

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

1. REASON FOR ISSUE. This revised Veterans Health Administration (VHA) Handbook defines minimum clinical 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 veterans, wherever they obtain care in VHA, have access to needed mental health services.

2. SUMMARY OF MAJOR CHANGES. This VHA Handbook incorporates the new standard requirements for VHA Mental Health Services nationwide. It also specifies those services that must be provided at each Department of Veterans Affairs (VA) Medical Center and each Community-Based Outpatient Clinic (CBOC).

3. RELATED DIRECTIVES. VHA Directive 1160 (to be published).

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. VHA Handbook 1160.01 dated June 11, 2008, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working date of September 2013.

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

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UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes minimum clinical 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 veterans, wherever they obtain care in VHA, have access to needed mental health services. It also specifies those services that must be provided at each Department of Veterans Affairs (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. **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.*

2. BACKGROUND

a. VHA places a high priority 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 Handbook 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. **NOTE:** *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 health care system.

c. Statutory and regulatory eligibility and enrollment criteria are different amongst the various programs discussed in this Handbook, which does not replace, change or supersede the existing statutory and regulatory criteria governing these programs. VHA employees are encouraged to become familiar with the statutory and regulatory eligibility and enrollment criteria for each of the programs discussed in this Handbook, and to consult their respective VHA program office or business office as needed.

3. SCOPE

a. This Handbook defines requirements for the services that must be provided as clinically needed at VA medical centers and CBOCs. 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.

(1) In this Handbook, the services that must be “available” are those that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible.

(2) The services that must be “provided” are those that must be delivered when clinically needed to patients receiving health care at a facility by appropriate staff located at that facility, or by telemental health.

(3) Some services or other provisions are mentioned, with wording indicating such that they “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 must 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 as needed to each veteran and those that must be provided as needed 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 an integrated component of overall health care.

4. RESPONSIBILITIES

a. **Facility and Veterans Integrated Service Network (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 must 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.

(c) Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).

(d) Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.

(e) The treatment plan is revised, when necessary.

(f) The principal therapist or principal mental health provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as patients with a diagnosis of schizophrenia or schizoaffective disorder, such communications needs to include discussions regarding future mental health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).

(g) The treatment plan reflects the patient's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the principal mental health provider suspects that the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure that the veteran's decision making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogates' verbal consent to the treatment plan.

(2) Each principal mental health provider must collaborate with the Suicide Prevention Coordinator (SPC) 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 increased monitoring and enhanced 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 (MST), 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 (see current VHA policy regarding service agreements).

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 are to 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 who are not veterans must have training about military and veterans' culture in order to 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 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, attentive to the veteran's values and preferences, and evidence-based 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. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

6. IMPLEMENTATION

a. VA Central Office recognizes that local and regional issues may affect the implementation of these clinical 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 using a sharing agreement, contract, or non-VA fee basis care to the extent that the veteran is eligible; 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 clinical requirements to the Office of Mental Health Services (116) for informational purposes and to the Deputy Under Secretary for Health for Operations and Management (10N) for approval. Any unresolved issues between the program office and (10N) must 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 clinical 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) Within each medical center, 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. **NOTE:** *Facilities are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council.* The facility Director may decide whether other professions (e.g., Recreation Therapists, Occupational Therapists, Chaplains, as well as representatives from the Integrated Ethics program, and others) are also to 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 policies on:

a. 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 needs to 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.

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 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' SPCs, 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 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 and PDHRA events.

(1) Outreach to OEF and OIF veterans has several goals:

(a) Informing recently discharged veterans of the nature of VA benefits including, but not limited to health care benefits;

(b) Screening veterans for signs and symptoms of mental health conditions; and

(c) Supporting engagement in clinical services as needed.

(2) Outreach can involve veterans' families, as well as the veterans themselves, consistent with VA's legal authority.

h. Facilities are strongly encouraged to implement and maintain 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 must be designated to serve as a liaison to the Council to facilitate communication with the leadership of the facility's mental health program.

(3) The Federal Advisory Committee Act (FACA) may be applicable to the Consumer-Advocate Liaison Council. Facilities must consult with Regional Counsel to ensure compliance with FACA, if applicable.

9. GENDER-SPECIFIC CARE

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

(1) Facilities are strongly encouraged, when clinically indicated, to give veterans (women and men) being treated for MST the option of being assigned a same-sex mental health provider, or opposite-sex provider if the trauma involved a same-sex perpetrator.

(2) Facilities are strongly encouraged to give patients treated for other mental health conditions the option of a consultation from a same-sex provider regarding gender-specific issues. **NOTE:** *Facilities are encouraged to offer men and women treated for other mental health conditions the option of a consultation or treatment from an opposite-sex mental health provider, when clinically appropriate.*

b. All VA facilities must 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 (EDs) have mental health coverage by an independent, licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, or advanced practice nurse) either on site or on call, on a 24/7 basis. For "Level 1A" facilities (those facilities that have higher utilization, higher risk patients, specialized intensive care units, and research, educational, and clinical missions), mental health coverage must at a minimum be on-site (based in the ED) from 7 am to 11 pm. At other times, it may be on-site or on-call. For other facilities, coverage may be either on-site or on-call at all times. 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 ED coverage. If that coverage is on site, then a psychiatry or psychology supervising attending must also be present in the ED. Psychiatry residents or psychology fellows who are on call and respond to requests for ED consultation are expected to contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop and recommend a plan of management.

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 EDs, 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 EDs and Urgent Care Centers, as well those in mental health care settings must be aware of relevant State laws for involuntary hospitalization, and consult Regional Counsel as needed.

(1) Facilities with locked and secure mental health inpatient units must be prepared when it is feasible to accept involuntary admissions resulting from civil commitments for those veterans for whom VHA provides health care services.

(2) All other facilities must have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when it is appropriate.

(3) Requirements for facilities to accept involuntary hospitalizations resulting from civil commitments do not apply when another agency of Federal, State, or local government has the duty to give the care or services in an institution of such government.

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

(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. All 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:

(1) Identify at least one accessible VA or community-based ED where veterans are directed to seek emergent care when necessary,

(2) Develop contracts, sharing agreements or other appropriate arrangements with them for sharing information, and

(3) 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 must be available to all 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 non-VA fee-basis referral to a community facility to the extent that the veteran is eligible.

b. Secured (locked) inpatient mental health units must be available for these veterans when symptoms or conditions require them. Secured inpatient units in VA medical centers must be prepared when it is feasible to accept involuntary hospitalizations resulting from civil commitments for veterans for whom VHA provides health care services.

(1) Requirements for facilities to accept involuntary hospitalizations resulting from civil commitments do not apply when another agency of Federal, State, or local government has the duty to give the care or services in an institution of such government.

(2) Facilities must consult regional counsel, as needed, to ensure that local policies are consistent with Federal, State, and other applicable laws.

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 as clinically indicated for 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 or mitigated prior to the next quarterly review. Requests for exceptions must be approved by the VISN Director and the VA Office of Mental Health Services.

h. Acute inpatient psychiatry units 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.

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

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

(1) The veteran or the veteran's authorized surrogate and, with the veteran's consent, family members must be encouraged to participate in inpatient treatment planning and discharge planning to the fullest extent possible. **NOTE:** *Involuntarily committed patients are to be presumed to have decision-making capacity, unless a formal assessment has determined they lack capacity for a specific treatment decision.*

(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:

(1) 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. 17.b); and

(2) Communication and coordination with primary care.

12. RESIDENTIAL REHABILITATION AND TREATMENT PROGRAMS (RRTP)

NOTE: *Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) provide residential rehabilitative and clinical treatment for veterans who have a wide range of problems, illnesses, or rehabilitative care needs. These can be medical, psychiatric, vocational, educational, and social and could be related to Substance Use Disorder (SUD), homelessness and other conditions or problems. The term MH RRTP is used to refer to those facilities currently designated as Psychosocial Residential Rehabilitation Treatment Programs (PRRTPs), Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Programs (PTSD-RRTPs), Substance Abuse Residential Rehabilitation Treatment Programs (SAR RTPs), and Compensated Work Therapy (CWT)-Transitional Residence (TRs), as well as Domiciliaries, also designated as Domiciliary Residential Rehabilitation Treatment Programs (DR RTPs), and Domiciliary Care for Homeless Veterans (DCHVs). Although these programs have different histories and different eligibility policies, the clinical policies and clinical practices are identical.*

a. Given their distinct mission to serve veterans with multiple and severe deficits, MH RRTPs must not be used as a substitute for community housing or as VA lodging or Hoptel facilities. Additionally, VA lodging or Hoptel facilities do not provide the necessary structure, programming, support, and are not an appropriate alternative or replacement for an MH RRTP

b. Each veteran who requires domiciliary care or residential rehabilitation and treatment programs must have timely access to these residential care programs as medically necessary to

meet the veteran's need for specialized, residential, intensive mental health treatment, and rehabilitation services.

c. Each medical center must provide access to MH RRTP services for veterans who require this type of care. This requirement can be met:

(1) On a local basis through the availability of MH RRTP at the facility,

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

(3) By sharing agreements, contracts, or non-VA fee basis care to the extent the veteran is eligible, in community facilities.

d. Each VISN must have residential care programs able to meet the needs of women veterans and veterans with a Serious Mental Illness (SMI), PTSD, MST, 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.

e. Mental health services must be provided as needed to female veterans at a level equivalent to their male counterparts at each facility. MH RRTP clinicians must possess training and competencies to meet the unique mental health needs of women veterans.

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 veterans awaiting admission to an RRTP have an urgent need for mental health care, appropriate mental health services must be provided.

i. Whenever there is a gap of greater than 2 weeks for any veteran accepted into an MH RRTP, providers must maintain clinical contact with the veteran until the time of admission, and address any urgent mental health care needs that arise.

j. When the referral to the MH RRTP involves a transfer between facilities, the referring facility must maintain full responsibility for the patient until the time of admission.

Responsibility for travel arrangements and transfer expenses must be determined in accordance with current VHA inter-facility transfer policy.

k. The use of cohort-based or closed group modalities can enhance the levels of trust and cohesiveness between 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 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 for veterans outside of the closed group in ambulatory, inpatient, or other residential care settings as appropriate.

(2) Pre-group preparation can be provided when needed 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 services based on a plan of care addressing clinical needs at time of discharge.

m. Facilities must ensure full compliance with MH RRTP Safe Medication Management (SMM) procedures. **NOTE:** *VHA Handbook 1108.3 Self Medication Program does not apply to MH RRTPs.*

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 for mental health rehabilitation and treatment services provided in CWT-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 when needed 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, but not limited to: the homeless; ethnic minorities; women; geriatric patients; those with SUD, PTSD, and other psychiatric comorbidities; infectious disease; Spinal Cord Injury (SCI); and Traumatic Brain Injury (TBI).

t. Based on the MH RRTP's mission and patient demographics, MH RRTP staff must have competencies to meet the individual needs of special populations.

u. Evidenced-based psychosocial treatment interventions must be provided when they are needed clinically in each MH RRTP. **NOTE:** *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 licensed independent 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 staff who can provide technical support as needed.

(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 Offices 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 ensures 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 veterans have an urgent need for mental health care, appropriate mental health services 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 when those receiving care from the medical centers need them.

(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 MST.

(2) Specialty mental health services include:

- (a) Consultation and treatment services for the full range of mental health conditions;
- (b) Evidence-based psychotherapy;
- (c) MHICM;
- (d) Psychosocial Rehabilitation Services, including: PRRCs, family psycho-education, family education, skills training, peer support, and CWT and supported employment;
- (e) PTSD teams or specialists;
- (f) MST 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 facility's patient population.

(1) Like medical centers, very large CBOCs, those seeing more than 10,000 unique veterans each year, must provide mental health services to those who need them 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 facility's patient population.

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

g. Facilities must offer options for needed mental health services to veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible.

(1) This may be through providing care in a MH RRTP when this is clinically necessary.

(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 by using a sharing agreement, contract, or non-VA fee basis to the extent that the veteran is eligible from appropriate community-based providers, when available.

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

h. Very large CBOCs, those serving 10,000 or more unique veterans each year, are encouraged to provide MHICM teams, PPRCs, intensive outpatient programs for SUD, and Grant and Per Diem programs for homeless veterans. They are required to provide the other ambulatory care services listed in paragraph 13 when these are needed.

i. Large CBOCs, those serving 5,000 or more unique veterans annually, must provide the general and specialty mental health services required (see subpar. 13e) for those who need them, 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 to the extent that the veteran is eligible.

j. Mid-sized CBOCs, those serving between 1,500 and 5,000 unique veterans annually, must provide general mental health services as required by their patients, using telemental health as needed. Other services must be available to those who need them by using:

- (1) On-site or telemental health;
- (b) Referral to a VA MH RRTP when this type of care is needed;
- (c) Referral to mental health services at a geographically-accessible VA medical center; or
- (d) A sharing agreement, contract, or non-VA fee basis to the extent that the veteran is eligible .

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 MH RRTP when this type of care is needed, by referral to mental health services at a geographically accessible VA medical center, or through either contracts or non-VA fee-basis to the extent the veteran is eligible 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) 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. When veterans refuse these evaluations, the refusal must be documented. When veterans miss scheduled appointments, there must be follow-up and documentation in the clinical record.

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 (SUD)

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 who need them.

(2) Services for tobacco-related disorders need to be provided to those who need them 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

(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) To the greatest extent practicable and consistent with clinical standards, interventions for substance use conditions must be provided when needed in a fashion that is sensitive to the needs of veterans and of specific populations including, but not limited to: the homeless; ethnic minorities; women; geriatric patients; and patients with PTSD, other psychiatric conditions, and patients with infectious diseases (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 disorders and SUD (dual diagnoses) in mental health settings, or in community settings through sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible. 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. These 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 must receive further assessments 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 must 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 and counseling regarding drinking limits and the adverse consequences of heavy drinking. When the excessive alcohol use is persistent, the patients are to receive brief motivational counseling by a health care worker with appropriate training in this area, referral to specialty providers, or other interventions depending upon the severity of the condition and the patient's preferences. 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 caring for an individual veteran must systematically promote the initiation of treatment and the ongoing engagement in care for patients with SUD.

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 are to utilize their interactions with the patient to address the substance use problems and to work with them to accept referrals. **NOTE:** *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; 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 are always to be characterized by a high-degree of provider empathy.

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

3. When patients are evaluated as appropriate and are willing to be admitted to inpatient or residential treatment settings for substance use conditions, but admission to those settings is not immediately available, interim services must be provided as needed 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, sedatives or hypnotics, or opioids.

1. Although withdrawal management can often be accomplished on an ambulatory basis, facilities must make inpatient withdrawal management available for those who require it. Services can be provided at the facility, by referral to another VA facility, or by sharing arrangement, contract, or non-VA fee basis arrangements to the extent that the veteran is eligible with a community-based facility.

2. Withdrawal management alone does not constitute treatment for dependence and must 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 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 MH RRTP, either in a facility that specializes in SUD services or a SUD track in another MH RRTP that provides a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regimen.

(h) Multiple (at least two) empirically-validated psychosocial interventions must be available for all patients with substance use disorders who need them, 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 for whom it is indicated and for whom there are no medical contraindications. It needs to be considered in developing treatment plans for all such patients. Pharmacotherapy, if prescribed, needs to be provided in addition to, and directly linked with, psychosocial treatment and support. When agonist treatment is contraindicated or not acceptable to the patient, antagonist medication (e.g., naltrexone) needs to be available and considered for use when needed. 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.

(j) Pharmacotherapy with an evidence-based treatment for alcohol dependence is to be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, must 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 patient's condition 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 where there are no medical contraindications, with appropriate coordination of care.

(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 to address the clinical needs of the veteran.

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

b. Facility- and Service-Based Requirements

(1) Medical centers must provide all of the services listed in subparagraph 15a(5) for veterans who clinically require them.

(2) CBOCs must make all of the services listed above available to veterans who need them. For each service that they do not provide, they must 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 subparagraphs 15a(5)(a) through 15a(5)(d), 15a(5)(e)1, and 15a(5)(e)2, for those who need them; they may also provide additional services. Specifically, they are encouraged to provide pharmacotherapy, when indicated, 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 to those who need them by referral to other accessible VA clinics or facilities, or through referral using a sharing arrangement, contract or non-VA fee basis services in the community to the extent that the veteran is eligible.

(4) Medical centers and very large CBOCs must provide care to meet the needs of 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)(d), 15a(5)(e)1, and 15a(5)(e)2, for those who need them.

(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) EDs must have the resources 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 as needed 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 to patients in all facilities with more than 1,500 patients on the Serious Mental Illness Research and Evaluation Center (SMITREC) psychosis registry. SMITREC distributes facility-specific counts to the facilities through 10N on at least an annual basis. At least four “on the street” Full-time Equivalent (FTE) employees are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA Medical Center in order that they can provide 24-hour coverage and emergency services.

(1) Each team must have a full time registered nurse and at least either a Psychiatrist or other M.D who is knowledgeable about psychopharmacological treatment, or an Advanced Practice Registered Nurse (APRN) as a prescriber dedicated to the team for at least 20 percent time.

(2) MHICM teams must provide the majority of their services in a community setting with an average of two to three contacts per patient per week; they are strongly encouraged to provide 75 percent of their services in the community.

d. VISNs and facilities are strongly encouraged to provide MHICM-Rural Access Network for Growth Enhancement (RANGE) programs for those who need them 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 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 a real-time computer link to the parent VA medical center to derive the full benefit of safety intercepts that prevent dispensing in case of unacceptably low levels of neutrophil or white blood cell counts in compliance with Federal Drug Administration (FDA) regulations.

(2) The Chief of the Mental Health Service at each facility is responsible for overseeing the implementation and maintenance of the CLZ Patient Management Program. If a psychiatrist, this individual may function as the CLZ Treatment Manager or may delegate this role to another qualified psychiatrist. If the Chief, Mental Health Services is not a psychiatrist, a qualified psychiatrist must be selected to serve in this role. All patients, physicians, and pharmacies using CLZ must be registered with the FDA. The VA National CLZ Coordinating Center (NCCC) performs the required registrations for all VA medical centers.

(3) 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 other antipsychotic medications, with an explanation of its potential risks and its potential benefits consistent with procedures for informed consent as outlined in VHA Handbook 1004.1. The patient’s informed consent for CLZ treatment, their

informed refusal of CLZ, or a psychiatrist's documentation of contraindications must be documented on the medical record.

f. Facilities are encouraged to develop procedures for advance care planning for patients with SMI as individuals in this patient population may be at risk for losing decision-making capacity (see VHA Handbook 1004.2).

g. 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 CBOCs.

(b) Working collaboratively with the other LRCs 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 any 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 Center (PRRC).** These PRRCs are distinct from MH RRTPs in that they provide ambulatory, not residential, services. Medical centers with 1,500 or more current patients included on the National Psychosis Registry (NPR) must have a PRRC. 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 in the program 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 need to 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 roles in the community roles that they consider meaningful.

(g) While services must be 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 key mental health 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 must include:

(a) Individual psychotherapy (e.g., cognitive behavioral therapy);

(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 as clinically indicated and coordinated with the program include:

- (a) Mental health diagnostic and treatment services;
- (b) Primary medical care;
- (c) Case management services (including MHICM); and
- (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 veterans in the full program and to others with SMI who require these services for rehabilitation and recovery.

(7) The VISN Director must make the services provided through PRRCs available to veterans living in areas distant from PRRCs who need them. These services can be provided through MH RRTPs when this level of care is needed, or in community-based programs by sharing arrangement, contracting, or non-VA fee-basis care to the extent that the veteran is eligible.

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 must 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. If the veteran's consent is unobtainable, this must be documented.

(2) Family consultation, family education, or family psycho-education within existing statutory and regulatory counseling authority for veterans with SMI must be provided for those who need them at all VA medical centers and very large CBOCs (see subpar. 3a).

(3) Opportunities for family consultation, family education, or psycho-education within existing statutory and regulatory counseling authority must be available to all veterans with SMI

on-site, by telemental health, or with community providers through sharing arrangements, contracting, or non-VA fee basis care to the extent that the veteran is eligible.

d. **Social Skills Training**

(1) Social skills training is an evidence-based psychosocial intervention that must be provided when clinically indicated at all medical centers and very large CBOCs (see subpar. 3a).

(2) Social skills training must be available to all veterans with SMI who would benefit from it, including those receiving care at CBOCs, whether it is provided on site, by referral, or by telemental health.

e. **Peer Counseling**

(1) All medical centers and very large CBOCs must provide individual or group counseling from peer support technicians for veterans treated for SMI when this service is clinically indicated and included in the veteran's treatment plan.

(2) Other CBOCs must make peer counseling available for veterans with SMI when it is clinically indicated and included in the veteran's treatment plan. Peer counseling may be made available by telemental health, referral to VA facilities that are geographically accessible, or by referral to community-based providers using contract mechanisms. Contracts for peer support services must ensure that peer providers have competencies and supervision equivalent to those required in VA facilities.

f. **CWT, Transitional Work Experience, and Supported Employment**

(1) Consultations about the need for and the likely benefits from therapeutic work-related rehabilitation programs must be available to veterans who may benefit from these programs 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 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) Participation in the CWT program must be available to any veteran receiving care through VA whom VA finds would benefit therapeutically from participation. To this end, information about the CWT Program and criteria for participation must be made available to staff of VA medical centers, to VA providers furnishing services through VA's telemental health programs or CBOCs, and to non-VA providers furnishing authorized health care services to veterans. Whether a particular patient's participation in the CWT program would be appropriate is a medical determination to be made by the responsible clinician, consistent with CWT Program criteria.

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 Therapy as designed and shown to be effective. Medical Centers and very large CBOCs must provide adequate staff to allow the delivery of evidence-based psychotherapy when it is clinically indicated for 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 when it is clinically indicated for their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary.

b. Evidence-based Somatic Therapies

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

(3) 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.

(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.

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

(a) ECT must be provided when it is clinically indicated consistent with VA clinical practice guidelines found at: http://vaww.oqp.med.va.gov/CPGintra/cpg/MDD/MDD_Base.htm , as well as those of the American Psychiatric Association. **NOTE:** *VA guidelines are located on an internal VA site that is not available to the public.*

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 veterans who are homeless, or at risk for homelessness, must be offered shelter through collaborative relationships with providers in the community. Facility staff must ensure that homeless veterans have a referral for emergency services and shelter or temporary housing. To the extent that it is possible under existing legal authority, facilities must facilitate the veteran's transportation to the shelter or temporary housing.

c. Each facility must develop and maintain collaborative formal, or informal, agreements with community providers for shelter, temporary housing, or basic emergency services. Medical centers may establish contracts for transitional therapeutic housing for the 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 for transitional therapeutic housing 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 veterans who require mental health treatment and rehabilitation programs with care in programs offering these services. This may include placement in a Grant and Per Diem Program, a VA Domiciliary, another VA MH RRTP, or other care settings that provide needed services. **NOTE:** *Eligibility criteria may differ between different types of programs.*

f. Use of emergency shelter services should generally not exceed 3 days, and is only to be used as a last resort. Within that period of time, homeless outreach staff or other qualified

clinical staff must evaluate the veteran's clinical needs, and refer or place the veteran for treatment and rehabilitation in therapeutic transitional housing, a MH RRTP, or another appropriate care setting. When longer stays in emergency shelters 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 transitional housing providing treatment or rehabilitation 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. **NOTE:** Refer to Grant and Per Diem program authority in 38 U.S.C. 61.80(b)(13).

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 for Grant and Per Diem patients, 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 rental assistance vouchers to homeless veterans referred by VA case management staff for permanent housing. VA provides case management and other clinical services to veterans in this program. 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 in the program.

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 (POC) for CHALENG.

l. **Stand Downs.** 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 VA's efforts to provide services to homeless veterans.

(1) They are typically 1 to 3 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.

(2) 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 veterans being released from State and Federal prisons. VISNs 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 POCs at each VISN medical center in primary care, homeless, substance abuse, and mental health service programs; and

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

b. VA is committed to the principle that when 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 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 fills two inter-related roles, both components of the facility's overall outreach and community education efforts:

(1) A police training coordinator, with a commitment to educating law enforcement personnel about PTSD, TBI, and other mental health issues relevant to the veteran population; and

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

c. This individual is responsible for:

(1) Working with community agencies in providing training to law enforcement personnel.

(2) Facilitating mental health assessments of veterans charged with non-violent crimes.

(3) 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.

(4) Collaborating with HCRV Specialists in supporting engagement in care for 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 professionals who are integral components of the primary care team and who can provide assessment and psychosocial treatment as needed 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 must include:

- (a) Monitoring adherence to treatment, treatment outcomes, and medication side effects;
- (b) Decision support;
- (c) Patient education and activation; and
- (d) 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 Behavioral Health Laboratory, TIDES, 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 an on-site presence of mental health services available to primary care patients who need them. 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 for those who require them 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 in these Centers meet the patient's needs and clinical standards of care;
- (5) Either sharing arrangements, contracts or non-VA fee basis care to the extent that the veteran is eligible with local providers; or organizations.

e. Mental health services including cognitive testing, diagnosis, evaluation, management of mental health and behavioral symptoms, and family consultations (when appropriate and when

veterans with adequate decision-making capacity consent) must be available for all patients with TBI who may require these services.

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. Within 24 hours of requests or referrals, each medical center must provide mental health consultations and evaluations on inpatient units, including evaluations of decision-making capacity.

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 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 following settings:

b. Each VA Community Living Center (CLC), previously known as Nursing Home Care Unit, needs to have a full range of integrated mental health services consisting of, at minimum, 1.0 FTE psychologist for a 100 bed facility. Services must include:

(1) Psychological assessment;

(2) Cognitive evaluations;

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

(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:

(a) Psychological assessment,

(b) Cognitive screening,

(c) Capacity evaluations,

(d) Evaluations of decision-making capacity, and

(e) 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, when this is consistent with existing legal authority for including families in care processes. **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 21 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. 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.

c. VISNs and facilities must make services available to address the needs of veterans awaiting admission to PTSD residential care programs. **NOTE:** *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. PCT or specialist care or consultation must be available to all veterans who may have PTSD.

e. All inpatient mental health units must have the capability to treat patients with PTSD. This can be accomplished by:

(1) Establishing units or tracks with staff trained to address the needs of acutely ill veterans with PTSD, including those from OIF and OEF; or

(2) Making care or consultation from members of PCTs or PTSD specialists available to inpatients

f. All CBOCs must:

(1) Have the capacity to provide diagnostic evaluations 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 mental health treatment services for those who need them.

(b) When CBOCs seeing less than 1,500 unique veterans are within 1 hour of other VA facilities, they may make services for PTSD available to those who need them by referral to these other facilities

(c) When there are no nearby facilities, smaller CBOCs must provide needed services by telemental health, or by referral to community-based providers using sharing arrangements, contracts, or non-VA fee-basis to the extent that the veteran is eligible .

(2) Make PCTs or Specialist available for consultation or care for veterans who may have PTSD, 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. These may include specialized programs of care management for these patients.

h. Care of the intensity available in a PTSD Day Hospital or MH RRTP needs to be available to all veterans receiving care from VHA to the extent that it is clinically indicated.

(1) Medical centers must provide these services for those who need them in a Hospital or a PTSD track in PRRC (see par. 17) or an equivalent program.

(2) CBOCs must make the services available for veterans who need them by:

(a) Referral to a program at a geographically-accessible medical center or a MH RRTP when this level of care is needed (see par. 17); or

(b) Through sharing arrangements, contracts, or fee-basis care to the extent that the veteran is eligible 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. **NOTE:** *There is a need to consider developing a number of these programs as national resources and to arrange processes for referral, discharge, and follow-up. VISNs or VA medical centers that do not have these programs need to develop Memoranda of Understanding (MOUs) with VISNs that have these services.*

24. MILITARY SEXUAL TRAUMA (MST)

NOTE: *This Handbook supplements current VHA policy with requirements related to the identification and treatment of mental disorders resulting from MST.*

a. **Medical Center Director.** Each Medical Center Director is responsible for ensuring that:

(1) A designated MST Coordinator is appointed; that a MST Counselor(s) or team is available so that all enrolled veterans, including OEF and OIF veterans, are screened for MST; and that necessary staff education and training is provided.

(2) Veterans receiving MST-related counseling and treatment are not billed for inpatient, outpatient, or pharmaceutical co-payments; however, applicable co-payments may be charged for services not related to MST or for other non-service connected conditions.

(3) Scheduling priority for outpatient sexual trauma counseling, care, and services is consistent with VHA performance standards for scheduling clinics.

(4) Accurate documentation of screening, referral, and treatment services provided to veterans, aggregated by gender, is maintained. This process includes use of the MST software and the MST clinical reminder to track and monitor the level of compliance with the standard (100 percent of enrolled veterans screened). The nationwide tracking system to ensure consistent data on screening and treatment of victims of MST must be used. **NOTE:** *The use of clinic stop code 524 or Purpose of Visit code 55 of the Fee Package is recommended so that collection of MST treatment data is accessible and consistent across the system.*

(5) MST counseling is provided by contract with a qualified mental health professional if it is clinically inadvisable to provide MST counseling in VA facilities or when VA facilities are not capable of furnishing such counseling to the veteran economically because of geographic inaccessibility or the inability of the medical center to provide counseling in a timely manner. **NOTE:** *Referral to the local Vet Center may be an appropriate alternative.*

(6) Veterans who report experiences of MST, but who are otherwise deemed ineligible for VA health care benefits based on length of military service requirements, may only be provided MST counseling and related treatment.

(7) The MST software application that activates the MST Clinical Reminder within CPRS has been installed at the facility. All veterans receiving VHA health care must be screened for MST using this clinical reminder.

(8) Veterans screening positive and requesting treatment are provided free care, with no inpatient, outpatient, or pharmacy copayments, for mental and physical health conditions resulting from their experiences of MST. Determination as to whether care is MST-related is made by the clinician providing care. All MST-related care must be designated by checking the MST box on the encounter form for the visit.

(9) The time frames for evaluations of veterans for possible mental disorders resulting from MST must follow the requirements in paragraph 13.

(10) Evidence-based mental health care is available to all veterans diagnosed with mental health conditions resulting from MST.

NOTE: *Facilities are strongly encouraged to provide same sex providers for veterans, men and women, receiving treatment in their facility for conditions related to MST, when clinically indicated.*

b. **VISN Director.** Each VISN Director is responsible for ensuring access is provided to MH RRTPs able to provide treatment, when clinically needed, for conditions resulting from MST for veterans who have severe conditions.

c. **Facility MST Coordinator.** The facility MST coordinator is responsible for:

(1) Monitoring and ensuring that national and VISN-level policies related to MST screening, education, training, and treatment are implemented at the facility;

(2) Serving as a point person and source of information and problem-solving for MST-related issues at the facility; and

(3) Establishing and monitoring mechanisms to ensure that veterans receiving VHA health care are screened for MST experiences and that those who screen positive have access to clinically-indicated treatments for conditions resulting from MST.

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. 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). **NOTE:** *Mechanisms for support may include appointing more than one SPC, appointing care managers for high-risk patients, or providing program support assistants.*

b. The SPC's commitment to suicide prevention activities must include, but is 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 plan or intent;

(4) Collaborating with community organizations and partners, and providing training to their staff members who have contact with veterans;

(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) Working with providers to ensure that:

(a) Monitoring and treatment is intensified for high risk patients; and

(b) High-risk patients receive education and support about approaches to reduce risks.

(7) Reporting on a monthly basis to mental health leadership and the National Suicide Prevention Coordinator on the veterans who attempted or completed suicide along with requested data 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.*

(8) Ensuring that providers follow-up on missed appointments for high-risk patients to ensure patient safety and in order to initiate problem-solving about any tensions or difficulties in the patient's ongoing care. The facility's SPC and each patient's principal mental health providers must work together to monitor high-risk patients to ensure that both their suicidality and their mental health or medical conditions are addressed.

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 help 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 (see current VHA policy for more detailed information).

***NOTE:** 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

Each VA medical center must have a Disruptive Behavior Committee 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. The specifications for those mental health services that must be made available to veterans to the extent that they are clinically necessary, and those services that must be provided for veterans who require them at medical centers or CBOCs, depending upon their size, apply to veterans in rural, and highly rural (which is defined as a county with less than seven civilians per square mile), 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:

(1) Increasing staffing or telemental health,

(2) Referring to another nearby VA facility,

(3) Making such services available through a referral to residential rehabilitation and treatment programs when it is clinically necessary, and

(4) Referring to community providers using sharing arrangement, contracts, or non-VA fee basis care to the extent that the veteran is eligible.

c. Combat veterans who require counseling to address problems related to their adjustment back to civilian life need to be referred to Vet Centers for these services. However, except where similar treatments are offered, services at Vet Centers are not to be provided in lieu of clinically-indicated outpatient mental health services.

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

(1) **Ambulatory Mental Health Care.** Facilities must offer options for needed mental health services to veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible. When necessary, this can include the provision of telemental health services with secure access near the veteran's home, or sharing arrangements, contracts, or non-VA fee basis care to the extent that the veteran is eligible from appropriate community-based providers, as available. It must be documented if the veteran declines these options because the veteran prefers to receive care from VA providers.

(2) **Residential Care.** Each veteran receiving VHA health care services must have timely access to MH RRTPs as medically necessary to meet the veteran's mental health needs. MH RRTPs provide specialized, intensive treatment and rehabilitation services to veterans who require them in a therapeutic environment. Veterans living in rural areas need to be referred to these programs when they are medically necessary to treat the veteran's mental health condition.

(3) **SMI.** VISNs and facilities are strongly encouraged to provide MHICM-RANGE programs for veterans who need them 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.