

UNIFORM MENTAL HEALTH SERVICES IN VHA MEDICAL POINTS OF SERVICE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive defines minimum administrative and clinical requirements for VHA mental health services. It delineates the essential components of mental health services to ensure that all Veterans, wherever they obtain care in VHA, have access to needed mental health care.

2. SUMMARY OF MAJOR CHANGES: This VHA directive is a comprehensive revision of VHA Handbook 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, and specifies services that must be provided at VHA medical points of service. **NOTE:** *The directive provides basic information about programs and services that are required. For detailed information about individual program requirements, refer to the specific policy for that program (see paragraph 19 for list of references).*

3. RELATED ISSUES:

- a. VHA Directives in the 1160, 1162 and 1163 series.
- b. VHA Directive 2010-053, Patient Record Flags, dated December 3, 2010.
- c. VHA Directive 1160, Re-Engaging Veterans with Targeted Serious Mental Illness in Treatment, dated February 7, 2018.
- d. VHA Directive 1163.07, Services for Veterans Experiencing Early Psychosis, dated October 7, 2020.
- e. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.
- f. Additional VHA directives cited throughout this directive are listed in paragraph 19.

4. RESPONSIBLE OFFICE: The Office of Mental Health and Suicide Prevention (11MHSP) is responsible for the contents of this directive. Questions may be referred to vha11mhspmentalhealthandsuicidepreventionaction@va.gov.

5. RESCISSION: VHA Handbook 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, and VHA Memorandum 2022-08-32, Requirements for Mental Health Same Day Access Standard Operating Procedures (SOP) Between Veterans Integrated Services Network (VISN) Clinical Contact Centers (CCC) and Department of Veterans Affairs (VA) Medical Facilities and All Associated Points of Care, dated August 23, 2022, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of April 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Erica M. Scavella, MD, FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

NOTE: *All references herein to Department of Veterans Affairs (VA) and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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UNIFORM MENTAL HEALTH SERVICES IN VHA MEDICAL POINTS OF SERVICE

1. PURPOSE

This Veterans Health Administration (VHA) directive states minimum administrative and clinical requirements for VHA mental health services that must be implemented nationally to ensure that all Veterans and those otherwise eligible for care, wherever they obtain care in VHA, have access to needed recovery-oriented mental health services. Throughout this directive, the term mental health services includes evidence-based services for the prevention, evaluation, diagnosis, treatment and rehabilitation of mental health conditions, including substance use disorders (SUD). Program-specific requirements are discussed in greater detail in program-specific directives. If no program-specific directive is available, access to more detailed information is provided in this directive (see paragraph 16). **NOTE:** *It is not the purpose of this directive to describe all mental health services that may be necessary and appropriate to address the mental health care needs of Veterans. Department of Veterans Affairs (VA) medical facilities are expected to adhere to principles of patient-centered, recovery-oriented mental health care in identifying appropriate resources, in accordance with Veterans' needs and local challenges, resources and opportunities.* **AUTHORITY:** 38 U.S.C. § 7301(b); 38 C.F.R. § 17.38.

2. BACKGROUND

VHA places a high priority on providing and enhancing patient-centered, recovery-oriented mental health and suicide prevention services for Veterans of all eras. These services are provided by VA with the understanding that they are part of a robust recovery-oriented continuum of care that is focused on engaging Veterans in lifelong health, well-being and resilience using a Whole Health approach. The requirements in this directive are based on the principle that mental health care is an essential component of overall health care. While this directive focuses specifically on mental health services, it does so in the context of a comprehensive and integrated health care system. As such, these services must be integrated and coordinated with other components of health care. VA mental health services are those authorized under 38 C.F.R. § 17.38 and are consistent with 38 C.F.R. § 17.107 that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate VA health care professionals, as defined in VHA Directive 1899(2), Health Care Professional Practice in VA, dated April 21, 2020, by any appropriate modality of care (e.g., in-person, video tele-mental health (TMH), audio-only), by referral to other VHA points of service or through the Veterans Community Care Program (VCCP), to the extent that the Veteran is eligible. While mental health services include suicide prevention services, those services are defined in depth in VHA Directive 1160.07, Suicide Prevention Program, dated May 24, 2021. VA medical facilities must use all available resources and authorities to ensure the availability of the services identified as needed.

3. DEFINITIONS

a. **Administrative Parent.** An Administrative Parent is a collection of all points of service that a leadership group (VA medical facility Director, Deputy VA medical facility Director, VA medical facility Chief of Staff, VA medical facility Associate Director for Patient Care Services, VA medical facility Assistant Director and VA medical facility Associate Chief Nurse Executive) manages. The points of service can include any institution where health care is delivered. All data that originate from these points of service roll up to a single station number representing the Administrative Parent for management and programmatic activities.

b. **Community-Based Outpatient Clinics.** For purposes of this directive, Community-Based Outpatient Clinics (CBOCs) refer to Multispecialty Community-Based Outpatient Clinics (MS-CBOCs), Primary Care Community-Based Outpatient Clinics (PC-CBOCs), Health Care Centers, other community sites of care and Other Outpatient Service sites that deliver primary care services or mental health services. The mental health services requirements for MS-CBOCs and PC-CBOCs may differ according to the number of unique Veterans served by that site.

c. **Electronic Health Record.** Electronic health record (EHR) is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. ***NOTE: The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.***

d. **Mental Health Providers.** Mental health providers include all Psychiatrists, Psychologists, Certified Nurse Practitioners, Certified Nurse Specialists, Physician Assistants (PAs), Marriage and Family Therapists (MFTs), Licensed Professional Mental Health Counselors (LPMHCs), Clinical Pharmacist Practitioners (CPP), Vocational Rehabilitation Counselors (VRCs) and Licensed Clinical Social Workers assigned to mental health programs (regardless of how that program is administratively aligned). ***NOTE: For the purpose of this directive, mental health providers include all the above. When referencing health care professionals, see VHA Directive 1899(2), which also includes but is not limited to the following: Registered Nurses, Licensed Practical/Vocational Nurses, Peer Specialists, Addiction Therapists and Vocational Rehabilitation Specialists.***

e. **Mental Health Services.** VHA defines mental health services as the prevention, evaluation, diagnosis, treatment and rehabilitation of a broad range of mental health conditions, including SUD.

f. **Point of Service.** A point of service within the VA health care system is a distinct place, usually defined by an address or a continuous range of addresses, that identifies the physical location where a Veteran interacts with VA health care providers, and

which is sufficiently distinct that it can be geocoded and mapped for the purposes of calculating drive times, mileage and access standards. **NOTE:** For further information, see VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.

g. **Recovery.** Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential. **NOTE:** For further information, see the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Working Definition of Recovery, located at <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>. This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.

h. **Serious Mental Illness.** For the purposes of this directive, serious mental illness (SMI) is a mental, behavioral or emotional disorder (excluding cognitive and developmental disorders and disorders due to a general medical condition) listed in the current American Psychiatric Association Diagnostic and Statistical Manual (DSM) of Mental Disorders that meets all the following criteria. **NOTE:** For further information, see SAMHSA's Working Definition of SMI, located at <https://www.samhsa.gov/serious-mental-illness>.

(1) Single unremitting episode of symptoms or with frequently recurring or prolonged episodes of symptoms.

(2) Symptoms result in impairments in mood, thinking, family or other interpersonal relationships, behavior (often resulting in socio-legal consequences) or self-care, which substantially interfere with or limit major life activities.

(3) The impact of these symptoms results in a significant functional impairment using any valid and reliable measure which has norms for a Veteran population.

i. **Substance Use Disorder.** SUD is a problematic pattern of substance use leading to clinically significant impairment or distress that meets diagnostic criteria according to the current DSM. **NOTE:** The diagnosis of SUD must be consistent with the criteria of the most current mental health diagnosis system approved by VA (i.e., the current edition of DSM). For further information, see VHA Directive 1160.04, VHA Programs for Veterans with Substance Use Disorder (SUD), dated December 8, 2022.

j. **Warm Handoff.** For purposes of this directive, a warm handoff is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient (and family if present) in-person or virtually. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care. **NOTE:** For additional information and resources regarding warm handoffs, see the Agency for Healthcare and Research Quality at: <https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html>.

k. **Whole Health.** Whole Health is VHA's approach to delivering personalized, proactive and patient-driven care to empower and equip Veterans to take charge of their health and well-being, as part of a Whole Health System of care. It focuses on what matters most to the Veteran and incorporates the use of evidence-based, complementary and integrative health approaches, health coaching, peer-facilitated groups and support and Whole Health clinical care. ***NOTE: For further information, see VHA Directive 1137, Provision of Complementary and Integrative Health, dated December 13, 2022.***

4. POLICY

It is VHA policy that clinically indicated comprehensive mental health care be provided to all eligible Veterans and other beneficiaries through evidence-based, recovery-oriented, culturally informed and patient-centered services that align with the Veterans' preference and values.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the Office of Mental Health and Suicide Prevention (OMHSP) with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for supporting the implementation of this directive with Patient Care Services program offices and providing clinical practice oversight and support as appropriate.

d. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Ensuring that each VISN Director has the sufficient resources to implement this directive in all VA medical facilities within that VISN.

(3) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(4) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

e. **Executive Director, Office of Mental Health and Suicide Prevention.** The Executive Director, OMHSP is responsible for:

(1) Developing national policy and procedures for all mental health services based on relevant laws, regulations and VHA's mission, goals and objectives. **NOTE:** For further information on SUD, see VHA Directive 1160.04. For further information on suicide prevention, see VHA Directive 1160.07.

(2) Providing consultation, technical assistance, data review, site visits and implementation guidance to VISNs and VHA Administrative Parents.

(3) Developing recommendations for process improvement based upon review of clinical and administrative data provided by Program Evaluations Centers and other data sources, and research findings provided by either the Mental Illness Research, Education and Clinical Center or the Mental Health Centers of Excellence. Recommendations are then provided to VISN and VA medical facility programs for information and implementation.

(4) Coordinating with all elements of OMHSP regarding provision of mental health care services for Veterans.

f. **Executive Director, Office of Primary Care Services.** The Executive Director, Office of Primary Care Services is responsible for coordinating with OMHSP regarding provision of mental health services for Veterans who are enrolled in Primary Care Services, including but not limited to formal Primary Care Mental Health Integration (PCMHI) programs, and fostering ongoing collaboration and communication between Mental Health and Primary Care to support full implementation of PCMHI programs within Patient Aligned Care Teams (PACTs). **NOTE:** For further information, see VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

g. **Executive Director, Office of Geriatrics and Extended Care.** The Executive Director, Office of Geriatrics and Extended Care is responsible for coordinating with OMHSP regarding provision of mental health services for Veterans who are enrolled in Geriatrics and Extended Care services. **NOTE:** For further information, see VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Facilities, dated March 24, 2022.

h. **Executive Director, Homeless Programs Office.** The Executive Director, Homeless Programs Office is responsible for coordinating with OMHSP regarding provision of mental health and SUD services for Veterans who are homeless or at risk of homelessness. **NOTE:** For further information, see VHA Directive 1160.04 and VHA Directive 1501, VHA Homeless Programs, dated October 21, 2016.

i. **Chief Officer, Office of Women's Health.** The Chief Officer, Office of Women's Health is responsible for coordinating with OMHSP regarding provision of mental health services and substance use disorder treatment for women Veterans in inpatient and outpatient settings and residential mental health programs to ensure the needs of

women Veterans are met across all treatment settings (including PCMHI, specialty mental health treatment and reproductive mental health) in a sensitive and safe environment. **NOTE:** For further information, see VHA Directive 1330.01(6), *Health Care Services for Women Veterans*, dated February 15, 2017.

j. **Executive Director, Office of Nursing Services/Deputy Chief Nursing Officer.**

The Executive Director, Office of Nursing Services/Deputy CNO is responsible for fostering ongoing collaboration and communication between nurse leaders, clinicians and other Mental Health providers to fully support mental health services to all enrolled Veterans. This involves coordinating with OMHSP regarding the provision of mental health and SUD nursing care to ensure the needs of Veterans are met across all treatment settings in a safe and therapeutic environment. **NOTE:** For further information see VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, dated January 18, 2023.

k. **Executive Director, Care Management and Social Work Services.** The Executive Director, Care Management and Social Work Services (CMSW) is responsible for coordinating with OMHSP regarding provision of mental health services provided by VHA social workers for Veterans, Service members, their families, caregivers, support persons and survivors. This involves fostering ongoing collaboration and communication between Mental Health and CMSW programs, including but not limited to: Social Work, Post 9/11 Military to VA Case Management, VA Liaison, Intimate Partner Violence Assistance and Fisher House and Family Hospitality Programs. **NOTE:** For further information, see VHA Directive 1110.02, *Social Work Professional Practice*, dated July 26, 2019, and VHA Directive 1198, *Intimate Partner Violence Assistance Program*, dated January 24, 2019.

l. **Executive Director, Pharmacy Benefits Management Services.** The Executive Director, Pharmacy Benefits Management (PBM) Services is responsible for coordinating with OMHSP regarding the provision of mental health services for Veterans, including but not limited to CPP integration into mental health teams and fostering ongoing collaboration and communication between OMHSP and PBM. **NOTE:** For further information, see VHA Handbook 1108.11(1), *Clinical Pharmacy Services*, dated July 1, 2015.

m. **Chief Officer, Readjustment Counseling Service.** The Chief Officer, Readjustment Counseling Service is responsible for coordinating with OMHSP regarding the availability of the full continuum of mental health services, including SUD and suicide prevention, to Veterans and active duty Service members who receive readjustment counseling services in accordance with specific eligibility, confidentiality and other requirements as outlined in VHA Directive 1500(2), *Readjustment Counseling Service*, dated January 26, 2021.

n. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Fully implementing this directive in all VHA Administrative Parents within the VISN to ensure that mental health services are provided and available as specified.

(2) Designating VISN-level positions within the mental health continuum of care with assigned protected time to accomplish their duties as outlined in all VHA mental health directives and listed on the OMHSP resource page at:

https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. **NOTE:** *This is an internal website that is not available to the public.*

(3) Establishing and maintaining the mental health continuum of care (including inpatient, residential and outpatient treatment programs) that is able to meet the needs of Veterans with SMI, Post Traumatic Stress Disorder (PTSD), SUD, homelessness or co-occurring medical concerns either through special programs or specific tracks, e.g., in general residential treatment settings).

(4) Ensuring compliance with VHA Directive 1165, Leadership Positions in Mental Health, dated May 12, 2021, to recruit multiple mental health disciplines for leadership positions in mental health.

(5) Ensuring VA medical facility Directors designate positions within the mental health continuum of care with assigned protected time to accomplish their duties as outlined in all VHA mental health directives and listed on the OMHSP resource page at:

https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(6) Ensuring that VHA points of service submit formal written requests (waivers) for local modifications or exceptions to clinical service requirements and direct them to OMHSP through the VISN for decision to approve or not approve. **NOTE:** *For further information about the waiver process, see VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023, and paragraph 15.*

(7) Ensuring that a VISN-level Mental Health Executive Council (MHEC) is incorporated into VISN governance, is chaired by the VISN Chief Mental Health Officer (CMHO) and includes in its membership a minimum of representation of each VA medical facility Chief Mental Health Lead (see paragraph 6.b.). **NOTE:** *The VISN MHEC may also be referred to as the VISN Mental Health Governance Council or the VISN Mental Health Integrated Clinical Community (MH ICC). The VA medical facility Chief Mental Health Lead may also be known as the Mental Health Service Line Director, Associate Chief of Staff for Mental Health or Chief of Mental Health.*

(8) In collaboration with the VA medical facility Director, appointing a select group of mental health providers to serve as public spokespersons on mental health issues of concern to the community. These individuals must be able to work collaboratively with public affairs, communications offices and leadership at the local, regional and national levels.

o. **Veterans Integrated Services Network Chief Medical Officer.** The VISN Chief Medical Officer (CMO) is responsible for providing appropriate medical oversight and

support to VA medical facilities for the implementation, direction, coordination, evaluation, review and improvement of the delivery of mental health services, including for cause and consultative site visits, and, in addition, providing support for the VISN CMHO and VISN MHEC.

p. **Veterans Integrated Services Network Chief Nursing Officer.** The VISN CNO is responsible for:

(1) Collaborating with the VISN CMO to provide the appropriate oversight and support to VA medical facilities for the implementation, direction, coordination, evaluation, review and improvement of operations of mental health services, including for cause and consultative site visits.

(2) Consulting with the Office of Nursing Services Mental Health Clinical Advisor and the Mental Health Field Advisory Committee to ensure optimal delivery of mental health services.

q. **Veterans Integrated Services Network Chief Human Resources Officer.** The VISN CHRO is responsible for collaborating with the VA medical facility Chief Mental Health Lead to identify staffing needs to ensure continuity of care for Veterans with mental health care needs.

r. **Veterans Integrated Services Network Chief Mental Health Officer.** The VISN CMHO is responsible for:

(1) Supporting implementation of this directive at local VHA Administrative Parents (VA medical facilities and all of their associated points of service) within the VISN.

(2) Providing oversight and support to VHA Administrative Parents within the VISN in their implementation, organization, direction, coordination, evaluation, review and improvement of operations of mental health services, including for cause and consultative site visits.

(3) Collaborating with the VISN clinical officers and leads (e.g., VISN CNO and VISN Social Work Leads) to ensure optimal delivery of mental health services at the VA medical facility level.

(4) Chairing the VISN MHEC and providing guidance and recommendations to VISN governance.

(5) Ensuring all VA medical facilities and other points of service (including CBOCs, Clinical Contact Centers and other VA clinics) have standard operating procedures (SOPs) for ensuring same-day access, screenings and warm handoffs for Veterans who attempt to engage regarding a mental health concern. ***NOTE: For additional information about same-day access, see paragraph 8.***

s. **Veterans Integrated Services Network Community Mental Health Point of Contact.** The VISN Community Mental Health Point of Contact (POC) is responsible for

ensuring coordination and providing oversight of VA activities with community providers at State, county and local mental health systems as outlined in paragraph 12. **NOTE:** *It is strongly recommended for the VISN CMHO to serve in this capacity.*

t. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring full implementation of this directive at the VA medical facility and its associated points of service.

(2) Ensuring that the requirements of this directive are communicated to all VA medical facility mental health providers and to other non-provider staff.

(3) Ensuring that the Administrative Parent governance includes a VA medical facility MHEC that reports up to and makes recommendations to senior leadership through the VA medical facility's governing body. See paragraph 6.d. **NOTE:** *The Administrative Parent MHEC may be referred to by various local designations as long as it is incorporated into VA medical facility/Administrative Parent governance.*

(4) Ensuring all mental health providers communicate and coordinate services among teams and programs, both within mental health as well as other services, to ensure Veterans receive seamless and integrated care and build a coherent, integrated program that coordinates the activities of a diverse group of disciplines and specialists.

(5) Putting mechanisms in place to collect input from Veterans receiving mental health care, their families, caregivers, community stakeholders and VA medical facility mental health providers across all mental health programs (e.g., Veteran's Satisfaction Survey and Veteran's Consumer Council, Mental Health Provider Survey, Veterans' Experience Office data).

(6) Ensuring that the VHA Administrative Parent hosts, and a member of the VA medical facility executive leadership team attends and participates in, at least one annual Mental Health Summit. See paragraph 12.c.(5) for more details.

(7) Ensuring that the VA medical facility Chief of Staff provides the environment in which VHA Administrative Parent-designated mental health and homeless leadership actively collaborate so that VA medical facility mental health and homeless staff at all VHA points of service work together to meet the needs of homeless Veterans with mental health conditions, including SUD.

(8) Providing professional oversight of the delivery of mental health care in associated points of service.

(9) Providing mechanisms for ensuring communication between the leadership of mental health services and that of the associated CBOCs.

(10) In collaboration with the VA medical facility Chief Mental Health Lead, deciding whether VRCs, CPPs, Recreation Therapists, Occupational Therapists, chaplains, Peer Specialists, Veterans, family members or caregivers, Whole Health, Patient Advocate, a

Veterans Mental Health Council (VMHC) representative or others must be represented on the VA medical facility MHEC.

(11) Hiring and designating positions for individuals within the mental health continuum with assigned protected time to accomplish their duties. For full-time positions where there is not a specific labor mapping requirement, VA medical facility Directors must ensure dedicated labor-mapped administrative time is provided consistent with the duties defined in the functional statement or position description. All required and recommended positions are listed at https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(12) Overseeing the collaboration between the VISN CHRO and the VA medical facility Chief Mental Health Lead to identify staffing needs and proactively prioritize and fill vacancies.

(13) Ensuring compliance with VHA Directive 1165 to recruit multiple mental health disciplines for leadership positions in mental health.

(14) Ensuring that if the VA medical facility is without acute mental health inpatient units, the VA medical facility has agreements with appropriate agencies or hospitals to arrange involuntary hospitalization when clinically necessary.

(15) Ensuring that if the VA medical facility has a locked mental health acute inpatient unit, that inpatient mental health care and appropriate post-discharge engagement is provided according to the requirements in VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013, and VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, dated May 12, 2017, as it applies to inpatient mental health settings.

(16) Ensuring that options for needed mental health services to Veterans living in rural areas who could not otherwise access such services are made available as outlined in paragraph 8.

(17) In collaboration with the VISN Director, appointing a select group of mental health providers to serve as public spokespersons on mental health issues of concern to the community. These individuals must be able to work collaboratively with public affairs, communications offices and leadership at the local, regional and national levels.

(18) Promoting collaborations between mental health providers and VA chaplains. VA medical facility mental health leadership and providers must also coordinate with Chaplaincy to develop interactions with community clergy, including facilitating collaboration, appropriate referral and coordination of services.

(19) Across all mental health programs, promoting Whole Health principles and collaborating with Whole Health programs in the delivery of patient-centered recovery-oriented care as defined in VHA Directive 1137.

u. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff is responsible for:

(1) Ensuring implementation of this directive at all sites of care administered by the VA medical facility which are required to provide mental health care.

(2) Ensuring governance structures are in place such that review of recommendations submitted by the VA medical facility MHEC, in collaboration with the VA medical facility Chief Mental Health Lead, are documented and addressed.

(3) Ensuring all VHA points of service in the Administrative Parent which do not have Emergency Departments (EDs) or 24/7 urgent care have predetermined written plans consistent with national policy for responding to mental health emergencies. **NOTE:** *For additional information about access to mental health care, see paragraph 8.*

(4) Ensuring that all clinical staff complete mandated mental health and suicide prevention training and education within the required time frames. **NOTE:** *For a listing of mandatory and recommended trainings, see the OMHSP Policy Support page at <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. This is an internal VA website that is not available to the public.*

(5) Collaborating with the VA medical facility Chief Mental Health Lead to review recommendations submitted by the VISN MHEC and VA medical facility MHEC.

(6) Promoting the expectation that capacity is built into schedules so that mental health staff conduct necessary team meetings for the purpose of a) interdisciplinary discussion of patients with complex clinical presentations, b) enhancing team communication skills and function and c) supporting performance improvement activities.

(7) Ensuring the collaboration between leadership of homeless and mental health programs in VA medical facilities where homeless and mental health are independent. Specifically, ensuring VA medical facility mental health and homeless staff at all VHA points of service work together to meet the needs of homeless Veterans with mental health conditions, including SUD.

(8) Ensuring the collaboration between leadership of mental health and other disciplines whose leadership is separate from mental health (e.g., Social Work, Nursing, PA, Pharmacy).

v. **VA Medical Facility Associate Director for Patient Care Services.** The VA medical facility Associate Director for Patient Care Services is responsible for fully supporting mental health services to all enrolled Veterans and coordinating with the VA medical facility Chief of Staff regarding the provision of mental health nursing care and SUD services to ensure the needs of Veterans are met across all treatment settings in a safe and therapeutic environment.

w. **VA Medical Facility Chief Mental Health Lead.** **NOTE:** *The VA medical facility Chief Mental Health Lead may also be known as the Mental Health Service Line Director, Associate Chief of Staff for Mental Health or Chief of Mental Health. The VA medical facility Chief Mental Health Lead is responsible for:*

(1) Establishing and chairing a VA medical facility MHEC or assigning a designee (see paragraph 6.d.). In their role as chair, the VA medical facility Chief Mental Health Lead is responsible for:

(a) Proposing strategies to VA medical facility leadership to improve mental health care for Veterans and to optimize safety for Veterans and health care providers, including methods for improvement and innovation in mental health treatment programs.

(b) Reviewing the timeliness of Veterans' access to mental health care, the resources available to mental health programs and the efficiency of the utilization of these resources. This review must use data readily available on access and must be done on at least a quarterly basis. Recommendations for improvements must be submitted to VA medical facility leadership for review and appropriate action.

(c) Ensuring clinical documentation of mental health service provision is completed in accordance with internal/external regulatory bodies, oversight bodies and VHA requirements.

(d) Ensuring that all mental health providers complete all required training. **NOTE:** *For a listing of mandatory and recommended trainings, see the OMHSP Policy Support page at <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. This is an internal VA website that is not available to the public.*

(e) Ensuring that the VA medical facility MHEC meets at least quarterly and communicates recommendations through the VA medical facility governing body.

(f) Ensuring that at least one VA mental health staff member is designated to serve as a liaison to the VA medical facility VMHC (e.g., a Local Recovery Coordinator (LRC)) to facilitate communication with the leadership of the VA medical facility and its mental health service.

(2) Collaborating with the VA medical facility Chief of Staff and the Associate Director for Patient Care Services to review recommendations submitted by the VISN MHEC and VA medical facility MHEC.

(3) Ensuring VA medical facility mental health staff at all VHA points of service work together to meet the needs of Veterans with mental health conditions, including SUD.

(4) In collaboration with the VA medical facility Director, deciding whether VRCs, CPPs, Recreation Therapists, Occupational Therapists, chaplains, Peer Specialists, Veterans, family members or caregivers, Whole Health, Patient Advocate, VMHC representatives and others must also be represented on the VA medical facility MHEC.

(5) Ensuring written plans consistent with national policy for responding to mental health emergencies are developed, updated and shared with VA medical facility leadership. Plans must be shared and communicated broadly across the health care system to ensure Veteran safety.

(6) Ensuring all VA medical facilities and other points of service (including CBOCs and other VA clinics) have SOPs for ensuring same day access, screenings and warm handoffs for Veterans who attempt to engage regarding a mental health concern, and reviewing, auditing and revising SOPs if appropriate at least annually. **NOTE:** *For additional information about same day access, see paragraph 8.*

(7) Collaborating with the VISN CHRO to identify staffing needs, ensuring continuity of care for Veterans with mental health care needs.

(8) Assisting the VA medical facility Director by serving as the VA medical facility Community Mental Health POC, or by recommending a highly skilled designee to be appointed as the VA medical facility Community Mental Health POC.

(9) Designating VA medical facility Mental Health Discipline Leaders for Psychology, Psychiatry, Mental Health Social Work and Mental Health Nursing regardless of organizational alignment and in collaboration with VA medical facility Nursing and Social Work leadership. Leaders for other Mental Health disciplines (Mental Health PAs, Mental Health CPPs, VRCs, MFTs and LPMHCs) should be considered if local circumstances warrant (e.g., a sufficient number of the discipline exist at a VA medical facility).

(10) Providing input into hiring decisions, performance rating and quality improvement initiatives for all mental health programs, including those that may be aligned under a different program office.

(11) Ensuring that care is provided at the highest practical level within the discipline (in collaboration with the VA medical facility Mental Health Discipline Leader where one exists) as defined by mental health providers' professional training and clinical privileging or scope of practice.

(12) Establishing clearly defined processes for how Veterans progress through the continuum of mental health care, including transitions to treatment settings where mental health care may be provided by a non-mental health care provider (e.g., in primary care with PCMHI support). The VA medical facility Chief Mental Health Lead must ensure that all mental health providers adhere to these processes. **NOTE:** *For additional information about the mental health continuum of care, see paragraph 9.*

(13) Ensuring completion of at least one annual Mental Health Summit. See paragraph 12.c.(5) for more details.

x. **VA Medical Facility Associate Chief Nurse for Mental Health.** The VA Medical Facility Associate Chief Nurse for Mental Health is responsible for fully supporting mental health services to all enrolled Veterans and coordinating with the VA medical

facility Chief Mental Health Lead regarding the provision of mental health nursing care and SUD services to ensure the needs of Veterans are met across all treatment settings in a safe and therapeutic environment.

y. **VA Medical Facility Designated Homeless Lead.** The VA medical facility designated Homeless Lead is responsible for ensuring the VA medical facility homeless program actively collaborates with the VA medical facility mental health program to ensure staff at all VHA points of service work together to meet the needs of homeless Veterans with mental health conditions, including SUD.

z. **VA Medical Facility Mental Health Discipline Leader.** The VA medical facility Mental Health Discipline Leader is responsible for:

(1) Ensuring all mental health staff are appropriately oriented and trained prior to provision of services.

(2) Ensuring professional development of VA health care providers in that discipline, including but not limited to instruction and maintaining professional skills, certifications and updating existing skills.

(3) Providing input to hiring decisions and performance evaluations at the VA medical facility and associated points of service for hires within their respective mental health disciplines, in coordination with the VISN CHRO ***NOTE: In some cases, the VA medical facility Mental Health Discipline Leader may also be the hiring decision maker.***

(4) Mentoring health care providers within their respective mental health disciplines (or related disciplines as described in paragraph 6.e. below) and contributing expertise with other VA medical facility Mental Health Discipline Leaders on the overall delivery of mental health services.

(5) Ensuring timely completion of peer reviews for Quality Management by the next review cycle before the reviews are due to ensure confidential and non-punitive assessments of care at the individual clinician level.

(6) Ensuring timely completion of Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations by the next review cycle before the evaluations are due.

(7) In collaboration with the VA medical facility Chief Mental Health Lead and the VA medical facility Associate Chief Nurse for Mental Health, ensuring that care is provided at the highest practical level within the discipline as defined by mental health care providers' professional training and clinical privileging or scope of practice.

aa. **VA Medical Facility Community Mental Health Point of Contact.** ***NOTE: This POC role is performed by the VA medical facility Chief Mental Health Lead or designee. This position requires dedicated time, refer to***

https://dva.gov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.a

[spx](#) for specific requirements. This is an internal VA website that is not available to the public. The VA medical facility Community Mental Health POC is responsible for:

(1) Acting as a liaison with community providers and State, county and local mental health systems.

(2) Coordinating VA activities with other public mental health and health systems, as outlined in paragraph 12.

bb. **VA Medical Facility Mental Health Disaster Response Point of Contact.** The VA medical facility Mental Health Disaster Response POC is responsible for serving as a member of the VA medical facility's Disaster Response Team.

cc. **VA Medical Facility Suicide Prevention Coordinator.** The VA medical facility Suicide Prevention Coordinator (SPC) is responsible for overseeing suicide prevention activities as outlined in VHA Directive 1160.07. **NOTE:** *This position requires dedicated time, refer to https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.a [spx](#) for specific requirements. This is an internal VA website that is not available to the public.*

dd. **VA Medical Facility Military Sexual Trauma Coordinator.** The VA medical facility Military Sexual Trauma (MST) Coordinator is responsible for monitoring and coordinating implementation of MST-related policy and serving as a point person for Veterans and staff for assistance with an MST-related issue. **NOTE:** *This position requires dedicated time, refer to https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.a [spx](#) for specific requirements. This is an internal VA website that is not available to the public. For a detailed discussion of these responsibilities, see VHA Directive 1115(1), Military Sexual Trauma (MST) Program, dated May 8, 2018.*

ee. **VA Medical Facility Mental Health Provider.** The VA medical facility mental health provider is responsible for:

(1) Communicating and coordinating services among teams and program areas to ensure Veterans receive seamless and integrated care, including collaborating with VA medical facility programs serving Veterans with complex needs and mental health conditions including SUD (e.g., homeless programs) at all VHA points of service.

(2) Providing care at the highest practical level defined by their professional training and clinical privileging or scope of practice.

6. STRUCTURE AND GOVERNANCE OF MENTAL HEALTH SERVICES

a. **The Office of Mental Health and Suicide Prevention Leadership.** OMHSP is a program office within VHA Clinical Services under the leadership of the Assistant Under Secretary for Health for Clinical Services. As such, OMHSP sets policy for delivery of safe, effective and timely mental health care and suicide prevention services. Its

governance function includes setting policy; developing and disseminating best practices, clinical tools and resources; providing consultation and technical support; and monitoring information and advising leadership about key performance metrics. These governance functions are shared as delegated by the Assistant Under Secretary for Health for Clinical Services with the National MH ICC, which is part of the VHA Governance Board structure. These functions are also informed by and coordinated with the structure of the Assistant Under Secretary for Health for Patient Care Services and the Assistant Under Secretary of Health for Operations. In accordance with VHA governance structure, the Assistant Under Secretary for Health for Operations is responsible for providing oversight and managing quality, compliance and risk for the VISNs and VA medical facilities, particularly through the VISN CMHOs.

b. **VISN Leadership.** Each VISN must appoint a full-time dedicated CMHO who also serves as chair of the VISN MHEC. The VISN MHEC must be incorporated into VISN governance and include participation from each VA medical facility Chief Mental Health Lead within the VISN and must also include at least one Readjustment Counseling Service representative. The VISN MHEC provides oversight and monitoring of quality, access and patient and provider satisfaction across the full continuum of mental health care delivery across the VISN; identifies areas of concern and utilizes shared resources to resolve them; facilitates the spreading of best practices; makes recommendations to VISN leadership; and communicates critical concerns to VISN and senior VA leadership. **NOTE:** *The VISN MHEC may also be referred to as the VISN Mental Health Governance Council or the VISN MH ICC.*

c. **VA Medical Facility Governing Body.** Each VHA Administrative Parent must include mental health leadership (e.g., VA medical facility Chief Mental Health Lead) as a voting member of its governing body. **NOTE:** *The VA medical facility governing body could be a Clinical Executive Board, Medical Executive Committee or equivalent body which is typically chaired by the VA medical facility Chief of Staff.*

d. **VA Medical Facility Mental Health Executive Council.**

(1) Each VHA Administrative Parent must establish and maintain a VA medical facility MHEC in its governance structure that reports into the VA medical facility's governing body to ensure the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans' preferences. The VA medical facility MHEC is chaired by the VA medical facility Chief Mental Health Lead or designee and must include at a minimum the following in its membership: the discipline leads for Psychiatry, Psychology, mental health Social Work, mental health Nursing, LPMHC (if applicable), MFT (if applicable); an SPC; an LRC; and representation from each level of the continuum of mental health care (e.g., inpatient, residential, outpatient) and from each Readjustment Counseling Service (Vet Centers) in the Administrative Parent's catchment area. Each VA medical facility MHEC must include at least one Veteran, and ideally one who is receiving mental health services within the Administrative Parent. It is also strongly recommended that the Veteran is not employed by the Administrative Parent. In addition, the VA medical facility MHEC's membership should include representatives with expertise in special populations such as women Veterans,

homeless Veterans, Veterans with SMIs or local tribal councils, as well as representatives from specialty mental health (SMH) programs and the VHA Administrative Parent's multiple sites of care (e.g., CBOCs). The VA medical facility Director, in collaboration with the VA medical facility Chief Mental Health Lead or equivalent leader, may decide whether other professions (e.g., VRCs, CPPs, Recreation Therapists, Occupational Therapists), chaplains, Peer Specialists, family members or caregivers, Whole Health, Patient Advocate, a VMHC representative or others must also be represented. VA medical facility MHECs must meet at least quarterly and record minutes that are accessible to all mental health clinical staff.

(2) Where there is a mental health service line or equivalent, the VA medical facility MHEC must report through that service line or equivalent to the VA medical facility governing body. **NOTE:** *This is a much-preferred structure for ensuring coordinated team based and interdisciplinary management of the full continuum of mental health services.*

(3) Where a mental health service line does not exist (e.g., there are separate service lines for Psychiatry and Psychology with no overarching VA medical facility Chief Mental Health Lead), the VA medical facility MHEC must report directly to the VA medical facility governing body led by the VA medical facility Chief of Staff. **NOTE:** *This is not an ideal structure for ensuring coordinated team based and interdisciplinary management of the full continuum of mental health services.*

e. VA Medical Facility Mental Health Leadership.

(1) Each VA medical facility must have a full-time dedicated VA medical facility Chief Mental Health Lead who has the overall responsibility for planning, organizing, directing, coordinating, reviewing, evaluating, implementing and improving the operations of mental health services within the VA medical facility, including oversight of all mental health programs that may be aligned under a different program office. As such, the VA medical facility Chief Mental Health Lead has the opportunity for input into hiring decisions, performance rating and quality improvement initiatives for these programs. This is a VA medical facility-level position that reports directly to the VA medical facility Director or designee in the executive leadership team and must be included in the membership of the VISN MHEC.

(2) Leadership of mental health services in VA medical facilities must oversee the delivery of mental health care in associated points of service. However, this oversight must not diminish or replace formal reporting structures for staff at the point of service (e.g., CBOCs), or for allocation of point of service 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 of outcomes are appropriately considered in the governance and decision-making processes of the associated VA medical facility. **NOTE:** *This requirement for oversight and communication is intended to ensure the ability of the point of service to respond to Veterans' mental health needs, regardless of*

the processes used to address them. It applies regardless of whether the point of service has dedicated mental health staffing.

(3) The VA medical facility Mental Health Discipline Leader is a person who is a formally assigned or designated lead professional for that clinical discipline regardless of organizational alignment. A VA medical facility must have a lead for Psychiatry, Psychology, Mental Health Social Work and Mental Health Nursing. In addition, it is recommended that a VA medical facility consider designating leads for Mental Health PAs, Mental Health CPPs, VRCs, MFTs and LPMHCs if local circumstances warrant (e.g. a sufficient number of the discipline exist at a VA medical facility). The VA medical facility Mental Health Discipline Leader may have direct supervision responsibilities within their discipline, managerial supervision responsibilities regardless of the discipline of their supervisees or both depending on local VA medical facility organizational structure.

(a) Within each VHA Administrative Parent, each mental health discipline must be represented by a designated leader in that discipline who takes responsibility for the professional practice of that discipline and has responsibility for professional development of health care providers in that discipline. This person must be responsible for or have direct input into hiring decisions and performance evaluations at the VA medical facility and associated points of service. This person must also provide professional staff mentoring and a venue to give input on delivery of clinical services. However, this input must not diminish or replace formal reporting structures for staff at the point of service (including interprofessional clinic or program level), or for decision-making about allocation of point of service resources.

(b) If there is no health care provider within a discipline who can fulfill the responsibilities described above in paragraph 6.e.(3) based on the qualification standards for that discipline, the VA medical facility Chief Mental Health Lead will coordinate with the VISN CMHO to ensure that appropriate clinical practice oversight is provided from the same discipline if possible.

7. PRINCIPLES OF CARE

a. VHA is responsible for ensuring access to care for new patients and continuity of care for established patients, including all patients with disruptive or concerning behaviors that may pose a barrier to optimal care delivery.

b. To ensure full coverage across a spectrum of needs, mental health services must be patient-centered, consistent with the medical benefits package and focused on what matters most to the Veteran. Clinical services provided must be team-based. While the requirements outlined in this directive are organized according to specific services and diagnoses, individual Veterans frequently present with more than one mental health concern and, often, other health concerns. Every program element described in this directive must be understood as an integral component of overall health and mental health care. All mental health care providers must communicate with and coordinate

services among different teams and program areas to ensure Veterans receive needed care.

c. VHA mental health care consists of programs that provide evidence-based practices including measurement-based care (MBC). Care should be measurement-based across the mental health continuum. The choice of measures should be based on programmatic objectives and Veterans' treatment goals and can include symptom measures, clinical outcomes (e.g., functioning, quality of life and other measures of Veterans' recovery and Whole Health), or process measures (e.g., therapeutic alliance and Veteran satisfaction). **NOTE:** Refer to VHA mental health program-specific guidance for more detail on MBC implementation, such as recommended measures and frequency of administration.

d. Care must be provided by qualified health care providers at an appropriate level of training and clinical privileging or scope of practice for the services they provide. All health care providers must have the administrative and clinical support required to allow them to work efficiently at the highest level of their licensure and clinical privileging or scope of practice.

e. Care should be delivered in a culturally competent manner. This includes cultural competence for individual difference variables including but not limited to age, race and ethnic differences, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression. It is vital to deliver optimal health at the population, community and individual levels, including the prevention of suicide.

f. VISNs and VA medical facilities are strongly encouraged to engage in research, evaluation and clinical innovation to identify and develop best practices and develop new strategies of recovery-focused mental health care.

g. Based on extensive VHA experience and a robust research evidence base with Veteran populations, telemental health (TMH) (including clinical video telehealth to clinics and to Veterans' homes/other non-VA locations) is an effective care modality that supports the delivery of services throughout the mental health continuum of care. TMH is encouraged as a mechanism for meeting requirements throughout this directive and is appropriate for most patients (i.e., there are no absolute contraindications or exclusion criteria for TMH services). Clinicians determine the most appropriate care modality or combination of modalities (e.g., clinical video telehealth to clinic, video to home, audio-only or in-person care) based on the needs and preferences of the Veteran and the state of technology and evidence-based practice to facilitate convenient, effective and safe access to care in accordance with VHA policy on use of telehealth technologies.

8. ACCESS TO MENTAL HEALTH CARE

a. 24 Hours A Day, 7 Days A Week Care.

(1) Veterans with an urgent need for mental health care must have same day access to appropriate mental health services based on clinical need (or Veteran preference when clinically appropriate). Veterans at elevated risk for suicide, or in need of immediate care by a health care provider for other reasons (e.g., confusion, severe pain, substance intoxication or withdrawal) must receive immediate attention. Any Veteran new to mental health with a non-urgent need will receive an initial screening evaluation the same day or no later than the next business day.

(2) Veterans must have access to appropriate emergency care at all times. VHA policy requires that all VA EDs have mental health coverage by an independent, licensed mental health provider. VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023, describes requirements in greater detail.

(3) All VHA telephone programs must have the capacity to triage and evaluate mental health, to include SUD, via telephone, based on VHA Directive 2007-033, Telephone Service for Clinical Care, dated October 11, 2007, by having:

(a) Mental health providers, training and protocols in place to allow responders to screen for mental health, to include SUD, and to know when to contact the mental health provider on-call for an evaluation of the screening findings.

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

(c) Procedures consistent with national policy to facilitate access to the Veterans Crisis Line when appropriate. See VHA Directive 1503(2), Operations of the Veterans Crisis Line Center, dated May 26, 2020.

(4) All VA medical facilities and other points of service (including CBOCs and other VA clinics) must have SOPs for ensuring same day access, screenings and warm handoffs for Veterans who attempt to engage regarding a mental health concern. These SOPs must be reviewed, audited and revised if appropriate at least annually. Supporting documents and guidance for same day access SOPs can be found on the OMHSP resource page:

https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Same_Day_Access.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(5) All VA medical facilities and other points of service which lack both EDs and 24/7 urgent care must have predetermined written plans (e.g., SOPs) for responding to mental health emergencies. They must:

(a) Identify at least one accessible VA or community-based ED where Veterans are directed to seek emergent care when necessary.

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

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

(d) Develop a plan to transport Veterans considered in need of urgent or emergency care to an accessible VA or community-based ED.

(6) Veterans presenting to ED or urgent care settings with mental health-related complaints must be evaluated to establish the urgency of care. When indicated, interventions must be initiated immediately, with follow-up as clinically appropriate.

(7) VA medical facilities with locked mental health acute inpatient units must be prepared, when it is feasible and consistent with State laws, to accept involuntary admissions resulting from civil commitments for those Veterans for whom VHA provides health care services. VA medical facilities without locked mental health acute inpatient units must have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when clinically necessary.

(8) Requirements for VA medical 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 deliver the care or services in an institution of such government. VHA Administrative Parents must consult the Office of Chief Counsel in the Districts, as needed, to ensure that local policies are consistent with Federal, State and other applicable laws.

b. Screening and Initial Evaluation Requirements.

(1) All new Veteran patients requesting or referred for mental health services who present in person must receive an initial screening evaluation the same day. For any Veteran with a non-urgent request contacting VA by virtual means (e.g., telephone, text or app), the evaluation must occur no later than the next business day. **NOTE:** *Initial screening evaluations are not required for patients self-referred or referred by a health care provider for interventions that are targeting solely a chronic health condition (e.g., smoking cessation, weight management, diabetes or other chronic disease management) or related to a medical procedure (e.g., bariatric surgery, transplant), unless a mental health condition was identified as part of the referral request. Referrals or requests for vocational rehabilitation services do not require an initial screening evaluation unless the Veteran presents with a mental health complaint or symptoms of a mental health condition, in which case the Veteran must be referred to an appropriately trained screener (see (paragraph 8.b.(3) below).*

(2) The primary goal of the initial screening evaluation (known as the 5-point screen) is to identify Veterans with urgent care needs and to initiate hospitalization or provide immediate outpatient care when needed. This evaluation must include the following elements:

- (a) Determining the urgency of need for care.
- (b) Identifying the appropriate setting for subsequent evaluations and treatment.
- (c) Arranging for treatment, as appropriate.

(d) Providing the Veteran with the name and contact information of a mental health professional that they can contact, even before they begin treatment, if they have questions or concerns, as well as instructions about accessing emergency services.

(e) Responding to the Veteran's questions or concerns and facilitating engagement in treatment.

(3) The initial screening evaluation can be conducted by primary care or other referring licensed independent practitioners (LIPs), including mental health (MH) LIPs, as well as appropriately trained Registered Nurses. **NOTE:** *For a definition of LIPs, see VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.*

(4) If a referral to general mental health (GMH) or SMH services is indicated by the initial screening evaluation, a more comprehensive diagnostic and treatment planning evaluation must be provided within 20 days (for GMH services) or 28 days (for SMH services). The full mental health evaluation must include the following documentation:

(a) Diagnostic assessment.

1. Use of the correct current procedural terminology code for the procedure performed.

2. Diagnosis/diagnoses given by a MH LIP according to the most recently published edition of the DSM or International Classification of Diseases. **NOTE:** *For a definition of LIP, see VHA Directive 1100.20.*

(b) Initial treatment plan mutually developed by the Veteran and the health care team after reviewing the available treatment options.

(5) For established patients, appointments for all mental health services should be scheduled within the requirements of VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022. If the treatment requires a series of appointments to provide a complete course of the intervention, the acceptable access timeline applies to the first appointment. All subsequent appointments must be scheduled in accordance with the appropriate clinical timing for the specific intervention/treatment plan (e.g., on a weekly recurring basis for 10-15 weeks for evidence-based psychotherapy).

c. Requirements for Points of Service and Extended Hours.

(1) VHA Administrative Parents must offer options as described in this directive for needed mental health services to Veterans living in urban and rural areas who could not otherwise access such services.

(2) As such, VHA Administrative Parents must comply with all provisions of VHA Directive 1231(3), Outpatient Clinic Practice Management, dated October 18, 2019, for all sites of care, including extended hours where required.

(3) VHA Administrative Parents are required to provide, onsite and at a minimum, a broad range of mental health services delivered through PCMH, Behavioral Health Interdisciplinary Program (BHIP) or SMH, including treatment for PTSD, SUD and SMI, as well as compensated work therapy, transitional work and supported employment services. Access to peer support services, or any mental health service not required or able to be delivered at the point of care (e.g., residential care, Psychosocial Rehabilitation and Recovery Center (PRRC) services, SUD Intensive Outpatient Programs (IOP) or Intensive Community Mental Health Recovery (ICMHR) services) must be made available either via telehealth or referral for care in the community through VCCP.

(4) In addition, very large CBOCs (those that serve more than 10,000 unique Veterans each year) are required to provide peer support services within GMH services and are strongly encouraged to provide onsite:

(a) ICMHR services.

(b) PRRC services.

(c) IOP for SUD.

(5) When there are gaps between the Veteran's needs and the mental health services accessible to the Veteran, the VHA Administrative Parent must extend the services by:

(a) Increasing staffing or access to TMH services (e.g., VA Video Connect, distribution of tablets, accessing the VISN Clinical Resource Hubs, onsite TMH space in CBOCs).

(b) Referring the Veteran to another nearby point of service.

(c) Ensuring, when appropriate, timely referral for care in the community following VHA Directive 1230.

(6) Services delivered through referral for care in the community or contracted services should meet the standards of this directive and quality and performance standards to ensure that Veterans receive the same standard of care regardless of where they receive services.

9. CONTINUUM OF CARE

a. VA mental health services are organized across a continuum of care and are provided in a team-based, interprofessional, patient-centered, recovery-oriented structure. The continuum must promote timely and effective treatment at the least intensive level of care appropriate to meet Veterans' needs, taking into consideration the severity and complexity of illness, what matters most to them in their lives and the Veteran's expressed preferences for treatment. Options for care include, but are not limited to, self-directed care, PCMH, GMH services (BHIP), specialty outpatient services, Whole Health services, psychosocial rehabilitation and community-based programs, residential and inpatient programs and crisis services.

b. **Required Services.** The following services must be made available by the VHA Administrative Parent across the continuum of care as appropriate to the program and patient care needs **NOTE:** *If a site of care within the VHA Administrative Parent does not offer the required services listed below, the service must be available through another VA resource.*

(1) Diagnosis, assessment and treatment for the full range of mental health problems, including SUD.

(2) Individual treatment using evidence-based pharmacotherapy, psychotherapy and somatic therapy (e.g., electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS)) for the full range of mental health conditions including SUD (see VHA Directive 1160.05, Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions, dated June 2, 2021).

(3) Group treatment using evidence-based pharmacotherapy or evidence-based psychotherapy.

(a) Psychotherapy groups can be either closed (also called cohort-based) or continually open to enrollment of new members. The provision of closed or cohort-based groups are permitted in a point of service only when the site's care system ensures that the Veteran seeking or referred for such a group can be monitored on a regular basis, evaluated for ongoing care needs and, if clinically appropriate, offered interim treatment. Such treatment may include but is not limited to individual treatment or options for self-help, peer support services or other Veteran-driven self-care activities.

(4) Peer support services (see VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019).

(5) Patient education, including mental health self-care, diagnostic formulations and their implications, medication management, post-discharge challenges and community resources.

(6) Family education, family consultation, family psychoeducation and couples/marriage and family counseling (see VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019).

(7) Vocational Rehabilitation Counseling services including transitional work and supported employment (see VHA Directive 1163).

(8) Psychological and neuropsychological evaluation and consultation services including evaluation of medical decision making and independent living capacities.

(a) In providing testing services, Psychologists, Neuropsychologists and other providers with appropriate credentials to provide such testing services in VA must abide by established standards for educational and psychological testing, such as those published jointly by the American Educational Research Association, American Psychological Association and the National Council on Measurement in Education. This includes administering and interpreting only those testing instruments for which they have appropriate scope of practice and training based on the instrument-specific user qualification restrictions or license agreements.

(b) For automated testing software tools, such as Mental Health Assistant, the supervising or senior Psychologist or designee ensures that proper security keys or User Level Access Controls are applied so only credentialed providers have access to psychological tests that require specific training or scope.

(9) Referrals and coordination of care between other levels of care and community treatment programs. **NOTE:** *Health care should strive to be comprehensive, Veteran-centered and evidence-based. Evidence-based care incorporates the clinical experience of the provider, patient values and preferences and the best available evidence from systematic research. While emphasizing specific treatments based on research, VA clinical practice guidelines are not prescriptions for management of every patient but are used to inform care within that context. It may be appropriate for health care providers to use complementary interventions beyond those defined by systematic research, so long as they are consistent with the clinical judgment of the health care provider and within that health care provider's scope of practice. In such cases, the potential benefits and risks must be reviewed in a shared decision-making process between providers and Veterans and be in accordance with VHA Directive 1137. These discussions must be documented in the EHR.*

c. Elements of the Continuum of Care.

(1) VA's mental health continuum of care promotes timely and effective care at the least intensive level of care appropriate to meet Veterans' needs. While Veterans may complete discrete episodes of care over finite periods of time, mental health services are available to them, as clinically indicated, across their lifetime. Key principles of the continuum include: starting with the least restrictive care, stepping up care to more intensive services as clinically indicated, using ongoing MBC and shared decision making to inform treatment choices and maximizing team-based care and flexible

service delivery methods (e.g., telehealth) to facilitate Veterans' Whole Health and recovery.

(2) The Patient Aligned Care Team (PACT) is the interdisciplinary foundation of the VA health care system, including mental health care. PACT providers manage and provide mental health care to their patients as part of their normal practice. PCMHI providers are integrated into PACT and provide consultation to PACT providers as well as time-limited mental health services for conditions that can be managed within PACT, based on staffing and expertise. PCMHI is considered the least intensive of direct mental health clinical care services along the continuum of care. Many Veterans are likely to receive all of their needed mental health services in the PACT setting. **NOTE:** *For more information, see VHA Handbook 1101.10(1).*

(3) Veterans may engage in self-directed care, with or without clinical support, as well as general and specialty outpatient, residential and inpatient programs, depending on their needs. Peer support services, crisis services, integrated employment services and community resources are available throughout the continuum. **NOTE:** *Veterans must not be denied access to any level of care based on the existence of a current substance use problem or the use of any controlled substances. When clinically indicated, tapering and discontinuing controlled medication can occur in coordination with SUD treatment.*

(4) Mental health services throughout the continuum of care must be team-based. Teams must be interprofessional and appropriate in size, discipline, and clinical expertise to meet the needs of the population served. All points of service must be flexible in the configuration of teams in order to maximize resources and provide a broad range of recovery-oriented and evidence-based mental health services. Flexible teams promote timely initial and sustained access to the appropriate type and level of care within the continuum of care. As Veterans complete an episode of care or move to another level of care, capacity must be created to ensure access for new patients and patients returning for a new episode of care.

(5) The following services and programs must be available along the continuum of care to address the range of clinical and psychosocial services to meet Veteran's needs:

(a) Primary Care Mental Health Integration. PCMHI is a required component of the PACT, providing mental and behavioral health expertise for Veterans whose conditions can be managed collaboratively in primary care. The primary care provider directs the overall care and treatment plan as part of PACT. Where primary care services are offered, PCMHI services must include Colocated Collaborative Care (CCC) providers who attend PACT huddles and provide consultative advice, brief assessment and problem-focused treatment, and Mental Health Collaborative Care Managers who use the evidence-based Mental Health Collaborative Care Management (CoCM) Model to provide longitudinal follow-up and decision support for specific mental health conditions. PCMHI staff work collaboratively with PACT, GMH/SMH and Mental Health Integration (MHI) programs and services to ensure Veterans receive the right level of care based

on symptom severity, functional impairment and Veteran preference. VA medical facilities should follow the PCMHI model's staffing ratio for CCC and CoCM which is considered the minimum necessary to adequately provide evidence-based and supportive treatment, care coordination and proactive population management. VA medical facilities must sufficiently staff PCMHI to provide required CCC and CoCM elements and functions as outlined in operational guidance. **NOTE:** For additional information about PCMHI, see the OMHSP resource page at: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Integrated%20MH.aspx>. This is an internal VA website that is not available to the public. In situations where Veterans are receiving their primary care services through specialty programs such as women's PACT, homeless PACT, GeriPACT or Home-Based Primary Care (HBPC), those programs' requirements ensure access to embedded mental health services. For more information, refer to VHA Directive 1140.07(2), Geriatric Patient Aligned Care Team, dated, March 23, 2021, VHA Directive 1411(1), Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated, June 5, 2017, VHA Handbook 1101.10(1) and VHA Directive 1330.01(6).

(b) Outpatient General Mental Health Service. Outpatient GMH service is delivered through BHIP teams and provides recovery-oriented care for mental health disorders across a full spectrum of diagnoses and conditions. Services may include those outlined in paragraph 9.b. and others as appropriate to the needs of the Veteran, including but not limited to suicidality, PTSD, mood disorders, traumatic brain injury (TBI), military sexual trauma (MST), SMI and SUD. Every VA medical facility is required to implement BHIP care. Full implementation means each BHIP team must incorporate the evidence-based Collaborative Chronic Care Model (CCM) as the practice model and be staffed to serve approximately 1,000 GMH unique Veterans. VA medical facilities should follow the BHIP model's staffing ratio, which is considered the minimum necessary to adequately provide evidence-based treatment and other indicated services, care coordination and proactive population management. VA medical facilities must sufficiently staff BHIP teams to provide required CCM elements as outlined in operational guidance. **NOTE:** For additional information about BHIP, see the OMHSP resource page at: [https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Behavioral-Health-Interdisciplinary-Program-\(BHIP\).aspx](https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Behavioral-Health-Interdisciplinary-Program-(BHIP).aspx). This is an internal VA website that is not available to the public.

(c) Outpatient Specialty Mental Health. Outpatient SMH programs provide time-limited, intensive, focused treatments; special population programming; program-specific assessment and diagnosis; evidence-based psychotherapy and psychoeducation; and modified, specialized care for Veterans with comorbidities (e.g., PTSD with TBI). Examples of SMH programs include:

1. PTSD Specialty Care Services (or PTSD Specialists). See VHA Directive 1160.03(1), Programs for Veterans with Posttraumatic Stress Disorder (PTSD), dated November 16, 2017.

2. Specialty SUD treatment services, including outpatient SUD services and intensive early recovery services, such as residential and intensive outpatient services. See VHA Directive 1160.04.

3. ICMHR programs, including Mental Health Intensive Case Management, Rural Access Network for Growth Enhancement (RANGE), and Enhanced RANGE (E-RANGE). See VHA Handbook 1163.06, Intensive Community Mental Health Services, dated January 7, 2016.

4. Care/case management services. See VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.

5. PRRC. See VHA Directive 1163.

6. VHA Vocational Rehabilitation Service, including compensated work therapy. See VHA Directive 1163.

7. Specialized MST-related care. See VHA Directive 1115(1).

(d) Mental Health Residential Rehabilitation Treatment Program. The Mental Health Residential Rehabilitation Treatment Program (MH RRTP) provides a 24-hour therapeutic setting utilizing professional and peer support to meet the needs of Veterans with complex, often co-occurring, mental health, substance use, psychosocial and medical needs. The MH RRTP continuum of programs include residential programs specific to the treatment of SUD, PTSD, homelessness, vocational concerns and general programs that address a range of mental health concerns. Consistent with VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019, all VISNs are expected to provide residential treatment services to meet the needs of women Veterans and Veterans with a SMI, PTSD, MST, SUD and homelessness either through specific bed sections, programs or treatment tracks in residential programs.

(e) Acute Inpatient Mental Health Services. Acute inpatient mental health services provide a safe and therapeutic environment to stabilize patients experiencing an acute mental health crisis. The goals of inpatient mental health include provision of comprehensive evidence-based and recovery-oriented mental health treatment to improve a Veteran's functional status in a safe and secure setting. Following stabilization, Veterans are transitioned to a less restrictive level of mental health services with the goal of having the Veteran return to the community when possible. Services are provided in accordance with VHA Handbook 1160.06. The needs of women Veterans must be considered and met including environment of care considerations specific to women Veterans (such as lactation support).

(f) Other Mental and Behavioral Health Services. Other services provided include:

1. Cognitive rehabilitation services.

2. Neuropsychology services.

3. Mental health services within HBPC and GeriPACT programs.

4. Mental health services within Community Living Centers (CLC) and Palliative Care Consult Teams. **NOTE:** For more information, see VHA Directive 1139, *Palliative Care Consult Teams and Veterans Integrated Service Network Leads*, dated September 9, 2022.

5. Consultation/liaison mental health services.

6. Mental and behavioral health services integrated into/with specialty medicine (e.g., pain, oncology), rehabilitation (e.g., spinal cord injury) and other medical programs or teams. MHI providers work collaboratively with medical providers and teams, PCMHI and GMH/SMH programs and services to ensure Veterans receive the right level of care based on symptom severity, functional impairment and Veteran preference and goals for health and wellbeing. Services are delivered by fully integrated, collaborative care providers who attend team meetings, provide consultative advice and conduct focused assessment and treatment for mental health and behavioral health needs. Operational guidance for MHI services is provided on the OMHSP resource page for Mental Health Integration into Medical Settings at:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Integrated%20MH.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(6) In addition to services at VA medical facilities, all eligible Veterans, as well as those otherwise eligible for care, may also receive services from the Readjustment Counseling Service (Vet Centers) based upon Veterans' preferences and needs. In these cases, care must be coordinated between the Vet Center and VA point of service through the designation of a liaison (see paragraph 12 for Community-Based Mental Health). **NOTE:** Except where similar treatments are offered, Vet Center services are not a substitute for the clinically indicated outpatient mental health services described in this directive. For further information on eligibility for these services, see VHA Directive 1500(2).

d. **Episodes of Care Along the Continuum.** VHA Administrative Parents should implement a stepped care model that promotes timely and effective treatment at the least intensive level of care appropriate to meet Veterans' needs in the moment and as needs change. Treatments are based on level of need and generally start with the least intensive appropriate treatments and step up to more intensive and specialist services as clinically required. The collaborative decision between Veteran and provider to step up or down is generally based on ongoing assessment of the Veteran's response to treatment, using validated measures of mental health symptoms and functioning. Mental Health and Primary Care leadership in VHA Administrative Parents must have clearly defined processes for how Veterans progress up and down the continuum of mental health care, including transitions to treatment settings where mental health care may be provided by a non-mental health care provider (e.g., in primary care with PCMHI support available as needed) and promotion of self-directed care and community integration.

e. **Treatment Planning Along the Continuum.** Veterans receiving GMH, SMH, residential and inpatient mental health services must have a mental health treatment plan. VHA Administrative Parents must follow program-specific requirements regarding treatment planning as defined by internal/external regulatory bodies, oversight bodies and VHA requirements. To access program-specific requirements, please see <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.* The mental health treatment plan should:

(1) Follow the Veteran from one treatment setting to another (rather than having separate, non-continuous plans in each setting).

(2) Be reviewed at a minimum on an annual basis.

(3) Be revised, as clinically indicated, to reflect significant changes in the Veteran's status, preferences or transitions in care. **NOTE:** *VHA Administrative Parents must include in their SOPs the frequency for recurring, periodic evaluations of treatment plans required by internal/external regulatory bodies, oversight bodies and VHA requirements.*

(4) Be recovery-oriented and support the Veteran's progression to a lower level of care as clinically appropriate.

(5) Be updated to track progress as care is delivered and the outcomes achieved, in a manner that is consistent with all applicable standards and informed by self-reported outcome measures collected as part of measurement-based care.

(6) Incorporate a shared decision-making process with input from the Veteran, including the discussion of self-reported outcome measures collected as part of MBC, and from the Veteran's family, friends or authorized surrogate, when appropriate, and with the Veteran's consent.

(7) Reflect the Veteran's goals and preferences for care as evidenced by documented discussions with the Veteran and the Veteran's authorized surrogate, family and friends, when appropriate.

(8) Account for all aspects of mental health care if the Veteran is receiving care from multiple mental health treatment programs or health care providers.

(9) Account for the Veteran's decision-making capacity. For Veterans who are determined to lack capacity, an authorized surrogate must be identified. The authorized surrogate must be included in all aspects of treatment planning outlined above and in accordance with VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

(10) Ensure care is integrated and coordinated across the mental health continuum and between mental health and other components of the health care system, and reflected in the Veteran's EHR in one comprehensive, integrated mental health

treatment plan. **NOTE:** *This requirement does not apply to mental health care provided in non-mental health specific settings, including: PACT by PCMHI health care providers, as the goals of mental health treatment are documented as part of the PACT treatment plan; HBPC team, as the goals of mental health treatment are documented as part of the HBPC treatment plan; and other settings such as inpatient medicine, rehabilitation and CLCs, where the goals of the mental health treatment are documented as part of the general treatment plan.*

f. Care Transitions.

(1) **Continuity of Care.** VHA Administrative Parents must ensure continuity of care during transitions from one level of care to another at any and all points of service. A clearly defined process for transition to and from all aspects of mental health care inclusive of PCMHI, GMH, SMH, residential and inpatient must be delineated in local SOPs and must include information related to the processing of consults, same day services and management of patient flow through the various levels of mental health care. The goal is to ensure ongoing access to appropriate care when moving from one site or program to another.

(2) **Admission.** When Veterans are referred for residential or inpatient mental health services, VA medical facilities must have processes in place to ensure that emergent needs are addressed prior to admission. When Veterans referred for residential treatment are not able to be admitted immediately, clinical follow-up must be provided consistent with the requirements specified by VHA Directive 1162.02.

(3) **Discharge.** VA medical facilities must implement and maintain a systematic (i.e., not an individual or position dependent) process for tracking Veterans following discharge from inpatient or residential care settings in order to facilitate engagement in post-discharge continuing care. VA medical facilities are encouraged to utilize clinical tools developed by OMHSP to facilitate care coordination and engagement. At the time of discharge, Veterans must:

(a) Receive information about how they can access mental health care on an emergency basis.

(b) Be given confirmed scheduled appointments for post-discharge engagement.

NOTE: *When Veterans decline follow-up mental health services, this must be documented. When Veterans miss scheduled appointments, there must be appropriate clinical follow-up and documentation in the EHR.*

10. GENDER-INFORMED AND GENDER-SPECIFIC CARE

a. All care provided in mental health must be compliant with VHA Directive 1330.01(6) and VHA Directive 1341(2), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018. All mental health care should be delivered in a manner that considers the influences of sex and gender on mental health.

b. Gender-informed mental health care accounts for the influence of gender and gender inequities on mental health. Gender encompasses male and female, as well as non-binary gender identities. For example, interpersonal traumas (e.g., sexual assault, intimate partner violence), which are associated with risk for PTSD, are more commonly experienced by women than by men.

c. Gender-informed mental health care addresses reproductive health, including reproductive mental health in all genders. Mental health care also must address intentions for pregnancy and family building. Mental health prescribers must be knowledgeable about the effects of medications on fertility and on teratogenicity, for both men and women.

d. Gender-specific mental health care is the application of evidence-informed knowledge about how sex and gender affect mental health conditions and their treatment. For example, mental health problems especially relevant to women include premenstrual dysphoric disorder, postpartum depression and mood changes related to perimenopause.

e. Women's mental health incorporates principles of gender-informed and gender-specific care. Women's mental health addresses the influences of sociocultural, behavioral and biological factors, and reproductive cycle stages on the mental health of individuals of female gender and sex.

11. INTEGRATING MENTAL HEALTH SERVICES IN THE CARE OF OLDER VETERANS

a. Older Veterans experience a wide range of behavioral and mental health concerns, including continuity/recurrence of earlier life mental disorders or onset of new challenges in late life. Guiding principles for providing mental health services for older Veterans include engagement of family or other caregivers as appropriate; communication and coordination with health care providers; assessment and optimization of Veteran functioning and participation in decision-making; and, when Veterans lack capacity for making certain decisions, engagement of surrogate decision-makers in care planning.

b. Each VA CLC must have, at minimum, 1.0 full-time equivalent (FTE) Psychologist as a core member of the interprofessional team for each 100 beds. Minimum dedicated FTE is 0.5 FTE for 50 beds or less; for 51-100 beds, FTE must be prorated at the rate of 1:100 beds (e.g., 0.8 FTE for 80-bed CLC). For CLCs that care for a relatively high proportion of Veterans with mental illness or provide specialized short- or long-stay Mental Health Recovery or Dementia Care services, the Psychologist staffing ratio should be increased to meet resident behavioral care needs.

c. Each VA HBPC team must have, at minimum, 1.0 FTE Psychologist or 1.0 FTE Psychiatrist with background and experience in psychological and cognitive assessment and psychosocial treatment as a core member of the interprofessional HBPC team for

each 140 Veterans served by the team. **NOTE:** For further information, see VHA Directive 1411(1).

d. Each CLC and HBPC team must possess or have access to psychopharmacology treatment capacity to provide the necessary evidence-based psychopharmacology treatment to Veterans served by the health care provider team.

e. VA medical facilities are encouraged to implement other programs and services to meet the mental health needs of their local and regional older adult populations (e.g., geriatric mental health clinics, GeriPACT, family caregiver support for older Veterans with dementia or mental illness). See further information at <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

12. COMMUNITY-BASED MENTAL HEALTH

a. The VISN and VA medical facility Community Mental Health POCs are mental health providers who work together in liaising with community providers and State, county and local mental health systems to ensure coordination of VA activities with other public mental health and health systems. Such activities may include:

(1) Providing information to 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 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 community-based services for Veterans and families (e.g., VCCP, co-location of staff, providing TMH).

(5) Collaborating with other VHA mental health team members (e.g., LRCs) to promote community-based activities.

(6) Ensuring that sharing agreements with the Department of Defense and military services are coordinated in accordance with the provisions of VHA Directive 1660, Department of Veterans Affairs - Department of Defense Health Care Resources Sharing Agreements, dated November 30, 2022.

(7) Addressing issues, in conjunction with the Office of Chief Counsel in the Districts and Office of General Counsel, regarding involuntary mental health treatments that occur under State laws and, sometimes, across State lines.

b. VISNs and VHA Administrative Parents must appoint a select group of mental health providers to serve as public spokespersons on mental health issues of concern

to the community. These individuals must be able to work collaboratively with public affairs, communications offices and leadership at the local, regional and national levels.

c. Combat Veterans and current Service members who require counseling to address problems related to their adjustment back to civilian life may choose to receive care at Vet Centers for these services. Veterans and current Service members who have experienced MST may also choose to receive MST-related counseling at Vet Centers. **NOTE:** *Except where similar treatments are offered, Vet Center services are not a substitute for clinically indicated evidence-based mental health services described in this directive.*

(1) Each VHA Administrative Parent must designate at least one individual to serve as a liaison with any Vet Centers in the area in order to ensure mental health care coordination and continuity of care for Veterans served through both systems. The liaison's duties should include participating in a Root Cause Analysis when it is known that a Veteran who died by suicide was receiving care simultaneously at the VA medical facility and at the Vet Center. **NOTE:** *This position is distinct from the VA medical facility Community Mental Health POC and requires its own dedicated/protected time. For more details see VHA Directive 1500(2).*

(2) Each VHA Administrative Parent must designate at least one individual to serve as Vet Center External Clinical Consultant. The External Clinical Consultant may be the same official as the liaison noted in paragraph 12.c.(1) depending on the logistical contingencies at the support VA medical facility. External Clinical Consultants must be VHA mental health professionals who are independently licensed and have completed the VA credentialing process. The External Clinical Consultant is responsible for providing Vet Center counseling staff with professional consultation concerning the mental health care and services necessary to fully support readjustment of eligible individuals. Consultation must occur through regularly scheduled peer case presentations onsite at the Vet Center or via telehealth (at least 4 hours monthly). Records of the individual case consultations are maintained by the Vet Center. **NOTE:** *This position is distinct from the VA medical facility Community Mental Health POC and requires its own dedicated/protected time. For more details see VHA Directive 1500(2).*

(3) Transition between active duty and Veteran status is a period of increased risk for mental health morbidity. VISNs and VHA Administrative Parents must collaborate with Vet Centers in outreach to transitioning Veterans. Outreach activities must be coordinated with the Transition and Care Management Team at the VA medical facility and can include presentations at National Guard or Reserve sites and post-deployment/separation events. **NOTE:** *See VHA Directive 1500(2) and VHA Directive 1010(1), Case Management of Transitioning Service Members and Post-9/11 Era Veterans, dated February 23, 2022.*

(4) The VHA Administrative Parent must develop mechanisms for obtaining input from stakeholders on the structure and operations of mental health services. Veterans Mental Health Councils (VMHC) are one way to achieve this goal. VA medical facilities are strongly encouraged to facilitate the development of a VMHC and, when one exists,

must strive to maintain the partnership with the VMHC. Other ways of seeking Veteran input include but are not limited to local townhalls, VA Mental Health Summits, program exit interviews and inviting representative Veterans to serve on local VA medical facility boards, committees and planning bodies.

(5) In addition, each VHA Administrative Parent is required to host one Mental Health Summit per year. A summit should include community partners and various stakeholders. VA participants should include at least one member of the VA medical facility executive leadership team and one member of the Mental Health leadership team. The Mental Health Summit should be coordinated by the VA medical facility Chief Mental Health Lead or designee (e.g., VA medical facility Community Mental Health Lead, LRC). Specific requirements are outlined annually and available on the OMHSP resource page at

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(6) VMHCs are composed primarily of Veterans who are current or past consumers of VA mental health services and family members of those Veterans and may include other stakeholders, including but not restricted to:

(a) Veteran Service Organizations.

(b) Representatives from the National Alliance for Mental Illness, Depression and Bipolar Support Alliance, and other mental health advocacy groups active within the local community.

(c) Local community employment and housing representatives.

(d) Representatives of women Veterans, tribal Veterans programs and other special populations.

(7) At least one VA mental health provider must be designated to serve as a liaison to the VMHC (e.g., LRC) to facilitate communication with the leadership of the VA medical facility's mental health program. Local VA medical facility mental health leadership is strongly encouraged to attend council meetings when invited and as appropriate.

(8) VHA Administrative Parents are strongly encouraged to invite a representative from the local VMHC to attend their VA medical facility MHEC meetings.

(9) The Federal Advisory Committee Act (FACA) may be applicable to the VMHC or other similar mechanisms for seeking Veteran input, especially when the VMHC is giving advice, opinions or recommendations as a collective whole. VHA Administrative Parents must consult with the Office of Chief Counsel in the Districts to ensure compliance with FACA. **NOTE:** More information on FACA is available at <https://www.gsa.gov/policy-regulations/policy/federal-advisory-committee-management/legislation-and-regulations/the-federal-advisory-committee-act>.

13. DISASTER PREPAREDNESS

All VA medical facilities must have a designated VA medical facility Mental Health Disaster Response POC who serves as a member of the VA medical facility's Disaster Response Team.

14. IMPLEMENTATION

a. Local and regional issues may affect the implementation of certain clinical service requirements described in this directive. OMHSP offers technical assistance to VISNs and local points of service in their efforts to implement the requirements. National Program Directors and other subject matter experts within OMHSP also are available for consultation and support in implementing requirements specified by this directive or by program-specific directives.

b. VHA points of service must submit formal written requests (waivers) for local modifications or exceptions to clinical service requirements (including discontinuation of, or major reductions or additions to, services) through their respective VISN governing body to OMHSP. OMHSP must concur in writing prior to any changes being made. Where applicable, these changes must follow requirements specified by VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016. **NOTE:** See *VHA Notice 2023-02 for more information.*

c. Requests for modifications and exceptions to clinical service requirements must include a request for related technical assistance, plans for ensuring the availability of all required services for Veterans who need them and, where relevant, timetables and milestones for implementation of the requirements.

15. WAIVERS FOR NONCOMPLIANCE

a. OMHSP has established a process for accepting, approving and monitoring waiver requests in accordance with requirements in VHA Notice 2023-02. If noncompliance with all or part of this directive is discovered, the VA medical facility must follow this OMHSP process until a resolution to the noncompliance can be made.

b. If noncompliance is identified and it is determined that it can be corrected within 30 days of identification, notification to OMHSP is required via email. This notification, once acknowledged by OMHSP, will act as a temporary waiver expiring 30 days from acknowledgement. Information in the notification includes policy number and section, reason for noncompliance, risk mitigation strategy until compliance can be achieved and an overall plan to resolve the noncompliance.

c. Noncompliance that is identified and determined to be uncorrectable within 30 days of identification or is not corrected within the temporary waiver timeframe must follow the OMHSP process to ensure the mitigation of the risk and meet the intent of this directive as written. This process is outlined on the OMHSP resource page at <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/WAIVERS.aspx>.

NOTE: *This is an internal VA website that is not available to the public.*

16. DIRECTIVE RESOURCES

OMHSP has developed a resource page that includes information on specific mental health topics, POCs and links to pertinent VHA directives that are related to mental health. These resource pages include program-specific policies, requirements and guidance that are critical to implementation. To access the OMHSP resource page, see <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

17. TRAINING

Individuals who work within mental health programs or come into contact with individuals in mental health programs or the physical structures/environments of mental health programs must complete training as required by internal/external regulatory bodies, oversight bodies and VHA requirements. **NOTE:** *There are no mandatory training requirements associated with this directive, however OMHSP has provided a listing of recommended and supplemental trainings on the OMHSP Training resource page.*

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. *This is an internal VA website that is not available to the public.*

18. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

19. REFERENCES

- a. 38 U.S.C. §§ 1710, 2032, 7301(b), 8110.
- b. 38 C.F.R. §§ 17.107, 17.38, 17.46-17.48.
- c. VHA Directive 1010(1), Case Management of Transitioning Service Members and Post-9/11 Era Veterans, dated February 23, 2022.
- d. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- e. VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.
- f. VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023.
- g. VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019.

h. VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.

i. VHA Directive 1115(1), Military Sexual Trauma (MST) Program, dated May 8, 2018.

j. VHA Directive 1137, Provision of Complementary and Integrative Health, dated December 13, 2022.

k. VHA Directive 1139, Palliative Care Consult Teams and Veterans Integrated Service Network Leads, dated September 9, 2022.

l. VHA Directive 1140.07(2), Geriatric Patient Aligned Care Team, dated March 23, 2021.

m. VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Facilities, dated March 24, 2022.

n. VHA Directive 1160, Re-Engaging Veterans with Targeted Serious Mental Illness in Treatment, dated February 7, 2018.

o. VHA Directive 1160.03(1), Programs for Veterans with Posttraumatic Stress Disorder (PTSD), dated November 16, 2017.

p. VHA Directive 1160.04, VHA Programs for Veterans with Substance Use Disorder, dated December 8, 2022.

q. VHA Directive 1160.05, Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions, dated June 2, 2021.

r. VHA Directive 1160.07, Suicide Prevention Program, dated May 24, 2021.

s. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

t. VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019.

u. VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019.

v. VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019.

w. VHA Directive 1163.07, Services for Veterans Experiencing Early Psychosis, dated October 7, 2020.

x. VHA Directive 1165, Leadership Positions in Mental Health, dated May 12, 2021.

y. VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, dated May 12, 2017.

z. VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019.

aa. VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022.

bb. VHA Directive 1231(3), Outpatient Clinic Practice Management, dated October 18, 2019.

cc. VHA Directive 1330.01(6), Health Care Services for Women Veterans, dated February 15, 2017.

dd. VHA Directive 1341(2), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

ee. VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023.

ff. VHA Directive 1411(1), Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017.

gg. VHA Directive 1500(2), Readjustment Counseling Service, dated January 26, 2021.

hh. VHA Directive 1501, VHA Homeless Programs, dated October 21, 2016.

ii. VHA Directive 1503(2), Operations of the Veterans Crisis Line Center, dated May 26, 2020.

jj. VHA Directive 1660, Department of Veterans Affairs - Department of Defense Health Care Resources Sharing Agreements, dated November 20, 2022.

kk. VHA Directive 1899(2), Health Care Professional Practice in VA, dated April 21, 2020.

ll. VHA Directive 2007-033, Telephone Service for Clinical Care, dated October 11, 2007.

mm. VHA Directive 2010-053, Patient Record Flags, dated December 3, 2010.

nn. VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023.

oo. VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

pp. VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.

qq. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

rr. VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015.

ss. VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013.

tt. VHA Handbook 1163.06, Intensive Community Mental Health Services, dated January 7, 2016.

uu. OMHSP BHIP Team-Based Care:

[https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Behavioral-Health-Interdisciplinary-Program-\(BHIP\).aspx](https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Behavioral-Health-Interdisciplinary-Program-(BHIP).aspx). **NOTE:** This is an internal VA website that is not available to the public.

vv. OMHSP Integrated Mental Health Services:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Integrated%20MH.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

ww. OMHSP Mental Health Policy Resource Page:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

xx. OMHSP Mental Health Required Staff Listing:

https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. **NOTE:** This is an internal VA website that is not available to the public.

yy. OMHSP Official Policy Waivers:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/WAIVERS.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

zz. OMHSP Same Day Services in Mental Health Care Settings:

https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Same_Day_Access.aspx. **NOTE:** This is an internal VA website that is not available to the public.

aaa. Agency for Healthcare and Research Quality, Warm Handoff: Intervention:

<https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html>.

bbb. SAMHSA. Living Well with Serious Mental Illness:

<https://www.samhsa.gov/serious-mental-illness>.

ccc. SAMHSA. SAMHSA's Working Definition of Recovery:

<https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>. **NOTE:** This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.

ddd. U.S. General Services Administration. The Federal Advisory Committee Act:
<https://www.gsa.gov/policy-regulations/policy/federal-advisory-committee-management/legislation-and-regulations/the-federal-advisory-committee-act>.