mental health services need to use targeted case-finding methods to identify patients who use illicit drugs or misuse prescription or over-the-counter agents. The methods need to include evaluation of signs and symptoms of substance use in patients with other relevant conditions (e.g., other mental health disorders, hepatitis C, or HIV disease).

(c) Patients who have a positive screen for, or an indication of, a substance use problem need to receive further assessment to determine the level of misuse and to establish a diagnosis. Diagnostic assessment can be conducted by primary care or other medical providers, mental health providers, or specialists in substance use disorders. Patients diagnosed with a substance use illness need to receive a multidimensional, bio-psychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting psychiatric or general medical conditions.

(d) All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines need to receive education about drinking limits and the adverse consequences of heavy drinking. Additionally, they should receive brief motivational counseling by a health care worker with appropriate training in this area. For patients who are identified as

dependent on alcohol, further treatment must be offered, with documentation of the offer and the care provided.

(e) All health care providers need to systematically promote the initiation of treatment and the ongoing engagement in care for patients with substance use disorders.

1. For patients with SUD who decline referral to specialty SUD treatment, providers in primary care, mental health or other settings need to continue to monitor patients and their substance use conditions. They should utilize their interactions with the patient to address the substance use problems, and to work with them to accept referrals. (Strategies that may enhance motivation to seek SUD specialty care include providing the patient easy-to-read information on the adverse consequences of drinking, having the patient identify problems that alcohol has caused him or her, urging the patient to maintain a contemporaneous diary of alcohol use and the circumstances and consequences associated with it, and frequent appointments with the patient. Interventions with SUD treatment-reluctant patients should always be characterized by a high-degree of provider empathy.)

2. Motivational counseling needs to be available to patients in all settings to support the initiation of treatment.

3. For patients evaluated as appropriate and willing to be admitted to inpatient or residential treatment settings that are not immediately available, interim services must be provided to ensure patient safety and promote treatment engagement.

(f) All facilities must make medically-supervised withdrawal management, available as needed, based on a systematic assessment of the symptoms and risks of serious adverse consequences related to the withdrawal process from alcohol, sedative 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 sharing arrangement, contract, or non-VA fee basis arrangements with a community-based facility.

2. Withdrawal management alone does not constitute treatment for dependence and needs to be linked with further treatment for SUD. Appointments for follow-up treatment must be provided within 1 week of completion of medically-supervised withdrawal management.

(g). Coordinated and intensive substance use treatment programs must be available for all eligible or enrolled veterans who require them to establish early remission from the SUD. These coordinated services can be provided through either or both of the following:

1. Intensive Outpatient services at least 3 hours per day at least 3 days per week in a designated program delivered by staff with documented training and competencies addressing SUD.

2. An all inclusive residential level of care for veterans with SUD provides a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regime.

(h) Multiple (at least two) empirically-validated psychosocial interventions must be available for all patients with substance use disorders, whether psychosocial intervention is the primary treatment or as an adjunctive component of a coordinated program that includes pharmacotherapy. Empirically-validated interventions include motivational enhancement therapy, cognitive behavioral therapy for relapse prevention, 12-step facilitation counseling, contingency management and SUD-focused behavioral couples counseling or family therapy.

(i) Pharmacotherapy with approved, appropriately regulated opioid agonists (e.g., buprenorphine or methadone) must be available to all patients diagnosed with opioid dependence and without medical contraindications. It needs to be considered in developing treatment plans for all such patients. Opioid Agonist Treatment can be delivered in either or both of the following settings:

1. Opioid Treatment Program (OTP). This setting of care involves a formally-approved and regulated opioid substitution clinic within which patients receive opioid agonist maintenance treatment using methadone or buprenorphine.

2. Office-based Buprenorphine Treatment. Buprenorphine can be prescribed as office-based treatment in non-specialty settings (e.g., primary care), but only by a “waivered” physician. Buprenorphine is not subject to all of the regulations required in officially-identified OTPs, but must be delivered consistent with treatment guidelines and Pharmacy Benefits Management criteria for use.

3. Contraindicated. When agonist treatment is contraindicated or not acceptable to the patient, antagonist medications (e.g., naltrexone) needs to be available and considered for use.

4. Pharmacotherapy, if prescribed, needs to be provided in addition to and directly linked with psychosocial treatment and support.

(j) Pharmacotherapy with an evidence-based treatment for alcohol dependence needs to be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, needs to be provided in addition to and directly linked with psychosocial treatment and support.

(k) Patients with substance use illness need to be offered long-term management for substance use illness and any other coexisting psychiatric and general medical conditions. The patients’ conditions needs to be monitored in an ongoing manner, and care needs to be modified, as appropriate, in response to changes in their clinical status.

(l) When PTSD or other mental health conditions co-occur with substance use disorders, evidence-based pharmacotherapy and psychosocial interventions for the other conditions need to be made available, with appropriate coordination of care, where there are no medical contraindications.

(m) Substance use illness must never be a barrier for treatment of patients with other mental health conditions. Conversely, other mental disorders must never be a barrier to treating patients with substance use illnesses. When it is appropriate to delay any specific treatment, other care must be provided.

(6). Consultations from specialist in substance use disorders or dual diagnosis must be available when needed to establish diagnosis and plan treatment.

**b. Facility- and Service-Based Requirements**

(1) Medical centers must provide all of the services listed in subparagraphs 15a through 15m.

(2) CBOCs must make all of the services listed above available to eligible or enrolled veterans. For each service that they do not provide, they need to identify available sites within the VA or community to support timely referral when required.

(3) Primary Care Clinics, whether in medical centers or CBOCs, must provide the components of care listed in preceding subparagraph 14a(5)(a) through 14a(5)(d), 14a(5)(e)1, and 14a(5)(e)2; they may also provide additional services. Specifically, they are encouraged to provide pharmacotherapy in combination with psychosocial interventions through on-site staff, or by telemedicine. Those services that are not provided in the clinics must be made available by referral to other accessible VA clinics or facilities, or through referral via sharing arrangement, contract or non-VA fee basis services in the community.

(4) Medical centers and very large CBOCs must provide care to meet the needs of eligible or enrolled veterans with other coexisting mental health and substance use disorders.

(a) To support the care of patients whose primary problem is a mental health condition, general mental health services must provide the components of care listed in subparagraphs 15a(5)(a) through 15a(5)(e) and 15a(5)(j) through 15a(5)(m).

(b) When care for mental health conditions and substance use disorders are provided in distinct services, there must be mechanisms in place to ensure coordination of care, e.g., care management.

(5) Emergency Departments must have the resources and expertise to evaluate substance-related conditions including intoxication and withdrawal. All medical centers with EDs must have resources to allow extended observations or evaluations for up to 23 hours when clinically necessary. This may be accomplished through accommodations such as observation beds in the ED, or through arrangements with inpatient units.

(6) Trained providers need to be available to administer appropriate brief treatments for substance use disorders face-to-face, by telemental health, or by telephone within 2 weeks of the time that the need is identified.

**16. SERIOUSLY MENTALLY ILL (SMI)**

- a. Recovery and rehabilitation-oriented programs must be available for all SMI patients.
- b. Medical care for SMI patients must meet the same performance measures and quality standards as other patients.
- c. Based upon the evidence for the effectiveness of Assertive Community Treatment services as modified for use in the VA, MHICM programs must be available in all facilities with more than 1,500 patients on the Serious Mental Illness Research and Evaluation Center (SMITREC) psychosis registry. At least four “on the Street” FTE are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA Medical Center so they can provide 24-hour coverage and emergency services. Each team must have a full time registered nurse and at least a Medical Doctor (psychiatrist) or Advanced Practice Registered Nurse (APRN) prescribers dedicated to the team for at least 20 percent time. MHICM teams must provide 75 percent of services in a community setting with an average of two to three contacts per patient per week.
- d. VISNs and facilities are strongly encouraged to provide MHICM-Rural Access Network for Growth Enhancement (MHICM-RANGE) programs in smaller facilities, especially in more rural areas. When implemented in smaller and more rural settings, the MHICM model may need to be modified. The RANGE model, designed for use rural settings, is based on two FTE teams that have collaborative linkages with other VA mental health professionals and with experienced full MHICM teams in the same VISN.
- e. Clozapine (CLZ) prescribing must be available to all eligible or enrolled veterans who may benefit from this agent.
  - (1) VA medical centers must have relevant mental health and pharmacy patches installed. CBOCs must be connected by real time computer link to the parent VA medical center to derive full benefit of safety intercepts that prevent dispensing in case of unacceptably low levels of neutrophil for white blood cell counts in compliance with Federal Drug Administration (FDA) regulations. Primary local responsibility for the program is given to the Chief of Mental Health, or a designee with a medical degree. All patients, physicians, and pharmacies using CLZ must be registered with the FDA. The VA National Clozapine Coordinating Center (NCCC) performs the required registrations for all VA medical centers.
  - (2) Except where it is medically contraindicated, all veterans diagnosed with schizophrenia or schizoaffective disorders with severe residual suffering, symptoms, or impairments must be offered CLZ after two trials of atypical antipsychotic medication with an explanation of its potential risks and its potential benefits. The patient’s consent for CLZ treatment, their refusal, or a psychiatrist’s documentation of contraindications must be documented on the medical record.
- e. Facilities are encouraged to add structured programs for care management for patients with bipolar disorder.

## 17. REHABILITATION AND RECOVERY-ORIENTED SERVICES

a. **Local Recovery Coordinators**: Each VA medical center must maintain the Local Recovery Coordinator (LRC) position first authorized in FY 2007 to help transform local VA mental health services to a recovery-oriented model of care, to sustain those changes, and to support further systemic change as new evidence becomes available on optimal delivery of recovery-oriented mental health care.

(1) The LRC is located within the mental health services line, or the facility's equivalent. In general, this position needs to report to the service line director, or equivalent.

(2) The LRC is responsible for:

(a) Leading the integration of recovery principles into all mental health services provided at the Medical Center and its affiliated CBOC's.

(b) Working collaboratively with the other LRC's in the VISN, one of whom must serve in a coordinator role for VISN level activities, and with national leadership.

(c) Being directly involved in the direct provision of recovery-oriented clinical services.

(d) Providing training and consultation to facility leadership, staff, veterans, and family members regarding the recovery transformation.

(e) Promoting the integration of recovery services across all mental health programs.

(f) Promoting activities to eliminate stigma associated with mental illness.

(g) Ensuring that veterans with SMI are given every opportunity to pursue and be responsible for their own goals.

b. **Psychosocial Rehabilitation and Recovery Programs (PRRC)**. Medical centers with 1,500 or more current patients included on the National Psychosis Registry (NPR) must have a PRRC. *NOTE: Other medical centers with over 1,000 patients on the NPR are strongly encouraged to have a PRRC.*

(1) Facilities currently having Day Treatment Centers (DTCs), day hospitals, partial hospitals, or analogous programs must transform their existing programs into PRRCs.

(2) PRRCs must provide a therapeutic and supportive learning environment for veterans designed to maximize functioning in all domains.

(a) Hours of operation are typically Monday through Friday from 8:00 am to 4:30 pm. However, the actual hours of operation can vary according to the number of patients served and their clinical needs.

(b) Evening and weekend hours must be available when the needs of the population require them.

(c) Typical admission criteria include a Global Assessment of Functioning, (GAF) of 50 or lower (i.e., serious psychiatric symptoms or any serious impairment in social, occupational, or school functioning) and an SMI (diagnosis of psychosis, schizoaffective disorder, major affective disorder, or severe PTSD).

(d) Following the evaluation and treatment planning process, most patients initially participate in the program on a daily or near daily basis.

(e) PRRCs offer a menu of daily treatment alternatives with sufficient variety to support meaningful choice. Veterans should be encouraged to make choices to participate in specific programming alternatives based on their perception of how their programming choices will assist them with goal attainment.

(f) In general, the intensity of each veteran's participation in the program diminishes over time, as skills are acquired so that the veteran can assume meaningful roles in the community.

(g) While services are available as long as necessary, discharge from the program is mutually determined by the veteran in treatment and the PRRC treatment team. Successful discharge from the program is expected when the veteran has gained mastery over any psychiatric challenges and has acquired or mastered the skills enabling the veteran to function in meaningful roles in the community. Following successful discharge from the program, the veteran may participate in any element of the program on an as-needed basis in the future.

(3) A minimum array of services available to veterans in the program through PRRC staff needs to include:

- (a) Individual psychotherapy (e.g., cognitive behavioral therapy for symptoms management);
- (b) Social Skills training;
- (c) Psycho-educational groups;
- (d) Illness management and recovery groups;
- (e) Wellness programming;
- (f) Family psycho-educational and family educational programs;
- (g) Peer support services; and
- (h) Treatment of co-occurring substance use disorders

(4) Additional services that need to be available to PRRC participants that need to be coordinated with the program include:

- (a) Psychiatric diagnostic and treatment services;
- (b) Primary medical care;
- (c) Case management services (including MHICM);
- (d) CWT, Transitional Work Experience, or Supportive Employment.

(5) Staffing recommended in the initial Request for Proposals ( RFP) establishing PRRCs includes a program coordinator, a social worker, a nurse, a psychologist, peer support technicians, and a program support assistant. Actual staffing in each program is determined by the number of veterans served and the services provided.

(6) The services provided within PRRCs need to be available to participants in the full program and to others with SMI who require these services for rehabilitation and recovery.

(7) The VISN Director must make equivalent services available to veterans living in areas distant from PRRCs. These services can be provided through RRTPs or by sharing arrangement, contracting or non-VA fee-basis care with community-based programs.

**c. Family Involvement**

(1) Providers need to discuss family involvement in care with all patients with SMI, at least annually and at the time of each discharge from an inpatient mental health unit. The treatment plan needs to identify at least one family contact, or the reason for the lack of a contact (e.g., absence of a family, veteran preference, lack of consent). As part of this process, providers need to seek consent from veterans to contact families in the future, as necessary, if the veteran experiences increased symptoms and families are needed to assist in care.

(2) Family consultation, and family education or family psychoeducation within existing statute and regulatory counseling authority for eligible veterans with SMI must be provided at all VA medical centers.

(3) Opportunities for family consultation and family education or psycho-education within existing statute and regulatory counseling authority must be provided for all veterans with SMI on-site, by telemental health, or through sharing arrangements, contracting or non-VA fee basis care with community providers.

**d. Social Skills Training**

(1) Social skills training is an evidence-based psychosocial intervention that must be available to all veterans with SMI, whether it is provided on site, by referral, or by telemental health.

(2) Social skills training must be provided at all medical centers.

**e. Peer Support**

(1) All veterans with SMI must have access to Peer Support Services, either on-site or within the community.

(2) Peer Support Technicians (PSTs) must have completed formal training and be certified by a state, where this is available. Where state certification is not available, PSTs must be certified by a non-profit organization approved by the Office of Mental Health Services. If current Human Resources policies do not allow for requirements for certification, hiring of additional PSTs needs to be deferred until requirements and policies can be reconciled.

(3) Current PSTs or others providing equivalent peer support services who were not previously certified are strongly encouraged to begin the certification process no later than August 1, 2008, and to complete it by August 1, 2009.

(4) PSTs must have position descriptions that specifically address the following:

(a) Supervision by mental health program managers (or equivalent) or the designated licensed independent mental health providers.

(b) Authorization to provide services only to eligible or enrolled veterans with mental illnesses who have referrals for peer support indicated in their individualized treatment plans.

(c) Ability to enter progress notes in Computerized Patient Record System (CPRS) with co-signatures by their supervisors, using the Current Procedural Terminology, code for peer support services (i.e., H0038).

(d) Documentation of adherence to ongoing continuing education, reexamination, and recertification requirements of their states or other certifying bodies, as well as adherence to continuing education requirements of local facilities to develop and enhance their specific career and professional skills.

(5) VA facilities must adopt policies and procedures which address the complex issues that may arise with PSTs; these include, but are not limited to policies for: recruitment, dual relationships, reasonable accommodations, and work performance.

(6) VA facilities that utilize volunteers or Without Compensation (WOC) employees to provide peer support services, must follow the same guidelines for training or certification and supervision found in the specifications for employed PSTs, as well as guidelines and training required for volunteers.

**f. Compensated Work Therapy (CWT), Transitional Work Experience, and Supported Employment**

(1) Consultations about the need for and the likely benefits from work-related rehabilitation programs must be available to all eligible or enrolled veterans in all facilities. This can be accomplished through outreach from medical centers or other mechanisms.

(2) Each medical center must offer CWT with both Transitional Work Experience and Supported Employment services for eligible or enrolled veterans with occupational dysfunctions resulting from their mental health conditions, or who are unsuccessful at obtaining or maintaining stable employment patterns due to mental illnesses or physical impairments co-occurring with mental illnesses.

(3) Each very large and large CBOC, those serving more than 5,000 unique veterans each year, needs to provide access to CWT services through outreach from programs based in medical centers using onsite staff, telemental health, or referral to geographically accessible medical centers. Mid-sized and small CBOCs may also utilize sharing arrangements, contracts, or non-VA fee basis referrals to local providers or organizations.

*NOTE: Sharing arrangements, contract and non-VA fee-basis CWT services require approval from CWT program leadership to ensure consistency with CWT regulations and policies.*

(4) When appropriate, services may be provided through referral to residential facilities that allow access to additional medical center-based programs.

## 18. EVIDENCE-BASED TREATMENTS

### a. Evidence-based Psychotherapies

(1) **Evidence-based Psychotherapy for PTSD.** All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) Therapy. Medical Centers and very large CBOCs must provide adequate staff capacity to allow the delivery of evidence-based psychotherapy to their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary.

(2) **Evidence-based Psychotherapy for Depression and Anxiety Disorders.** All veterans with depression or anxiety disorders must have access to Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy. Medical Centers and very large CBOCs must provide adequate staff capacity to allow the delivery of evidence-based psychotherapy to their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary.

*NOTE: Evidence-based psychotherapies and psychosocial interventions are addressed in other paragraphs (see pars. 15, 17, and 24)).*

### b. Evidence-based Somatic Therapies

(1) All care sites, medical centers and CBOCs need to provide evidence-based pharmacotherapy for mood disorders; anxiety disorders including: PTSD; psychotic disorders, SUD, dementia, and other cognitive disorders. Such care is to be consistent with current VA clinical practice guidelines and informed by current scientific literature. *NOTE: Current VA clinical practice guidelines which can be found at:*

*<http://vawww.oqp.med.va.gov/CPGIntra/cpg/cpg.htm> ; and*

<http://vaww.national.cmop.va.gov/PBM/Clinical%20Guidance/Forms/AllItems.aspx> . These are internal VA sites that are not available to the public.

(2) Care can be provided by a physician or appropriately credentialed and supervised advanced practice nurse or physician assistant, and may be provided using telemental health when appropriate.

(a) VISNs and medical centers are encouraged to develop and implement mechanisms for making technical assistance and decision-supports for use of psychopharmacological treatments available to providers at CBOCs as necessary.

(b) Medical centers are strongly encouraged to include clinical pharmacists on their care teams to provide patient and family education and patient monitoring.

(c) Because in many cases combined psychosocial and psychopharmacological treatment has been shown to be more effective than either intervention alone, veterans must have access to combined treatment when indicated. Pharmacotherapy needs to be coordinated with other psychosocial or psychological interventions patients may be receiving, as well as primary and other specialty medical care.

(3) Veterans must have access to electroconvulsive therapy (ECT) in the VISN in which they receive care.

(a) ECT must be provided consistent with VA clinical practice guidelines found at: [http://vaww.oqp.med.va.gov/CPGIntra/cpg/MDD/MDD\\_Base.htm](http://vaww.oqp.med.va.gov/CPGIntra/cpg/MDD/MDD_Base.htm) *NOTE: This is an internal VA site that are not available to the public*), as well as those of the American Psychiatric Association.

1. Staff needs to be knowledgeable about the current scientific literature.

2. Electroconvulsive therapy needs to be coordinated with other psychosocial/psychological, psychopharmacological, and medical care that patients may be receiving.

(b) Patients who respond to ECT require some form of continuation or maintenance treatment to prevent relapses or recurrences.

## 19. HOMELESS PROGRAMS

a. To ensure the availability of outreach and referral services to homeless veterans, all Medical centers and very large CBOCs must designate at least one outreach specialist, usually a clinical social worker, to provide services to homeless veterans. *NOTE: In smaller facilities, this may be a collateral assignment.*

b. All eligible or enrolled veterans who are homeless or at risk for homelessness need to be offered shelter and emergency services either at the nearest VA medical center or through collaborative relationships with providers in the community. Facility staff must ensure that the

homeless veteran has a referral for emergency services and shelter or temporary housing, and transportation as needed to access these services.

c. Each facility must develop and maintain collaborative formal or informal agreements with community providers for shelter, temporary housing, or basic emergency services if those services cannot be provided at the facility. Medical centers may establish contracts for the residential treatment of homeless veterans or those at risk of becoming homeless who are diagnosed with a SMI including those with co-occurring SUD. **NOTE:** *Contract authority is provided in Title 38 United States Code (U.S.C.) 2031 which has been extended until December, 2011.*

d. Each medical center is to develop and maintain relationships with community agencies and providers to support them in working together to allow appropriate placement for veterans together with their families when they are homeless or at risk of homelessness.

e. All facilities must provide homeless eligible veterans, who require more extensive supports, with residential treatment programs. Facilities need to utilize the established programs to relieve the veteran of their homelessness. This may include placement in a Grant and Per Diem Program, Domiciliary or similar residential bed temporary housing, or other transitional housing and supportive service programs.

f. Use of emergency shelter services should generally not exceed 3 days, and should only be used as a last resort. Within that period of time, homeless outreach staff or other qualified clinical staff need to evaluate the veteran and place the veteran in transitional housing, a residential treatment program, or a similar setting as expeditiously as possible. When longer stays are unavoidable, this must be documented in the medical record; in these cases, ongoing Case Management, assessment and evaluation, and referral services must continue until more stable arrangements for housing and treatment have been made.

g. All VA medical centers with an estimated 100 homeless veterans or more in their Primary Service Area must have one Grant and Per Diem Program or alternative residential care setting for homeless veterans.

h. Grant and Per Diem Programs must ensure residential supervision by trained staff on a 24/7 basis. If the supervision is provided by a program volunteer or senior resident, a paid staff member (from the Grant and Per Diem funded program) must be on call for emergencies 24/7.

i. Each VA medical center that has a designated Grant and Per Diem funded program in its area is responsible for designating a Grant and Per Diem Liaison. Each liaison is to provide case management services, and oversight of the Grant and Per Diem funded program as outlined in VHA Handbook 1162.01.

j. Department of Housing and Urban Development (HUD)-VA Supported Housing (VASH) Programs have been established in areas that have a high concentration of homeless veterans. Through a partnership agreement, HUD provides vouchers for permanent housing to veterans who are homeless or at risk for homelessness, while VA provides case management and other clinical services. When appropriate, the housing vouchers can be provided to veterans together

with their families. HUD-VASH programs require one case manager for each 35 veterans served.

k. Each VA medical center is required to hold one Community Homeless Assessment Local Education and Networking Groups (CHALENG) meeting annually with community partners to collaboratively assess the need for services to homeless veterans. Each VA medical center is required to have a designated Point of Contact for CHALENG.

l. Facilities are strongly encouraged to hold Stand Downs annually as part of their outreach activities to homeless veterans and their families. Stand Downs are a significant part of the Department of Veterans Affairs' efforts to provide services to homeless veterans. They are typically one to three day events providing services to homeless veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VA facilities, other government agencies, and community agencies who serve the homeless.

## **20. INCARCERATED VETERANS**

a. Each VISN must appoint and maintain at least one full-time Health Care for Reentry Veterans (HCRV) Specialist to support eligible veterans being released from State and Federal prisons. VISN are encouraged to provide one such specialist for each State, collaborating with other VISNs when States are served by more than one VISN. With assistance from VISN Mental Health leadership, the HCRV Specialist is responsible for:

(1) Identifying and maintaining a system of VA Points of Contact (POC) at each VISN medical center in primary care, homeless, substance abuse, and mental health service programs; and

(2) Working with POCs to engage with eligible veterans being released from prison in need of care.

b. VA is committed to the principle that when eligible veterans' non-violent offenses are products of mental illness, veterans and their communities are often better served by mental health treatment than incarceration. Police encounters and pre-trial court proceedings are often-missed opportunities to connect eligible veterans with VA mental health services as a negotiated alternative to incarceration or other criminal sanctions. Therefore, each VA medical center is strongly encouraged to appoint and maintain an individual who will serve two inter-related functions, both components of the facility's overall outreach and community education efforts: a police training coordinator, with a commitment to educating law enforcement personnel about PTSD, TBI, and other mental health issues relevant to the eligible veteran population.

(1) A Veterans' Justice Outreach coordinator, committed to interfacing and coordinating with the local criminal justice system, including jails and courts.

(2) This individual is responsible for:

- (a) Working with community agencies in providing training to law enforcement personnel.
- (b) Facilitating mental health assessments of eligible veterans charged with nonviolent crimes.
- (c) Working either alone or as part of a team of community and justice system partners to develop and provide to the court a plan of community-based alternatives to incarceration.
- (d) Collaborating with HCRV Specialists in supporting engagement in care for eligible veterans recently discharged from State and Federal prisons.

## **21. INTEGRATING MENTAL HEALTH INTO MEDICAL CARE SETTINGS**

a. VA medical centers and very large CBOCs, those seeing more than 10,000 unique veterans each year, must have integrated mental health services that operate in their primary care clinics on a full-time basis. These services need to utilize a blended model that includes co-located collaborative care and care management.

(1) The co-located, collaborative care model involves one or more mental health professional who are integral components of the primary care team and who can provide assessment and psychosocial treatment for a variety of mental health problems, which include depression and problem drinking.

(2) The care management component can be based on the Behavioral Health Laboratory, the Translating Initiatives for Depression into Effective Solutions (TIDES) model, or other evidence-based strategies approved by the Office of Mental Health Services. It includes mechanisms for systematic monitoring of symptoms and treatment emergent problems such as non-adherence or side effects; decision support; patient education and activation; and assistance in referral to specialty mental health care programs, when needed.

b. Large CBOCs, those seeing between 5,000 and 10,000 unique veterans each year, must have on-site integrated care clinics utilizing a blended model that includes co-located collaborative care and care management, using the TIDES, Behavioral Health Laboratory, or other evidence-based models. The hours and days of availability of integrated care services can vary depending upon the clinical needs of the patient population.

c. Mid-sized CBOCs, those seeing between 1,500 and 5,000 unique veterans, must have a substantial on-site presence of mental health services available to primary care patients. The distribution of services between integrated care and mental health clinics can vary depending upon the clinical needs of the patient population.

d. Smaller CBOCs must provide access to general and specialty mental health services by:

- (1) On-site full or part-time mental health staff;
- (2) Telemental health;

- (3) Referrals to nearby VA medical centers;
- (4) Referrals to nearby Vet Centers, when the services provided meet the patient's needs;
- (5) Either sharing arrangements, contracts or non-VA fee basis care with local providers; or organizations.
  - e. Mental health services including cognitive testing; diagnosis, evaluation, and management of mental health and behavioral symptoms; and family consultation (as appropriate) must be available for all patients with TBI.
  - f. Mental health staffing must be included in polytrauma programs. The extent of staffing must be sufficient to meet the clinical needs of the patient population, and the educational needs of patients, families, and staff.
  - g. All facilities must provide mental health consultations and evaluations on inpatient units, including evaluations of decision-making capacity, within 24 hours of requests or referrals.
  - h. Each SCI center must have integrated mental health assessment and intervention services as part of the inpatient SCI team and outpatient SCI clinics. The extent of staffing must be adequate to address clinical needs of the patient population and the educational needs of patients, families, and staff.
  - i. Each blind rehabilitation center must have integrated mental health assessment and intervention services as part of the Visual Impairment Service Team. The extent of staffing needs to be adequate to address the clinical needs of the patient population and the educational needs of patients, families, and staff.
  - j. Each VA Palliative Care Consult Teams must include a mental health professional as a core member of the team who can focus is on the delivery of mental health services. The extent of staffing must be adequate to address the clinical needs of the patient population and the educational needs of patients, families, and staff.

## **22. INTEGRATING MENTAL HEALTH SERVICES IN THE CARE OF OLDER VETERANS**

- a. Integrated mental health services are especially critical to ensuring access, quality, coordination, and continuity of care for older veterans who are often otherwise much less likely to access mental health services. Accordingly, mental health specialists need to be included in teams serving the needs of older veterans. The extent of staffing must be sufficient to ensure timely access to high quality, integrated care services in each of the settings identified below.
- b. Each VA Community Living Center (CLC) needs to have a full range of integrated mental health services (consisting of, at minimum, 1.0 FTE psychologist for a 100 bed facility) that includes:
  - (1) Psychological assessment.

(2) Cognitive evaluations

(3) Psychological treatment services, specifically including psychosocial, environmental, and behavioral management services.

(4) Geriatric psychopharmacology treatment capacity available to meet the needs of its residents.

c. Each VA Home-Based Primary Care (HBPC) team must have a full-time psychologist or psychiatrist as a core member of the interdisciplinary HBPC team.

(1) The duties of the HBPC mental health provider include psychological assessment, cognitive screening, capacity evaluations, and evidence-based psychosocial treatment and prevention services.

(2) Each HBPC team needs to have geriatric psychopharmacology treatment capacity available to meet the needs of its patients.

d. All VA medical centers and very large CBOCs must have the capacity for conducting dementia screening, diagnostic evaluations and evidence-based interventions. When families or significant others are involved in care giving, the management of veterans with late life dementia needs to include education and support for them, as appropriate. *NOTE: There is a robust evidence-base demonstrating that these interventions benefit the patient.*

e. All VA medical centers and very large CBOCs must have the capacity for evaluating the ability older veterans have for independent living and medical decision-making.

*NOTE: It is strongly recommended that each geriatric clinic have integrated, co-located mental health services consistent with the specifications described in paragraph 13 for general Primary Care clinics, with such services provided by professionals with specific experience in mental health and aging issues.*

### **23. SPECIALIZED PTSD SERVICES**

a. Enrolled veterans with PTSD can be treated in Specialized PTSD Services, general Mental Health Services, or primary care.

b. All VISNs must have specialized residential or inpatient care programs to address the needs of veterans with severe symptoms and impairments related to PTSD. Each VISN must provide timely access to residential care services to address the needs of those veterans with severe conditions and those from rural areas beyond the reach of PTSD Day Hospitals or PRRCs.

c. VISNs and facilities must make services available to address the needs of veterans awaiting admission to PTSD residential care programs. Both condition-focused treatment and pre-group preparation need to be considered.

d. All VA medical centers and very large CBOCs must have:

(1) Specialized outpatient PTSD programs and the ability to provide care and support for veterans with PTSD.

(2) Staff with training and expertise to serve the OEF and OIF population either through an OEF and OIF team, or PTSD program staff.

(3) Either a PTSD Clinical team (PCT) or PTSD specialists, based on locally-determined patient population needs. Consultation and care from PCTs or specialists must be available to all enrolled veterans.

e. All inpatient mental health units must have the capability to treat patients with PTSD.

(1) Larger VA medical centers are encouraged to consider establishing units or tracks with staff trained to address the needs of acutely ill veterans with PTSD, including those from OIF and OEF.

(2) Smaller facilities need to make care or consultation from members of PTSD clinical teams or PTSD specialists available to inpatients

f. All CBOCs need to:

(1) Have the capacity to provide diagnoses and treatment planning for PTSD through full- or part-time staffing or by telemental health with parent VA medical centers.

(a) CBOCs seeing more than 1,500 unique veterans each year must provide treatment services.

(b) When CBOCs seeing less than 1,500 unique veterans are within 1 hour of other VA facilities, they may provide services for PTSD by referral to these other facilities. However, they must consider alternative arrangements for care for those veterans whose travel to the other site would represent a hardship.

(c) When there are no nearby facilities, smaller CBOCs must provide services by telemental health, or by sharing arrangement, contract or non-VA fee-basis referrals to community-based providers.

(2) Make PCTs or Specialist available for consultation and/or care, either on site, by referral to nearby VA medical centers, or by telemental health.

g. All PTSD or Specialist programs must be able to address the care needs of veterans with both PTSD and SUD. These needs can be addressed in two ways with:

(1) Distinct PTSD dual diagnosis programs or tracks that include providers with specific expertise in both PTSD and SUD, or

(2) Structures, processes and formal mechanisms to support the coordination of care for PTSD with that provided in SUD programs. This may include specialized programs of care management for these patients.

h. Care of the intensity available in a PTSD Day Hospital or residential care program needs to be available to all veterans who need it.

(1) Medical centers must provide these services in a PTSD Day Hospital or a PTSD track in PRRC (see par. 17).

(2) CBOCs must make the services available by referral to a program at a geographically accessible medical center, a MH RRTP (see par. 8), or through sharing arrangements, contracts, or fee-basis care with community providers.

i. Although specialized residential care for women and residential dual diagnosis programs can provide needed services, the number of those who require this type of care may currently be below the threshold that would require a facility in each VISN. There is a need to develop a number of these programs as national resources and to arrange processes for referral, discharge, and follow-up. *NOTE: VISNs or VA medical centers that do not have these programs need to develop MOUs with VISNs that have these services.*

## 24. MILITARY SEXUAL TRAUMA

a. All facilities have been required to install the military sexual trauma software application that activates the military sexual trauma Clinical Reminder within CPRS. All eligible or enrolled veterans must be screened for military sexual trauma using this clinical reminder.

b. Veterans screening positive and requesting treatment must be provided free care for mental and physical health conditions related to their experiences of military sexual trauma. Determination as to whether care is military sexual trauma-related is made by the clinician providing care. All military sexual trauma-related care must be designated by checking the military sexual trauma box on the encounter form for the visit.

c. Evidence-based mental health care must be available to all veterans diagnosed with mental health conditions related to military sexual trauma.

d. All medical centers must provide this care through clinicians with particular expertise in sexual trauma treatment.

e. CBOCs need to make care available on-site, by referral to nearby VA medical centers, or by telemental health. Care for military sexual trauma needs to be provided in VA facilities in almost all cases. Sharing agreements, contracts or non-VA fee basis care is to be used only when VA is not able to provide needed services due to geographical inaccessibility.

f. Each VISN Director is responsible for:

(1) Appointing a military sexual trauma POC to monitor and ensure that national and VISN-level policies related to military sexual trauma are implemented at individual facilities within the VISN; and

(2) Providing access to residential military sexual trauma programs for those eligible or enrolled veterans with severe conditions and those who cannot access care on an outpatient basis.

g. Each medical center must appoint a military sexual trauma coordinator to:

(1) Monitor and ensure that national and VISN-level policies related to military sexual trauma screening, education and training, and treatment are implemented at the facility;

(2) Serve as a point person and source of information and problem-solving for military sexual trauma-related issues at the facility; and

(3) Establish and monitor mechanisms to ensure that enrolled veterans with experiences of military sexual trauma are screened and have access to appropriate treatment.

h. When clinically indicated, enrolled veterans (women and men) requesting same sex providers for treatment related to military sexual trauma need to be accommodated in these requests.

## 25. SUICIDE PREVENTION

a. Each VA Medical Center and very large CBOC must appoint and maintain a Suicide Prevention Coordinator (SPC) with a full-time commitment to suicide prevention activities. These activities include but are not limited to:

(1) Tracking and reporting on veterans determined to be at high risk for suicide and veterans who attempt suicide;

(2) Responding to referrals from the National Suicide Prevention Hotline and other staff;

(3) Training of all VA Staff who have contact with patients, including clerks, schedulers and those who are in telephone contact with veterans, so they know how to get immediate help when veterans express any suicide plans or intent

(4) Training those with contact with veterans in community organizations and partners;

(5) Providing general consultation to providers concerning resources for suicidal individuals, as well as expertise and direction in the areas of system design to prevent suicidal deaths within their local VA medical centers.

(6) Ongoing work with providers to ensure that monitoring and treatment is intensified for high risk patients; and

(7) Working with providers to ensure that high-risk patients receive education and support about approaches to reduce risks.

b. SPCs in medical centers must have adequate support to meet these responsibilities in the parent medical center and in the associated CBOCs (except for those with their own SPCs). Mechanisms for support may include appointing more than one SPC, appointing care managers for high risk patients, or providing program support assistants.

c. Facility SPCs must report on a monthly basis to mental health leadership and the National Suicide Prevention Coordinator on the veterans who attempted or completed suicide along with information that is used to determine characteristics and risks associated with these groups of veterans. *NOTE: This information is tracked and trended on a national level by the Center of Excellence at Canandaigua, NY.*

d. Each VA medical center must establish a high risk for suicide list and a process for establishing a Category II Patient Record Flag (PRF) to ensure that patients determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments. (A Category II flag is locally established by individual VISNs or facilities. Category II PRFs are currently used in various VHA facilities for a range of purposes. Some appropriate uses include flagging patients who are enrolled in research trials involving investigatory pharmaceuticals, patients with documented drug-seeking behavior, patients with spinal cord injuries, and homeless veterans who have urgent medical test results. The use of a Category II PRF, like a Category I PRF, needs to be strictly limited to information that is immediately essential for the delivery of safe and appropriate health care.)

e. The facility's SPC and patients' principal mental health providers must work together to monitor high risk patients and to ensure that their care addresses both their suicidality and their mental health or medical conditions. They must ensure that providers follow-up on missed appointments to ensure patient safety and to initiate problem-solving about any tensions or difficulties in the patient's ongoing care.

f. VISNs, VA medical centers, and CBOCs must support and implement each component of VA's Suicide Prevention Program, and support the activities of the SPCs by ensuring they have the time and resources needed.

## **26. PREVENTION AND MANAGEMENT OF VIOLENCE**

All VA medical centers must have Disruptive Behavior Committees responsible for meeting the current training requirements on the prevention and management of disruptive behavior. This training is to extend to all CBOC staff.

## **27. DISASTER PREPAREDNESS**

All facilities must have a designated Mental Health Disaster POC, who can serve as a member of the Facility's Disaster Response Team. Training for the Mental Health Disaster POC needs to be coordinated with training for other disaster response clinicians and emergency management teams at the facility and VISN levels.

## 28. RURAL MENTAL HEALTH CARE

a. This Handbook includes specifications for mental health services for all eligible or enrolled veterans, requirements for those services that must be made available to individuals who need them, and those services that must be provided at medical centers or CBOCs, depending upon their size. These specifications apply to veterans in rural and very rural, as well as urban areas.

b. When there are gaps between needed services, and those that are available at the VA facility nearest to the patient's home, the facility must extend the services available at the facility by: increased staffing or telemental health, referral to another nearby VA facility, making such services available through a referral for residential care when appropriate, and through referrals to community providers using sharing arrangement, contracts or non-VA fee basis care.

c. Combat veterans who require psychotherapy and counseling should be referred to Vet Centers for these services.

d. Basic principles of care for veterans in rural or very rural areas include:

(1) **Ambulatory Mental Health Care.** Facilities must offer options for needed mental health services to enrolled veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible. When necessary, this may be by providing residential care in a setting that allows access to needed treatment. In other cases, it can include provision of telemental health services with secure access near the veteran's home, or sharing arrangements, contracts or non-VA fee basis care from appropriate community-based providers, when available. It must be documented if the veteran declines these options because he or she prefers to receive care from VA providers.

(2) **Residential Care.** Each eligible or enrolled veteran must have timely access to residential care facilities as medically necessary to meet their mental health needs. Mental health residential care facilities provide specialized, intensive treatment and rehabilitation services; supported housing; and a therapeutic environment allowing veterans living in rural areas access the full array of needed and medically necessary mental health services.

(3) **SMI.** VISNs and facilities are strongly encouraged to provide MHICM-RANGE programs in smaller facilities, especially in more rural areas. When implemented in smaller and more rural settings, the MHICM model may need to be modified. The RANGE model, designed for use rural settings, is based on two FTE teams that have collaborative linkages with other VA mental health professionals and with experienced full MHICM teams in the same VISN.

(4) **Specialized PTSD Services.** Each VISN must provide timely access to residential care services to address the needs of those veterans with severe conditions and those from rural areas beyond the reach of PTSD Day Hospitals or PRRCs.