Department of Veterans Affairs **VHA HANDBOOK 1163.03**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **July 1, 2011**

PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTERS (PRRC)

1. PURPOSE. This Veterans Health Administration (VHA) Handbook provides the procedures, and expectations for developing new Psychosocial Rehabilitation and Recovery Centers (PRRC) or for transforming existing Day Treatment, Day Hospital, or analogous programs to a PRRC.

2. SUMMARY OF CHANGES. This is a new VHA Handbook.

3. RELATED ISSUES. VHA Handbook 1160.01, VHA Directive 1163 and VHA Handbooks in the 1163 series.

4. RESPONSIBLE OFFICE. The Office of Mental Health Services (116) in the Office of Patient Care Services is responsible for the contents of this Handbook. Questions may be referred to the Associate Chief Consultant for Psychosocial Rehabilitation and Recovery Services (352) 376-1611 ext. 4642.

5. RESCISSIONS. None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on/or before the last working day of July 2016.

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PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTERS (PRRC)

1. PURPOSE. This Veterans Health Administration (VHA) Handbook provides the procedures, and expectations for developing new PRRCs or for transforming existing day treatment, day hospital, or analogous programs to a PRRC.

2. BACKGROUND

The President's New Freedom Commission on Mental Health, the Department of Veterans Affairs (VA) Mental Health Strategic Plan (MHSP), and the Uniform Mental Health Services in VA Medical Centers (VAMC) and Clinics (VHA Handbook 1160.01) all call for a transformation of mental health care to a recovery-oriented model. A key component of this transformation, detailed in VHA Handbook 1160.01, involves transforming all existing day treatment centers (DTC), day hospitals, partial hospitals, or analogous programs to PRRCs and establishing new PRRCs where they are needed.

a. These older DTC programs are outpatient stabilization programs for Veterans challenged with serious mental illness and significant functional impairment. The primary aim of these programs has been to manage chronic symptoms and to assist Veterans with avoiding re-hospitalization. These older programs have limited expectations for those in the program to recover or to be fully integrated into the community.

b. PRRCs will replace these programs, and are designed to help Veterans challenged with serious mental illness and significant functional impairment recovery, and integrate into meaningful, self-determined community roles.

3. DEFINITIONS

a. **PRRC:** PRRCs are outpatient transitional learning centers designed to support recovery and integration into meaningful self-determined community roles for Veterans challenged with serious mental illness and severe functional impairment. Programming is curriculum-based and is specifically designed to teach the requisite skills that are necessary for defining and realizing Veteran's self-chosen roles and goals in all domains of health and life. PRRC services are part of the mental health continuum of care and are coordinated with other services in the VAMC and in the community.

b. **Wellness Programming:** Wellness programming is comprised of psychoeducational interventions that teach skills necessary to acquire an active and healthy lifestyle.

4. SCOPE

a. Medical centers with 1500 or more current patients included on the National Psychosis Registry (NPR) must have a PRRC. ***NOTE:*** *This information can be found on: http://vaww.va.gov/HSRDCOMPUTERSUPPORT/annarbor-hsrd/index_smitrec.htm. This is an internal VA Web site not available to the public*

b. Medical Centers with 1000 to 1499 current (Fiscal Year (FY) 2006 and later) patients included on the National Psychosis Registry (NPR) are strongly encouraged to have a PRRC. ***NOTE:*** *This information can be found on: http://vaww.va.gov/HSRDCOMPUTERSUPPORT/annarbor-hsrd/index_smitrec.htm. This is an internal VA Web site not available to the public.*

c. Facilities currently having day treatment centers (DTC), day hospitals, partial hospitals, or analogous programs must transform their existing programs into PRRCs. A formal waiver process is available for some day hospital programs that are time limited and closely associated with Acute Inpatient Psychiatry when there is also a PRRC available.

d. Very large community-based outpatient clinics (CBOC), (i.e., those currently treating 10,000 or more unique Veterans annually, are encouraged to have a PRRC).

e. The services provided within PRRCs need to be available to all enrolled participants of the full program, and to others with serious mental illnesses that require them as needed for rehabilitation and recovery.

f. The VISN Director must make available the services provided through PRRCs to Veterans living in areas distant from PRRCs who need them. These services can be provided through Residential Rehabilitation and Treatment Programs when this level of care is needed or in community-based programs by sharing agreement, contract, or non-VA fee-basis care to the extent that the Veteran is eligible.

g. Any development of new PRRCs or transformation of day of treatment, day hospital, or analogous programs currently must come from local facility funds.

h. The office of Mental Health Services (OHMS) in VA Central Office is responsible for establishing, maintaining, and communicating policy regarding PRRCs and for evaluating the effectiveness of the program.

5. MISSION, VISION, AND VALUES

a. **Mission.** PRRCs provide Veterans with a transitional educational center that will inspire and assist them to reclaim their lives, instill hope, validate strengths, teach life skills, and facilitate community integration in meaningful self-determined roles. PRRCs provide Veterans with serious mental illnesses an avenue to define and pursue a personal mission and vision for their future based on their identified strengths and self-chosen values, interests, personal roles, and goals.

b. **Vision.** All Veterans served in PRRCs will define and pursue a self-determined personal mission and vision for their lives and have access to support, education, and effective treatment that fosters improvements in all domains of their lives. These Veterans will develop the skills necessary to set and achieve self-determined goals that result in meaningful roles in the community. They will have consistent access to recovery-oriented interventions and natural community-based supports--essentials for living, working, learning, and contributing fully in the

community. PRRC staff will embrace, incorporate and practice using the core principles of psychosocial rehabilitation in all interactions, interventions and program development.

c. **Values**

(1) All individuals have the capacity to learn and grow. Recovery is the ultimate goal of PRRC programming. Interventions must facilitate the process of recovery.

(2) PRRC programming helps Veterans re-establish normal roles in the community.

(3) PRRC services are individualized; person-centered; strength-based and promote hope, responsibility, and respect.

(4) PRRC services facilitate an enhanced quality of life for each person receiving them.

(5) All people are to be treated with dignity and respect.

(6) Veterans receiving PRRC services have the right to direct their own affairs, including those that are related to any psychiatric illness. Veterans must be educated on how they can plan ahead for periods of acute illness.

(7) PRRC services are designed to address the unique needs of each Veteran consistent with the Veteran's cultural values and norms.

(8) PRRC staff make a conscious effort to eliminate labeling, stigma, and discrimination particularly based upon a disabling condition.

(9) Cultural, ethnic, religious or spiritual beliefs, and individual differences must not be limiting factors in the provision of PRRC services, and they can play an important role in the recovery process as sources of strength and enrichment for the individual Veteran as well as for the program.

(10) PRRC staff actively encourages and support program participants in community activities throughout their involvement in the rehabilitation process.

(11) PRRC services are to be coordinated, accessible, and readily available as long as needed.

(12) Veterans with serious mental illness can participate in meaningful self-determined community roles such as school, work, personal relationships, and recreational, spiritual, or volunteer activities.

(13) The involvement of family members and significant others is often an essential ingredient of the process of rehabilitation and recovery. After obtaining consent as set forth in VHA Directive 1004.1 and VHA Handbook 1160.01 from the Veteran, the involvement of family members must be supported in every situation where it is appropriate.

(14) PRRC staff need to constantly strive to improve the services they provide.

6. PRRC PROGRAM ELEMENTS

a. **Program Structure**

(1) PRRCs are outpatient programs.

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

(3) **Hours of Operation and Weekend Programming.** 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 Veterans served and their clinical needs. During evening and weekend hours all Veterans are encouraged to develop and make use of natural community opportunities (e.g., social activities, parks, libraries, churches, museums, preferred houses of worship) and relationships (e.g., family, friends, and social groups). Evening and weekend hours must be available on an as-needed basis to support Veterans' emerging skill development and integration in the community. ***NOTE:*** *See subpar 4g.*

b. **Core Services.** A minimum array of services available to Veterans through PRRC staff should include:

(1) Individual recovery planning,

(2) Individual psychotherapy (e.g., cognitive behavioral therapy, motivational enhancement therapy, and/or supportive therapy to assist with defining/realizing the Veteran's preferred life roles and goals),

(3) Social Skills training classes,

(4) Psycho-educational classes,

(5) Illness management classes,

(6) Wellness programming to promote an active and healthy lifestyle (e.g., nutrition, importance of regular meals, sleep hygiene, exercise, smoking cessation, healthy leisure activities, weight management, pain management, chronic disease management),

(7) Family psychoeducational and family educational programs,

(8) Peer Support Services, and

(9) Treatment of co-occurring substance use disorders.

c. **Responsibilities of Program Manager or Coordinator.** The Program Manager or Coordinator reports to the local facility mental health leader or designee. The Program Manager or Coordinator is responsible for:

(1) Oversight of day-to-day program operations.

(2) Coordination of other Physical, Mental Health, or Psychosocial services.

(3) Ensuring that program staff adhere to the PRRC policies and procedures.

d. **Characteristics of PRRCs**

(1) PRRCs must provide a therapeutic and supportive learning environment for Veterans and must be designed to maximize functioning in all domains of health and life.

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

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

(4) In general, Veteran participation diminishes over time as skills are acquired to assume meaningful roles in the community.

e. **Programs and Services to be coordinated with PRRCs.** Other services that must be available to PRRC participants as clinically indicated and coordinated with the program include:

(1) Psychiatric diagnostic and treatment services,

(2) Primary medical care,

(3) Case management services including Mental Health Intensive Case Management, and

(4) Compensated Work Therapy including Transitional Work Experience and Supportive Employment as clinically indicated.

f. **Location.** Ideally, PRRCs are located in the community with readily accessible public transportation. When PRRCs are on Medical Center grounds, efforts should be made to locate it in an outpatient area which is separate from the mental health clinic, and separate from where other traditional mental health services are provided.

g. **Staffing Guidelines/Recommended Panel Sizes**

(1) Staffing recommended in the initial Request for Proposals (RFP) establishing PRRCs

includes: 1.0 Program Manager or Coordinator, 1.0 Masters prepared Social Worker, 1.0 Masters prepared Advanced Practice Nurse, 1.0 Psychologist, 1.0 to 2.0 Peer Support Technicians, and 1.0 Program Support Assistant. Actual staffing in each program is determined by the number of Veterans served, severity of impairment, and the services provided.

h. **Supervision of Unlicensed Staff.** Supervision of unlicensed staff (e.g., peer support providers and other non-licensed providers) must be conducted in a structured manner which ensures the delivery of safe and effective clinical services. Licensed independent providers must be located in the same area, and be readily available to unlicensed staff. Additionally, supervision of peer support providers must comply with the guidelines outlined in Appendix B, Peer Support, in this Handbook.

i. **Screening and Admission Criteria**

(1) Diagnostic inclusion criteria: All Veterans initially admitted to the program must have a primary diagnosis of serious mental illness. Veterans with co-morbid substance use disorder issues are candidates for admission. 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 a serious mental illness diagnosis of any psychotic disorder (e.g., schizophrenia or schizoaffective disorder), a major affective disorder (e.g., bipolar disorder or major depressive disorder), or severe Post-Traumatic Stress Disorder (PTSD).

(2) Diagnostic exclusion criteria: Diagnostic exclusion criteria include severe personality disorder, debilitating active (untreated) substance use disorders, dementia and severe organicity that would significantly impair learning in a curriculum-based environment.

j. **Drug and Alcohol Screening**

(1) All individuals with a co-occurring alcohol or other substance use disorders are screened for current use prior to admission to the program. Substance use illness must never be an insurmountable barrier for treatment of Veterans with mental health conditions. Veterans cannot be denied admission to PRRCs based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number or recency of previous treatment episodes, the appropriate use of prescribed controlled substances or legal history. The screening process must consider each of these special circumstances and determine whether the PRRC can meet the individual Veteran's needs appropriately while maintaining the program's safety, security, and integrity. However, individuals will be prohibited from participating in PRRC services while under the influence of alcohol or other non-prescribed drugs since this limits their ability to benefit from the program and may interfere with the progress of other Veterans in the program.

(2) PRRCs may not provide the appropriate treatment objectives and therapies for many Veterans with active (untreated) substance use disorders. In these cases, efforts need to be made to partner with the Veteran and the primary treatment team to identify therapeutic services that would meet the Veteran’s current needs. PRRC programming will be made available when the Veteran is more likely to benefit from the array of PRRC services.

(3) To ensure a substance-free environment, Veterans enrolled in the PRRC must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their personal recovery plans. Individuals who do not adhere to this monitoring policy are subject to discharge from the PRRC with continuing services provided in appropriate alternate levels of care.

k. **Recovery Plans.** A recovery plan must be completed with each Veteran admitted in the program for 10 days or longer. The recovery plan is jointly completed by the Veteran and their clinical team. The recovery plan reflects an organized approach toward assisting Veterans with identifying specific meaningful roles and goals. Additionally, there is a clear link between Veteran's participation in specific elements of PRRC programming and accomplishing specific goals and objectives detailed in the recovery plan.

l. **Clinical Documentation.** Appropriate documentation of program involvement and progress for each Veteran towards accomplishing their recovery plan occurs for each day of participation in the program. Clinical documentation reflects adequate supervision of services provided by unlicensed clinical staff.

m. **Duration of Treatment and Discharge Criteria**

(1) While services are available as long as necessary, discharge from the program is mutually determined by Veterans in treatment and the PRRC treatment team. Successful discharge from the program to a less intensive level of care is expected when Veterans have gained mastery over their psychiatric challenges and have acquired or mastered the skills that enable them to function in meaningful roles in the community.

(2) Following successful discharge from the program, Veterans may participate in any element of the program on an as-needed basis in the future.

n. **Meals.** Including meals is not a requirement of PRRC programming. If meals are provided, there needs to be a clear, written psychosocial rehabilitation rationale in the participating Veteran's recovery plan which includes successive approximations and ultimate independence in this area.

o. **Transportation of Veterans.** Integration into meaningful roles in the community is one of the primary aims of PRRC programming. Acquiring transportation independence significantly expands the Veteran's options available to them in the community. When transportation is provided to eligible Veterans at the PRRC as part of their treatment, the transportation should be part of an overall plan of facilitating community integration and transportation independence.

p. **National PRRC Program Monitoring/Data Collection**

(1) Program monitoring and outcome measures are under development. OHMS is responsible for developing and implementing outcome measures for PRRCs, analyzing the data

it receives, and communicating the findings with the local facilities.When the program monitoring process is implemented, PRRC staff will actively participate. This includes timely submission of all required information as requested.

(2) Workload for PRRC is captured using the following stop codes:

(a) 582- PRRC individual.

(b) 583- PRRC group.

(c) 584- PRRC telephone.

q. **Quality Improvement Initiative.** As required by the Commission on Accreditation of Rehabilitation Facilities (CARF), PRRCs will have organized, regular, and planned quality improvement initiatives to systematically improve their services.

r. **Accreditation.** Endorsement from external accreditation agencies is an important aspect of ensuring ongoing high quality programming. In connection with this, PRRCs will meet the most recent version of the CARF Behavioral Health Standards (Sections 1 and 2 as well as Community Integration Standards). PRRCs will also obtain and maintain the applicable Joint Commission Behavioral Health Standards detailed in the most recent version of the Joint Commission Accreditation Manual for Hospitals. All PRRCs must have CARF and Joint Commission accreditation by FY 2012 and comply with the OMHS schedule for applying for accreditation.