Vision, Goals, and Principles of VHA Handbook 1160.01: UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS

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VA/Veteran Population Facts

• 23.8 million veterans
  – 1.8 million women

• 7.8 million enrolled for health care in Department of Veterans Affairs (VA)

• About 5.5 million seen / yr
  – 23% of all veterans

• 1.6 million with MH Diagnoses
  – Almost 30% of all veterans seen
Current Returning Veterans: Eligible for Care

• Congressional authority:
  Any Veteran separating after FY2002 has eligibility for VA health care for 5 years, regardless of other eligibility

• Our hope:
  All returning Veterans will establish VA care during this window
VA’s Commitment: Quality Care

• Our nation’s commitment to a new generation of Veterans, for their lifetime:
  – Treat returning Veterans early in the course of mental health problems
  – Provide holistic, integrated care for physical and mental health problems:
    
    *Mental health is an essential component of overall health care*

• Being there for *their* lifetime and for the lifetime of all Veterans we are serving, from all eras
• Attrition of VA MH services in the late 1990s up to about 2003

• Major Rebuilding & Innovation since 2004
  – VHA Comprehensive MH Strategic Plan
    • Developed in 2003-04 and approved November, 2004
    • Major rebuilding efforts for MH began with this document
  – Uniform MH Services Package
    • Defines mental health services that must be provided to all enrolled veterans
    • Completes implementation of Strategic Plan for patient services
Hiring to Date

New Mental Health Enhancement Positions
Committed 4345 positions funded 4030
Committed
VA Psychologists GS11-GS15 by Fiscal Year, FY95-March FY09
• VHA Handbook 1160.01: Uniform Mental Health Services In VA Medical Centers and Clinics
• Final version distributed September 12, 2008
• Key principle of the handbook:

  Mental Health care is an essential component of overall heath care
• Handbook is designed to capture the culmination of the MHSP

• Lays out minimum requirements for VHA Mental Health Services
  ▪ Delineates essential components of mental health care that are to be implemented nationally,
  ▪ to ensure that all veterans, wherever they obtain care, have access to needed mental health services
Overview

• Program specifications are not described in high levels of detail
  ▪ opportunities for local choice to address local variation in presenting problems

• Communication and coordination between services are expected.

• Every program element should be understood as a component of comprehensive, holistic care
Domains of the Uniform Services

- Structure & Governance
- Community MH
- Gender specific care
- 24/7
- Inpatient
- Residential
- Ambulatory
- Care transitions
- Substance use
- Serious mental illness
- Recovery transformation
- Evidence-based care
- Homelessness
- Incarcerated veterans
- Primary care integration
- Older adult services
- PTSD
- Military sexual trauma
- Suicide prevention
- Managing violence
- Disaster preparedness
- Rural health
• Considerable funding has been made available to support the implementation of these requirements through the
  – Mental Health Enhancement Initiative
  – Congressional Supplemental Budget, FY 2007
  – Veteran Equitable Resource Allocation (VERA) funding
  – Special funding for SUD initiatives
  – Additional funding for programs related to mental health services for homeless veterans and to prevent homelessness
Funding Update

• All programs established as MH enhancement since FY05 received recurring funding in FY 2009
  – Final decisions underway concerning mechanisms of distribution of recurring funds in FY2010
  – Full intent that recurring funding will be available, but specific mechanisms not finalized

• Jump start funding of $1.29 million to support immediate implementation of UMHSH sent to the field at the start of FY09
Funding Update

• FY09: Over $557 million in VA MHEI budget and over $3.8 billion overall in MH funding
  – $120 million new funding for UMHSH implementation
  – 2/3 of that $120 million was distributed on the basis of number of unique patients seen in the VISN
  – Last 1/3 was distributed in Jan. 09, after Technical Assistance from VACO to all VISNs, determining need and methodologies for implementation

• Additional funding sent and forthcoming for Homeless programs and SUD programs
Expectations for FY2010

- Final President’s Budget not yet released, so specifics not available
- FY 2010 will be a year to emphasize sustainability, not continued dramatic enhancement
- Full implementation of the UMHSH is still mandated for end of FY 2009, so sustainability will be paired with accountability for full delivery of services in the Handbook
Implementation

Local and regional issues may affect implementation of the requirements. Potential barriers:

(a) Space limitations,
(b) Lack of availability in certain regions of mental health clinicians who could be recruited to VA,
(c) Difficulties in meeting information technology needs,
(d) Distances for patient travel,
(e) Limitations in the availability of community-based providers who could provide services via sharing agreement, contract or non-VA fee basis care, and
(f) Time required to develop contacts or other arrangements with local provider organizations.

NOTE: The Office of Mental Health services needs to be kept informed about such difficulties as they arise and evolve.
• VISNs must request modifications or exceptions for each medical center and CBOC for those requirements that cannot be met in Fiscal Year 2009 with available and projected resources.

• Requests to be submitted to the Deputy Undersecretary for Operations and Management (10N) and the Office of Mental Health Services (116) for review and approval

TO DATE, NO REQUESTS FOR EXCEPTIONS HAVE BEEN SUBMITTED TO VACO
Elements

• OMHS Section Leads will discuss their components of the Handbook

• I will emphasize samples of
  – General elements not associated with a lead
  – Elements whose OMHS Section Leads are not here
Excerpt:
b. Where there are mental health services lines, or equivalents, recruitment of leadership must be compliant with current VHA policy, which specifies that all mental health leadership positions must be advertised for all of the core mental health professions (Psychiatry, Psychology, Social Work, and Nursing), and that selection must be equitable among candidates. Evaluation of candidates and selection of leadership needs to consider all relevant factors.
• Distributed February 27, 2009

• Two changes from prior Directive
  1. Definition of a MH leadership position:
     Mental health leadership positions include all positions where the incumbent has responsibility for an interdisciplinary work force.
  2. List of relevant professions to be included:
     Announcements for filling VHA leadership positions in mental health contain language inviting applicants from the four core mental health professional disciplines: nursing, psychiatry, psychology, and social work.
Continued Implementation of Directive

• Implementation charged to OMHS, with back-up from 10N
• You are our eyes and ears – please alert me if you see a violation of the Directive
• The sword cuts both ways – positions that are leadership and have been held by psychologists cannot only be advertised for psychologists
Further Info on Governance

c. Regardless of the structure of mental health services and of their leadership, there must be mechanisms for ensuring that leadership has coordinated input from all of the core mental health professions, and from each of the specialized programs within mental health.

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

• Each of the core mental health professions needs to be:
  1. Represented by a designated leader in that profession
  2. Who takes responsibility for the professional practice of that discipline and
  3. Who has responsibilities for mentoring and professional development of staff in that profession.
  4. This person needs to have responsibilities for, or direct input into, hiring decisions and performance evaluations.
(2) Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center.
Principal Therapist

• Every veteran seen in mental health services must have a principal therapist or principal mental health provider with whom they meet on a regular basis.

• When veterans are seeing more than one mental health provider, and when they are involved in more than one program, the identity of the principal therapist or principal mental health provider must be made clear to the patient and identified in the medical record.
The principal therapist or principal mental health provider is responsible for:

- Coordinating development of the veteran’s treatment plan, incorporating input from the veteran (and, when appropriate, the family),
- Communicating with the veteran (and family, when appropriate) about the treatment plan
- Monitoring progress
- Coordinating any revisions to the treatment plan
- Addressing any of the veteran’s problems or concerns about their care
PTSD

- Specialized outpatient programs – either PTSD Clinical Team or PTSD Specialist(s)
- Evidence-Based Psychotherapy for PTSD (CPT or PE) must be available to all who need and want it
- Inpatient care must have a PTSD unit or track
- SUD Specialists in PTSD programs
- Care equivalent to residential care available to all who need it
  - Residential care program must exist in the VISN and be available to all veterans who need it
Women Veterans

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

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

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

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

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

• Each veteran who requires domiciliary care or residential rehabilitation and treatment programs must have timely access to these residential care programs.

• MH RRTPs must be Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited in Behavioral Health Residential Standards.
Facilities must ensure that waits for admission to a MH RRTP do not delay the implementation of care by instituting processes that include:

1. Ongoing monitoring and case management of referred patients.

2. Provision of treatment as needed to ensure stabilization of target conditions and management of comorbidities. NOTE: This may include inpatient care.

3. Utilizing waiting periods to provide pre-group preparation to enhance the experience and benefits of group treatment. Pre-group preparation can be provided on an outpatient basis provided veterans are in a safe and secure environment.
Whenever veterans awaiting admission to an RRTP have an urgent need for mental health care, appropriate mental health services must be provided.

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

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

• Each VISN must appoint and maintain at least one full-time Health Care for Reentry Veterans (HCRV) Specialist to support veterans being released from State and Federal prisons.

• With assistance from VISN Mental Health leadership, the HCRV Specialist is responsible for:

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

  (2) Working with POCs to engage with veterans being released from prison in need of care.
• When veterans’ non-violent offenses are products of mental illness, veterans and their communities are often better served by mental health treatment than incarceration. Police encounters and pre-trial court proceedings are often missed opportunities to connect veterans with VA mental health services as a negotiated alternative to incarceration or other criminal sanctions. Each VA medical center is strongly encouraged to appoint and maintain an individual who fills two inter-related roles:

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

(2) A Veterans’ Justice Outreach coordinator, committed to interfacing and coordinating with the local criminal justice system, including jails and courts.
• This is a huge endeavor
• There will be problems and pains
• We are all in it together
• Let’s discuss opportunities, questions, concerns, . . .
• First, Dr. Cuerdon will discuss how implementation will be measured