

March 7, 2005

## AUTHORITY FOR MENTAL HEALTH PROGRAM CHANGES

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive describes procedures for requesting changes in mental health programs in VHA.

### 2. BACKGROUND

a. VHA's mental health programs are a benchmark for the Nation for the treatment of conditions such as severe and chronic mental illness, post-traumatic stress disorder (PTSD), addiction disorders, homelessness and the treatment of dual diagnoses, among other areas.

b. Mental health services include inpatient, outpatient, and residential programs for the severely, chronically mentally ill veterans, those with PTSD, veterans with substance abuse disorders, and those who have been dually-diagnosed (i.e., substance abuse and another mental disorder). Mental health services also include Healthcare for Homeless Veterans Programs, Psychosocial Rehabilitation Programs (including Incentive Therapy, Compensated Work Therapy and Supported Employment), and all other mental health programs and services, including those found in Community-Based Outpatient Clinics (CBOCs). Domiciliary Residential Rehabilitation and Treatment Programs are also included.

c. As VHA continues to transform its operations, there is a need to clarify and redefine the role of VHA Central Office in overseeing operational and/or programmatic changes in behavioral health programs.

d. Changes to mental health services or programs that will significantly impact mental health care by location or by specialty service or result in resource reallocations and/or changes in capacity should be discussed with the Mental Health Strategic Healthcare Group (MHSHG). These discussions will ensure that program shifts, new services, and reallocations of resources are consistent with workload projections, policy and clinical practice guidelines, maintenance or enhancement of access to specialized mental health services, and that VA maintains capacity for specialized mental health services to veterans.

e. The determination of what is significant cannot be made solely based on numbers or percentages. However, guidelines for making this determination include:

(1) Closure of a unit or cessation of services at a location.

(2) Reductions or additions of staff that result in reductions to capacity or that result in changes of missions or clinical comprehensiveness due to addition or loss of specialized skills.

(3) Staffing or programmatic changes to any component program of the mental health service where the component program is operating with four or fewer staff.

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f. The establishment of VHA specialized mental health programs has been accompanied by national program evaluations, which provide program-specific information about the effectiveness and efficiency of the specialized programs. Information from these national evaluations provides guidance to field-based managers on strategies to improve local program performance. All specialized behavioral and mental health programs are expected to be enrolled in, and fully participating in, the appropriate national program evaluations.

g. The purpose of requiring VHA Central Office review and approval of proposed changes is not to prevent needed changes from being made, but it is, instead, to ensure that the Department of Veterans Affairs (VA) maintains its national system of mental health care and implements changes consistent with national strategic planning, such as ensuring the inclusion of mental health services in CBOCs according to established standards for the number of unique patients.

**3. POLICY:** It is VHA policy that any significant change to a mental health service or program, including substance abuse treatment programs, requires approval from the Office of the Under Secretary for Health; this includes changes in mission, comprehensiveness of services provided, staffing, or bed levels.

### 4. ACTION

a. **Medical Center Director.** The Medical Center Director is responsible for:

(1) Developing proposals regarding changes in mission, staffing, or bed levels with a detailed plan which addresses, at a minimum, how the change fits into the Veterans Integrated Services Network (VISN) strategic plan in the current and upcoming fiscal years in consultation with the MHSHG prior to sending to the relevant VISN office for review.

(2) Forwarding all proposed changes to the relevant VISN offices for review and approval.  
*NOTE: Depending on the specific catchment area, this may involve more than one VISN office.*

(a) This proposal must indicate how the change fits into the VISN strategic plan in the current and upcoming fiscal years in terms of: *NOTE: The VISN Directors are responsible for ensuring that Network strategic plans include, as a matter of routine, specific plans related to how it will ensure a full continuum of accessible inpatient, outpatient and community-based services, including care and quality management, and performance expectations for behavioral and mental health services.*

1. Local mental health clinician and stakeholder involvement in the proposed change.

2. Expected impact on the numbers of veterans treated.

3. The capacity and infrastructure, both in place and planned, for management or rehabilitation of veterans with problems of substance abuse, PTSD, homelessness, and psychoses both as inpatients and as outpatients in the community.

4. Adherence to VHA relevant policy and practice guidelines.

5. Methods that will be used to monitor the impact on the affected population, including use of standard national data from the national mental health program performance monitoring system and special program reports.

6. Performance measures to ensure continuation of high quality care to affected patients.

(b) In the case of proposed bed closures, proposals must include, as appropriate to the affected program, the specific plans for ensuring:

1. The availability of intensive case management services and other community-based services;

2. Increased access to outpatient follow-up care and community supports:

3. Uniform access to appropriate anti-psychotic or substance abuse therapies, including medications and psychotherapy;

4. Ready access to crisis management support comparable to that available to patients with other conditions or health care needs; and

5. Continuity of care.

(c) The proposal must include the plans or mechanisms to determine and monitor the patient-specific impacts on any patients with continuous lengths of stay of over 30 days or cumulative lengths of stay of more than 90 days in any given 12-month period.

(3) Submitting the formal submission to the Deputy Under Secretary for Health for Operations and Management (10N) for approval.

b. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for:

(1) Forwarding the proposal from 10N to the MSHSG (116) for concurrence. The proposal is then forwarded through Patient Cares Services (11) back to 10N.

(2) Advancing the proposal(s) within the Office of the Under Secretary for Health for decision. *NOTE: Every effort will be made to reach consensus between relevant entities prior to the forwarding of recommendations to the Under Secretary for Health. Areas where consensus has not been achieved will be specifically noted and discussed.*

c. **Office of the Under Secretary for Health.** The Office of the Under Secretary for Health is responsible for notifying the requesting VISN and the MSHSG of the final disposition within 30 days, assuming information provided to address the relevant issues is complete.

**5. REFERENCES:** None.

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**6. FOLLOW-UP RESPONSIBILITY:** The Office of the Chief Consultant, MSHSG, is responsible for the contents of this Directive. Questions may be referred to (202) 273-8434 or (202) 273-7322.

**7. RESCISSION:** VHA Directive 99-030 is rescinded. This VHA Directive expires on March 31, 2010.

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