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CHAPTER 3. MENTAL HEALTH PROGRAMS

PARAGRAPH **PAGE**

RESCISSIONS

The following material is rescinded:

PARTIAL RESCISSION

M-2, Part X, Chapter 3, pages 3-21 and 3-22, dated June 29, 1993.

CHAPTER 3. MENTAL HEALTH PROGRAMS

3.01 INTEGRATED MENTAL HEALTH SERVICES

a. Integrated Psychiatric Continuum of Care

(1) The purpose of an integrated continuum of care is to provide that specific level of care required to maximize independence and control over symptoms. For many patients, either too much care, such as a prolonged, unproductive hospitalization, or too little care, as seen with premature discharge into an unsupportive community, has resulted in regressed behavior subsequently requiring increased professional intervention.

(2) Many psychiatric patients experience their mental illness not as episodic, but as a continuous, or fluctuating, series of symptoms at various levels of intensity. A dichotomous model that assumes either health, at which time no care is needed, or illness, at which time one seeks care, has proven ineffective both clinically and economically.

b. Case Management

(1) For psychiatric patients whose symptoms affect their planning and judgment, a failure of life management skills is often an additional burden. Veterans found on the streets, in jails, or in some "custodial" facilities are examples of this failure. In addition to the availability of a continuum of care, these patients require case management, or a similar ongoing connection with VA (Department of Veterans Affairs), so that medical, psychosocial, and vocational services can be planned, developed, integrated, and maintained with them.

(2) Case Management provides a systematic approach to locating, coordinating, and monitoring a defined group of services for a designated target population. This approach provides for planned and systematic use of the full range of VA and community services and requires a dual focus on meeting the veteran's needs and conserving agency and community resources.

(a) Emphasis on continuity of care from the point of preadmission assessment through admission to inpatient, or outpatient care, to discharge planning and aftercare services is included.

(b) Ideally, the same case manager should follow the patient. If this is not possible, a model that promotes communication and coordination among levels of care is critical.

(c) Components of Case Management include:

1. Screening and assessment,

2. Care planning,

3. Implementation,

4. Monitoring, and

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5. Periodic reassessment.

NOTE: A significant number of patients who now reside in long-term care facilities may be reintegrated in the community when a comprehensive, flexible case management policy is implemented.

c. Psychiatric Consortia or Collaborative Networks. Patients should be encouraged to receive their treatment near their homes and within one medical center. Since every VA medical center cannot offer a full-range of mental health services, VA policy:

(1) Defines a collaborative network or consortium of those medical centers that currently interact.

(2) Requires joint planning, designated responsibility for patients independent of current location, and collaboration among inpatient and outpatient facilities, and with non-VA community resources.

d. Psychiatric Levels of Care

(1) In order to ensure effective, high quality psychiatric treatment in VA, seven distinct levels of care for psychiatric patients are described. Within each level of care are a number of programs designed for specific patient groups.

(a) Smaller facilities may choose to combine such programs on one unit.

(b) Some special patients who may require different settings for the entire range of care include those associated with:

1. PTSD (Post-Traumatic Stress Disorder),

2. Psychogeriatric disorders,

3. Chronic mental illness, or

4. Substance abuse.

(2) Figure 1, entitled Patient Flowsheet, illustrates a possible integration of the major levels of care. This example is considered to be neither exhaustive nor limiting. NOTE: Examples of all programs listed currently exist within VA medical centers.

(a) As suggested in Figure 1, the great majority of VA psychiatric patients are seen primarily in outpatient settings, admission/triage areas, and general psychiatric wards.

(b) Within the larger hospitals, the general psychiatric ward is usually the center of evaluation, treatment, and referral activity, initiating referrals to specialty and longer term programs when clinically indicated.

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Figure 1.

(3) The choice of services and patterns of admitting and referral developed at any specific medical center is determined by:

(a) Mission,

(b) Local conditions,

(c) Size and location of facilities,

(d) Pattern of patient needs, and

(e) The results of joint planning among collaborating VA medical centers.

(4) In keeping with the current definition of Intermediate Care Programs in VA (M-9, Ch. 9, App. 9H, Subpar. 3.c.), levels of care criteria are statements of intensity of clinical intervention rather than a LOS (length-of-stay) statement. This distinction is made because the word "acute" often implies both high intensity and short-duration qualities that are not necessarily related.

NOTE: Authorized mental health programs are defined in M-9, chapter 9, appendix 9P.

3.02 ALTERNATIVES TO LONG-TERM PSYCHIATRIC CARE

a. Long-term psychiatry is no longer described as a level of VA care. Patients with a chronic mental illness who respond poorly to our standard treatments still require care at various levels of intensity and in different settings depending upon individualized diagnosis, comorbidities, and prognosis as well as socioeconomic factors and the availability of care.

(1) There are several issues to be kept in mind when considering the newer levels of care. Both Intermediate and STAR (Sustained Treatment and Rehabilitation) levels are considered hospital care. The focus is rehabilitative, not custodial. Patients in the STAR or Nursing Home Programs must not be written off as hopeless or "in for life" even though some may indeed never recover sufficiently to live without some kind of institutional structure.

(2) Even patients with progressive dementing illness generally need differing levels of care during the course of their deterioration and a focus on maintaining quality of life.

b. Patients with non-dementing disorders, in particular, are unpredictable in their potential for remission or partial recovery.

(1) Many seemingly regressed schizophrenic patients are acutely aware of the attitudes of staff, family, volunteers, and patients around them and respond to both hopefulness and resignation by those they consider important.

(2) The literature of the last 30 years has been replete with stories of back-ward patients who recovered and returned home following the advent of a new activity program, a new doctor, a new theory of treatment, transfer to a new ward or hospital, an exciting research program, or a significant change in family relations such as the death of a parent.

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(3) These factors have in common only the infectious qualities of hope, energy, and possibility.

NOTE: The continued introduction of new psychotropic medications opens further possibilities for those who have not responded to our current pharmacopoeia.

c. The enthusiasm and funds that accompanied the community mental health movement in the '60s and '70s, including the availability of Half-way Programs and community care, and the continual introduction of new and powerful psychotropic medications also led to significant shrinking of State and VA psychiatric hospitals.

(1) Funding pressures to shorten LOS played a successful part in forcing staff to look for alternatives to continued hospitalization for patients that might have been considered "chronic" or otherwise not worth the investment of time and energy.

(2) In some locations, community alternatives are still not available and the enormous growth and visibility of the homeless mentally ill is evidence that alternatives to institutional care have not been adequately developed or funded.

d. There is a small but visible number of patients who do not respond to current medications and behave in unpredictable and destructive ways that preclude discharge or placement outside of a hospital or specialized nursing home setting. Such patients need and deserve active hospital treatment, no matter how prolonged. These patients change over the years, and, given time, consistent opportunity, and periodic review, may gain the confidence to try a less intensive setting. NOTE: Aging may often decrease the intensity of a psychotic process.

e. Pressure to be discharged, which often results in counter pressure and/or regression by patients fighting against a psychotic illness, must be measured against the ability of patients to recover at their own pace. Some patients respond paradoxically to a "time out" from formal treatment by self-generated improvement. Sensitivity, encouragement, and being open to opportunity are proper staff roles toward such patients.

f. The STAR (Sustained Treatment and Rehabilitation) Programs, particularly STAR II and STAR III, are designed for this small, but important minority of long-term psychiatric patients who do not fit into existing acute (intensive), or intermediate (time-limited), levels of care. Even the important emphasis on "quality of life" rather than discharge in STAR I and STAR III Programs should keep open the continued possibility that many patients can and do improve over time and should not be deprived of the opportunity to attain greater self determination.

g. Without a sense of therapeutic optimism and hope, no program is likely to be very helpful to patients. Active efforts to improve both communication and effectiveness demonstrate to staff and patients that positive change is both necessary and possible. Staff commitment to progress over time is a fundamental requirement for effective long-term care.

3.03 HIGH INTENSITY PSYCHIATRIC CARE

a. PICU (Psychiatric Intensive Care Unit) (See M-9, Ch. 9, App. 9P, Subpar. 1.01a.). The PICU offers smaller size, increased staffing, security (safe quiet/seclusion rooms), and more specialized clinical expertise than a general

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psychiatric ward. A PICU may be physically within or adjacent to a traditional 20 to 30 bed (open or closed), admitting or general psychiatric ward.

(1) Patients admitted to this level of care will have the most severe behavioral problems including:

(a) High suicide risk,

(b) Assaultiveness,

(c) Severe agitation,

(d) Disorganized behavior secondary to psychosis,

(e) Confusion, or

(f) Other severe psychiatric disorders.

(2) Psychiatric patients presenting with such symptoms may be rapidly stabilized on such a unit, obviating the need for transfer to a long-term or more secure facility often some distance away.

b. General Psychiatric Ward (Psychiatric Evaluation and Treatment Units) (See M-9, Ch. 9, App. 9P, Subpar. 1.01b.). Psychiatric Evaluation and Treatment Units offer careful, comprehensive, psychiatric, and psychosocial diagnosis and treatment in a hospital environment for new patients as well as for those patients experiencing recurrence of illness who cannot be assessed, or treated, at a lesser level of care. The primary objective is to provide this treatment in a relatively short duration, ordinarily 10 to 20 days, and occasionally up to 30 or 40 days, and then assist in location of appropriate follow-up needed for successful treatment and/or rehabilitation at a less intensive level of care. All or parts of such units should be securable.

c. Brief Stay Medical/Psychiatric Programs (See M-9, Ch. 9, App. 9P, Subpar. 1.01c.). This program offers a short-term, high quality setting in selected VA medical centers to veterans with combined medical and psychiatric problems who are unable to be evaluated, treated, or managed appropriately in existing medical or psychiatric settings. The setting concentrates staff skilled in both medical and psychiatric areas. The program may provide a resource for nearby VA medical centers.

d. Brief Stay Psychogeriatric Unit. These programs are designed as part of a continuum of care for elderly patients with depressive, organic brain (e.g., dementia), or other psychiatric disorders, including patients with medical comorbidities. Focus is on evaluation, stabilization and relatively brief stay. Programs may include respite beds to relieve care takers, and brief stay Alzheimer/ dementia units.

e. Brief Substance Abuse Treatment (including detoxification)

(1) This program offers patients with drug, alcohol, and other chemical abuse and dependency disorders an intense, brief (under 30 days) treatment of:

(a) Withdrawal symptoms;

(b) Evaluation of physical, psychological, social, and vocational problems;

(c) Family interventions; and

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(d) Initiation of individual and group therapies, and support groups that may be continued on an outpatient basis.

(2) Patients who require longer periods of inpatient treatment may be transferred to a less intensive level of care (see Subpar. 3.04d, Substance Abuse Rehabilitation Programs, and Par. 3.07, VA Domiciliary Care), or to community Contract Half-way House Programs.

(3) Programs dealing with comorbidities of substance abuse include:

(a) Major mental illness,

(b) PTSD,

(c) Spinal cord injury,

(d) Psychogeriatric disorders, or

(e) Stabilized chronic medical conditions.

f. Brief Stay/Respite Psychiatric Care

(1) Designed to help the long-term psychiatric patient maximize time out of the hospital by scheduling brief readmissions, this inpatient unit (or beds on an existing unit) offers an alternative to continued hospitalizations or brief stays and frequent readmissions.

(a) The number of days out of the hospital for selected, seriously psychiatrically ill patients can be increased significantly by planning a readmission ahead of time.

(b) Institutionalized patients who are reluctant to live with their families or in residential care facilities are often able to "hang on" outside of the hospital if they know they are guaranteed a readmission on a given date without having to stop taking medication, regressing, or becoming disturbed. NOTE: Alternatively, families or caregivers may be able to continue their efforts if the responsibility for care is shared with a Respite Program.

(2) If the patient is involved in planning and feels in control of the process, a readmission may be planned ahead of time to last only a few days.

(a) Estimated LOS for this level is from 2 to 14 days.

(b) Brief stay/respite care may also be integrated into existing ward programs.

NOTE: For a separate unit, staffing may be somewhat less than on a general psychiatric unit because patients will generally not be out of control.

(3) Brief Stay Respite/Programs for geropsychiatric patients may be developed on high intensity, intermediate, STAR, nursing home care, or lesser levels of care, depending upon the intensity of intervention required.

g. EBTPU (Evaluation and Brief Treatment PTSD Unit). EBTPUs are units of eight to ten beds designed to provide short-term inpatient PTSD care for patients close to their homes.

h. CEPC (Continued Extensive Psychiatric Care) (See M-9, Ch. 9, App. 9P, Subpar. 1.01d.). The CEPC, a long-term but high intensity program, is

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authorized in recognition of a relatively small but persistent group of psychiatric patients found primarily

in the larger, predominately psychiatric medical centers who require a high intensity level of staffing because their behavior is such that it cannot be managed on a STAR level program and they are too disruptive and unresponsive to remain for long on a general psychiatric ward or PICU.

(1) Many of these patients can benefit from new therapeutic trials, attempts at resocialization, behavior therapies, and rehabilitation.

(2) CEPCs may serve as a regional resource, and should be conceived of as referral programs for patients who have proved unmanageable or poorly responsive to treatment in other psychiatric treatment settings.

(3) The primary objective of the CEPC is to provide intensive monitoring and intervention, often over a protracted period, which will allow the patient to progress to the point where the patient can be returned to a less restrictive environment.

3.04 PSYCHIATRIC INTERMEDIATE CARE

a. Background

(1) For those medical centers which choose an individual service model over a combined model for organizing Intermediate Care Units, the Intermediate Psychiatric Treatment Program provides an excellent opportunity for continuity of care from one level of psychiatric care to another.

(a) Estimated LOS in these programs is under 90 days.

(b) This category includes many specialized treatment and rehabilitation programs generally found in the larger psychiatric hospitals.

NOTE: M-9, Chapter 9, Appendix 9H, "Intermediate Care Planning Guidelines and Criteria and Standards," recommends staffing levels and services generally between those of acute (High Intensity) care and Sustained Treatment or Extended VA Care.

(2) In past decades, "Intermediate Care" in VA medical centers has often referred to long-term care for patients who were not receiving care in the expectation of an improved status or rehabilitation. As used in this manual, the term "Intermediate Psychiatric Care" is used for a category of programs which are directed toward rehabilitation. The level of care (and corresponding staffing) is subacute and, rather than custodial, is actively directed toward a return to former or improved levels of functioning and health.

b. SIPU (Specialized Inpatient PTSD Units)

(1) SIPUs offer comprehensive treatment aimed at resolution of war-related problems, resumption of personal development, restoration of ability to deal with close relationships, social participation, employment, and other aspects of productive living.

(2) For some veterans with PTSD, specially designated PTSD Inpatient Programs offer the appropriate level of treatment.

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(3) VA medical centers should consider alternative approaches for treatment of veterans with PTSD such as the development of PCTs (PTSD Clinical Teams), and the

treatment of veterans with PTSD on general psychiatric inpatient units and domiciliaries, EBTPUs, and specialized outpatient treatments including referral to Veterans Outreach Centers. NOTE: See Paragraph 3.10.b for a generic description of PTSD Programs.

c. Substance Abuse Rehabilitation Programs. These programs provide an inpatient rehabilitation setting for veterans with serious chemical dependency who require more than detoxification or a brief stay because they still have a significant risk of resumption of their abuse problems on return to the community.

d. Psychiatric Rehabilitation Programs

(1) Psychiatric Rehabilitation Programs represent a group of specialized programs designed for long-term patients requiring:

(a) Training or relearning in social skills,

(b) Group living,

(c) Reentry,

(d) Discharge planning, and

(e) Community survival skills, etc.

(2) The long-term psychiatric patient often needs help with:

(a) Housing,

(b) Shopping,

(c) Consuming appropriate food, and

(d) Understanding the nature of the individual's illness and the need for continued medications.

(3) Family members and caregivers also need help in understanding their roles in providing a stable post-hospital environment.

NOTE: In smaller psychiatric services, these programs may be incorporated within existing ward programs.

e. Psychiatric Night Hospital. Psychiatric Night Hospitals are programs of partial hospitalization for patients who are unable to move directly to an outpatient status.

(a) Patients in a night hospital are to be off the ward during the day either in:

1. Compensated Work Therapy Program,

2. Community college or Vocational Education Program, or

3. Other Day Treatment Programs.

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(b) Patients should be on self-medications in preparation for outpatient status. Self-medication Programs will meet the minimum requirements outlined in current VA policy.

NOTE: Day staffing is minimal except for weekends.

(c) Evenings and weekends, patients are involved in group therapy and counseling regarding:

1. Work;

2. Family, or school, problems;

3. Problems in social interaction on, or off, the ward;

4. Discharge planning;

5. Budgeting; or

6. Development of social and leisure time skills.

NOTE: The program should be time limited but may be integrated with a sheltered workshop or rent payment program to provide gradual but continued incentives for the patient to make the move out of the night hospital setting.

NOTE: Where available, a domiciliary setting or PRRTP (Psychiatric Residential Rehabilitation and Treatment Program), may achieve similar goals. (See Subpar 3.08a.)

3.05 STAR (SUSTAINED TREATMENT AND REHABILITATION) UNITS

The essence of this level of care is its emphasis on sustained treatment and rehabilitation for varied groups of patients who have failed to achieve sufficient recovery in 90 days to be discharged to a nursing home, domiciliary, or community residential level of care. Staffing levels within this new level of care vary considerably, but are generally not as resource intensive as required in a high intensity setting. Education of staff and caregivers regarding appropriate and realistic expectations of the patients' abilities, and practical suggestions for modifying the environment to maximize patients' functioning must be a prominent component of the STAR patient education effort.

a. STAR I (Sustained Medical-Psychiatric Unit (See M-9, Ch. 9, App. 9P, Subpar. 3.01a.). Patients in this setting have medical, neurological, and psychiatric disorders that interact in such a way as to make care in traditional long-term psychiatric or medical programs (including traditional nursing homes) difficult or impossible.

(1) The units must have the capability to provide treatment, care, and safety for both moderately physically active, psychotic patients and those who are semi-bedridden and/or confused. Physical separation of the two groups may often be necessary.

(2) These units must be securable and have the capacity to protect patients from harming themselves and others while they are receiving medical and psychiatric treatments.

(3) The goal is to enhance the quality of life and augment acceptable levels of behavior.

(4) Knowledge of both medical and psychiatric care and treatment is required by staff.

b. Sustained Psychogeriatric Unit. The Sustained Psychogeriatric Unit comprises the long-term inpatient phase of a continuum of care for elderly patients with depressive, organic brain (e.g., dementia), or other psychiatric disorders, including patients with medical comorbidities. Emphasis is on quality of life, promoting self-care, and supportive work with families. The unit may have respite beds for relief of caregivers and may include long-term Alzheimer patients.

c. STAR II (Community Reentry Rehabilitation Care) (See M-9, Ch. 9, App. 9P, Subpar. 3.01b.) This program is appropriate for chronically ill psychiatric patients who may have adjusted to the hospital environment, but have marked deficits in social-functional skills and poor judgment and are judged to have potential for discharge following an intensive psychological, social and vocational evaluation, and functional skills training program. Generally, these psychiatric patients should have no significant medical problems that would prevent out-placement and be a low current risk for dangerous behavior in the community. The emphasis should be on patient self-help and self-care as opposed to staff caregiving.

d. STAR III (Skilled Psychiatric Nursing Unit). (See M-9, ch. 9, app. 9P, subpar. 3.01c.) This program offers skilled psychiatric nursing care for patients with chronic, refractory, partially stabilized, major psychiatric or organic brain disorders who no longer can use intensive treatment, are not actively suicidal or chronically assaultive, and are medically stable.

(1) The patients' impared judgment and disruptive and uncooperative behaviors make them unsuitable for placement in VA or community nursing homes or other community settings. Many are admitted under an involuntary legal status because of their unwillingness or inability to remain in treatment voluntarily, and the settings are generally secureable.

(2) The goal is to improve their quality of life and their general level of functioning with eventual placement into a less restrictive setting.

NOTE: Alternatively, originally uncooperative patients may recover enough to participate in more active treatment and be transferred to an intensive or intermediate level of care.

e. The distinction between STAR II and STAR III is the need in STAR III for a secured setting, a lower expectation for discharge and higher emphasis on skilled psychiatric nursing rather than rehabilitation care. Unlike the CEPC Program (Par. 3.03), this unit is not designed to treat patients who are actively suicidal or repeatedly assaultive.

(1) In distinction to STAR I, STAR III Programs do not offer the medical expertise present in STAR I.

(2) Compared to Psychogeriatric Sections of NHCUs (Nursing Home Care Units), these programs generally emphasize younger patients without

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significant ADL (Activities of Daily Living) limitations or medical complications.

(3) As with all other settings, all patients will have interdisciplinary psychiatric treatment care plans.

3.06 VA NURSING HOME CARE

a. VA NHCU (Nursing Home Care Units)

VA NHCUs offer skilled nursing care at a lower level of intensity than hospital programs. While their focus has been primarily on patients with chronic medical problems requiring help with ADL, increasing numbers of aging patients with depression and anxiety, various dementing illnesses, and former psychiatric patients with chronic medical disabilities have led to well over half of NHCU patients having a diagnosed psychiatric disorder.

(1) NHCUs are frequently unable to manage patients presenting with high levels of disturbed behavior because they become disruptive to both staff and fellow patients and a physical threat to the frail elderly with primarily medical ailments.

(2) In most cases, the severely disruptive patient should not be placed in a NHCU but should be admitted to a more specialized setting.

b. Psychogeriatric Sections within NHCUs. Psychogeriatric Sections within NHCUs are self-contained, distinct sections of a NHCU which are authorized for patients who require nursing home care (i.e., maintenance or restoration of patient's physical functioning in physical activities of daily living), and who also manifest behavioral disturbances which are manageable within the context of a nursing home with staff skilled in behavioral interventions.

(1) These special sections may be securable to prevent patients from wandering away or harming themselves unescorted outside of the facility.

NOTE: A locked unit is considered by JCAHO long-term standards to be a restraint and is permitted only when it is medically documented with doctors' orders that this restraint is needed for each patient so confined.

(2) Psychogeriatric NHCU sections must meet long-term care standards and will remain under supervision of the NHCU.

3.07 VA DOMICILIARY CARE

a. Domiciliaries represent the least intensive and least costly of VA's institutional programs which provide service for long-term VA patients. This level of care is currently available for many patients who do not require hospital or nursing home care, but are unable to live independently because of medical or psychiatric disabilities.

b. The necessary treatments, rehabilitative assistance, and other therapeutic interventions are provided on an ambulatory basis from the host facility, while patients reside in the structured, homelike environment of the domiciliary.

c. Special Domiciliary Care Programs for homeless veterans are a rapidly expanding addition to VA care. NOTE: Many states offer veterans homes which can provide an alternative option, where available.

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d. The addition of clinical staff to some domiciliaries enables them to provide care for a wider range of psychiatric patients. Some patients who must be transferred back to general psychiatry during a brief flare up of symptoms may be managed without transfer on such a unit.

e. Where possible under current VA policy, unused beds in some medical centers may be converted to domiciliary care in order to meet the demands of homeless veterans. Such programs add to the continuum of care when run in conjunction with:

(1) Substance Abuse Programs,

(2) Compensated Work Therapy Programs,

(3) PTSD,

(4) HIV (Human Immunodeficiency Virus)-AIDS (Acquired Immune Deficiency Syndrome), or

(5) Dual Diagnosis Programs.

3.08 RESIDENTIAL BED CARE

a. PRRTP (Psychiatric Residential Rehabilitation Treatment Program)

(1) Definition. VHA (Veterans Health Administration) is authorized to establish a new level of bed care, PRRTP, defined as a structured and supervised, 24-hour-a-day, therapeutic setting which embodies strong treatment values with peer and professional support to CMI (chronically mentally ill) veterans in need of extended rehabilitation and treatment. A variety of residential therapeutic settings are authorized under the PRRTP framework.

(2) Supervision. Each PRRTP will be under the supervision of the Chief of a clinical service designated by the Chief of Staff who has overall responsibility for the clinical care provided in the residence.

(3) Staffing. The PRRTP will have 24-hour-per-day, on-site staffing although the level of staff may be professional, para-professional, trained non-professional, or volunteer.

(a) At all times, a member of the professional PRRTP staff must be on call by radio telephone, or beeper, and clear channels of communication with VA medical center on-call staff will always be maintained.

(b) Coverage may also be provided by paid or unpaid, on-site house managers.

(4) Training. Ongoing training of all staff regarding emergency procedures will be documented.

(5) Beds. PRRTPs may be on VA medical center grounds or on VA owned, rented, or donated property in the community. In any PRRTP setting, beds will be counted on the medical center census.

(6) Oversight. The establishment of PRRTPs will be centrally monitored by the NEPEC (Northeast Program Evaluation Center) at the VA Medical Center, West Haven, CT.

They will be evaluated through 1998 to assess the clinical effectiveness and cost efficiency of this new level of care.

(a) To ensure careful monitoring, the number of conversions of current wards to PRRTPs will be limited to 10, nationwide, through FY (Fiscal Year) 1997.

(b) The number of new PRRTP Programs, created with new PTSD, substance abuse, long-term psychiatric care, or Homeless Veterans Treatment Program funds will not be limited.

(7) QM (Quality Management). A PRRTP QM plan will be documented and incorporated into the overall medical center QM Program.

b. SARRTP (Substance Abuse Residential Rehabilitation Treatment Program). A SARRTP is a PRRTP focusing on treatment of patients with substance abuse problems.

c. PRRP (PTSD Residential Rehabilitation Program). A PRRP is a PRRTP focusing on the treatment and rehabilitation of PTSD patients.

d. CWT (Compensated Work Therapy or Veterans Industries)/TR (Transitional Residences)

(1) Authorized by Public Law 102-54, June 13, 1991, this program involves mental health patients enrolled in a CWT Program; these are patients who require a supportive setting as part of treatment and rehabilitation.

(a) Group homes are purchased, or leased by VA, or an affiliated non-profit corporation.

(b) Patients pay rent and utilities and purchase and prepare their own food.

(c) Generally, no staff or residential care supervision is available on site; however, home managers provide 24-hour coverage and 24-hour on-call professional coverage is required.

(2) Substance Abuse CWT/TR. A CWT/TR focusing on substance abuse problems.

(3) HCMI (Homeless Chronically Mentally Ill)/TR. A HCMI/TR is a CWT/TR focusing on problems of the HCMI patients. (See Subpar. 3.10d.)

3.09 OUTPATIENT AND COMMUNITY-BASED TREATMENT

a. MHCs (Mental Health Clinics). MHCs are the basic outpatient units within the mental health care delivery system. These programs provide primary mental health care for patients whose mental health problems can be resolved and stabilized within the community, and essential aftercare for patients following a period of hospitalization.

(1) The MHCs are designed to provide direct services including all modalities of modern mental health assessment and treatment short of hospitalization.

(2) Examples of special modalities that may be found within MHCs are:

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(a) Crisis intervention,

(b) Admission triage teams,

(c) Family therapy,

(d) Special programs for POWs (Prisoners of War) or PTSD patients,

(e) Primary ambulatory medical care for psychiatric patients, and

(f) Case Management.

(3) Satellite and mobile clinics are increasingly used to provide mental health care nearer the veteran's home.

b. Substance Abuse Treatment Clinics

(1) ADTPs (Alcohol Dependence Treatment Programs), DDTPs (Drug Dependence Treatment Programs), and combined Substance Abuse Treatment Programs provide outpatient care to patients with alcoholism and drug dependence disorders. Such care is designed to provide the full-range of treatment services for patients with alcohol and drug dependence disorders, including:

(a) Detoxification,

(b) Methadone maintenance, and

(c) Treatment of the psychological and behavioral aspects of addiction.

(2) Outpatient care emphasizes the development of social and vocational skills and the abstinence necessary to successfully remain in the community.

NOTE: Methadone Maintenance Programs will meet the requirements outlined in 21 CFR (Code of Federal Regulations) 310.305, and M-2, Part VII, Paragraph 3.03.

c. Day Hospital Programs. Day Hospital Programs are the most labor-intensive ambulatory psychiatric care programs. They provide a specialized form of care that falls between full hospitalization and the more traditional models of ambulatory care.

(1) These programs are designed to:

(a) Assist the veteran in avoiding full hospitalization and to allow the veteran to maintain community ties.

(b) Provide intensive diagnostic and treatment services to patients following inpatient care to allow shortened lengths of stay and a more rapid return to the community.

(c) Provide transitional treatment and further stabilization of psychiatric conditions in order to prevent rehospitalization.

(d) Provide therapeutic services to:

1. Young chronic schizophrenic patients,

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2. Chronic psychiatric patients in crisis,

3. Patients with medical/surgical impairments who are having difficulty adjusting to the limitations imposed by their illnesses, and

4. Veterans with PTSD.

(2) Patients who benefit from Day Hospital Programs include those with few previous significant mental health problems whose condition has been precipitated in-part by situational crisis.

(3) Following a period of intense treatment in Day Hospital Programs, patients may receive additional, less intense treatment in MHCs, or may be prepared to return to full independent living.

(4) Day Hospitals may:

(a) Be used for initial evaluation of patients applying for psychiatric care.

(b) Work closely with IPCC (intensive psychiatric community care) teams.

(c) Have a psychogeriatric emphasis.

d. Day Treatment Centers. Day Treatment Centers are designed to maintain chronic psychiatric patients at relatively stable levels of functioning within the community.

(1) These programs provide:

(a) A supportive learning environment for patients having chronic, severe psychiatric illnesses and difficulties with community adjustment, interpersonal relations, and vocational or educational problems.

(b) An environment permitting patients to remain within their social and family environment while receiving treatment.

(c) Cost-effective alternatives to repeated or prolonged hospitalizations.

(d) Improvement of the quality of life.

(e) Maximum social and vocational rehabilitation.

(2) These patients often have had long and/or multiple periods of hospitalizations and need continued monitoring of their general health and medication needs. Patients in Day Treatment Centers may receive treatment in this program 1 to 5 days per week or more and may continue for months or years.

(3) Some Day Treatment Centers:

(a) Offer services on weekends,

(b) May work closely with IPCC teams, and/or

(c) Develop special programs for psychogeriatric patients.

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e. Specialized MHCs

(1) PCTs (PTSD Clinical Teams). PCTs provide a specialized focus for outpatient care of patients with PTSD who have not previously received care. These treatment teams are responsible for:

(a) Providing direct clinical care and integrating treatment offered in Vet Centers, general hospital (inpatient and outpatient) programs, and special PTSD units in order to ensure continuity of care for all veterans.

(b) Providing consultation and liaison to general psychiatry units, medical, and surgical units.

(c) Supervising educational programs on PTSD.

(d) Monitoring utilization patterns of patients with PTSD.

(2) Consultation and Liaison Programs. Consultation and Liaison Services provide psychiatric assessment and treatment for veterans who are receiving care in non-psychiatric hospital and clinic programs.

(a) These services assist in:

1. Early detection of concomitant psychiatric disorders,

2. Early definitive treatment,

3. Staff support and education, and

4. Increased awareness of psychiatric disabilities requiring referral and treatment.

(b) Issues of depression, anxiety, substance abuse, and treatment compliance have great impact on the success of treatment efforts in medical and surgical clinics.

NOTE: Programs may have a psychogeriatric focus.

(3) Vocational Services Programs. Vocational Services Programs provide vocational services including assessment through interviews, testing (interest aptitude, intelligence, personality), and counseling. Services are available on both an inpatient and outpatient basis. (See Subpar. 3.10e.)

(4) Health Psychology Programs. Health Psychology Programs are focused on the prevention of illness through psychological-behavioral interventions. Such at risk groups as the obese, hypertensives, smokers, and persons with problems handling stress are provided evaluation and treatment. The treatment may include:

(a) Biofeedback,

(b) Relaxation training,

(c) Smoking cessation,

(d) Exercise,

(e) Nutrition counseling, and

(f) Stress Management Programs among other behavioral and/or educative interventions.

(5) Neuropsychology Programs. Neuropsychology Programs provide assessment of brain dysfunction through use of sophisticated neuropsychological test batteries to determine location and extent of damage. Results of these assessments are used in development of appropriate individualized treatment and rehabilitation plans. NOTE: When resources are available, cognitive rehabilitation programming for the brain impaired is conducted.

(6) Geropsychology/Long-Term Care Programs

(a) Geropsychology Long-term Care Programs provide psychological assessment and/or diagnostic services to the elderly including:

1. Mental status exams,

2. Cognitive intellectual screening,

3. Reality orientation assessment,

4. Depression screening, and

5. Assessment of psychosocial adjustment to a long-term care setting.

(b) Appropriate intervention with elderly patients and their families may be offered; such psychological interventions include:

1. Patient education,

2. Social skills training,

3. Remotivation therapy,

4. Reminiscence review,

5. Self-awareness training,

6. Grief reaction, and

7. Logotherapy.

(c) Staff and/or family consultations include:

1. Behavioral management,

2. Environmental modification,

3. Palliative support groups,

4. Family support systems, and

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5. A staff support system.

(7) Psychogeriatric Clinics. Psychogeriatric outpatient clinics are designed to provide all modalities of modern mental health assessment and treatment to eligible veterans and their caregivers. NOTE: Collaboration with other VA and non-VA programs providing services for the elderly is encouraged.

f. Psychiatric Community-based Residential Treatment Programs. These programs include psychiatric half-way houses, structured therapeutic group homes, and other community-based residential treatment facilities.

(1) They are designed to provide transitional therapeutic experiences for patients who have just been discharged from VA psychiatric inpatient programs. In these settings veterans may consolidate gains acquired in the hospital and further prepare themselves for full reentry into the community.

(2) In contrast to PRRTP's, these programs are generally owned by private entrepreneurs, non-profit groups, or veterans organizations; these "half-way houses," or other similar programs provide room and board plus limited treatment programs.

(3) Sometimes VA staff may be directly assigned to provide or augment care.

(4) Except for VA contract half-way houses for drug and alcohol abusers, and HCMI, the veterans generally must pay rent from their own funds.

NOTE: The exception is HCMI PRRTP Program contracts which do not require previous inpatient care.

g. IPCC (Intensive Psychiatric Community Care)

(a) This program, a modification of the "community crisis teams" and the intensive care management team provided at some VA medical centers, brings needed levels of interdisciplinary professional supervision to severely psychiatrically disabled patients residing in the community, i.e., in community residential care, in family homes, and in psychiatric and general nursing homes.

(b) Aspects of IPCC which help prevent clinical deterioration which often leads to re-hospitalization are:

1. Provision of medication maintenance,

2. Behavioral intervention,

3. Family counseling,

4. Crisis intervention services, and

5. Community-based rehabilitation .

(c) The program is relatively resource intensive and should be seen primarily as an alternative to long-term hospital care.

h. Community Residential Care

(1) The Community Residential Care Program provides residential care, including room, board, and limited personal care and supervision (often including supervision of

medications depending upon individual State laws) to veterans who do not require hospital or nursing home care, but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family resources to provide needed care.

(a) This program, originally designated as "Foster Care," began in the 1950s as a community reentry program for psychiatric patients no longer in need of acute hospital care.

(b) Although the Community Residential Care Program has been expanded to include general medical and surgical patients, nearly 75 percent of the 11,000 veterans currently enrolled in the program have primary psychiatric diagnoses.

(2) The patient must essentially be capable of performing activities of daily living with minimal, or no assistance, exhibit socially acceptable behavior, and not be a threat to self or others.

(a) Care is provided at the veteran's own expense in private homes or licensed private care facilities inspected by VA, but chosen by the veteran.

(b) The veteran receives at least monthly follow-up visits from VA social workers and other health care professionals as indicated, and is an outpatient of the local VA medical centers.

i. General Community Nursing Homes. The Community Nursing Home Program, involving an over 7,823 average daily census in 1992, is available at every VA medical center for the community out-placement of veterans requiring skilled nursing care.

(a) These facilities will generally accept veterans who require nursing care for combined medical/psychiatric problems, but who present only minimal behavioral problems.

NOTE: Recent HCFA (Health Care Financing Administration) regulations require independent psychiatric screening for patients placed in those community nursing homes which accept Medicare or Medicaid in order to ensure that psychiatric placements are appropriate and that such patients will receive active treatment if needed.

(b) In some areas, State-run nursing homes are available for veterans.

j. Other Innovative Treatment Approaches. Innovative approaches to non-hospital care continue to receive VA Central Office and Regional Office support. Programs which are encouraged within existing Psychiatric Outpatient Programs include:

(a) Those emphasizing outreach to veterans living in single-room occupancy hotels and homeless shelters;

(b) Housing specialists who assist veterans in obtaining suitable housing prior to discharge;

(c) Aggressive Case Management across facilities;

(d) Vet centers located in communities across the country specially designed to help Vietnam veterans; and

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(e) Collaboration with community mental health centers and other community groups.

NOTE: *Innovative approaches may occur as local initiatives as part of a reorganization of mental health services.*

3.10 SPECIAL PROGRAMS

a. **Substance (Drug and Alcohol) Abuse and Dependency Programs**

(1) Since 1973, VA Drug and Alcohol Abuse and Dependency Programs (now called Substance Abuse Programs) have been an integral part of Mental Health and Behavioral Sciences Service (MH&BSS) and currently constitute a significant workload and investment. Substance Abuse Programs are authorized throughout the integrated continuum and should be available at all VA facilities.

(2) Contract community half-way houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities for eligible veterans suffering from alcohol and/or drug dependence were originally authorized by Public Law 96-22, Section 104. Subsequent legislation authorized the program to continue through December 1995 (38 CFR Sections 17.53a, 17.53b, 17.53c,17.53d.).

b. **PTSD Programs**

(1) General Policy. PTSD is an anxiety disorder which may have acute and chronic manifestations. Because of the significant incidence of PTSD as a result of the traumas of war, PTSD is of major concern for VA health care providers. It may present as a single episode, or be recurrent. Patients generally seen are those veterans whose military service has included exposure to psychologically traumatic events that are generally outside the range of usual human experience. Victims of extraordinary trauma outside of combat, such as natural disasters, sexual or physical abuse, are also seen. Particularly in its chronic forms, PTSD has a high incidence of comorbidity, especially with substance use disorders.

NOTE: The diagnosis of PTSD must be consistent with the criteria of the psychiatric diagnosis system approved by VA, e.g., the current edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM-III-R).

(2) Location. While not every VA health care facility will necessarily have a specialized or funded PTSD Program, every VA health care facility with a mental health section or service should have at least the capability to correctly diagnose and provide some basic treatment for this disorder. Active linkages and two-way referrals will be provided by VA medical center staff and program staff from VA Readjustment Counseling Vet Centers.

(3) Special Programs. Since 1985, VA has established a number of specialized treatment programs for inpatient and outpatient treatment of PTSD designed to provide a continuum of care for veterans suffering from this disorder who require specialized care. Since complex clinical diagnostic studies are required for such patients (i.e., to identify associated organic mental disorders, to rule out thought disorders, substance abuse disorders, etc.) special concerns are exercised for the selection of qualified staff to service and lead such units. MH&BSS PTSD Programs are primarily oriented toward clinical care delivery, although there is a significant component dedicated to promoting research and education on PTSD, which is coordinated through VA's National Center for PTSD.

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c. **Psychogeriatric Programs**

(1) Geriatric psychiatry and geropsychology are bodies of knowledge and clinical skills aimed specifically at caring for the psychiatric and psychological needs of the older population. Psychogeriatric Programs, like those in general psychiatry, require an integrated continuum of care addressing the needs of elderly patients with psychiatric disorders, including the dementias.

(a) Typical patients include:

1. Those with depression, anxiety, paranoia and/or memory disorders;

2. Frail elderly with multiple comorbidities;

3. Aging chronically mentally ill;

4. Homeless elderly mentally ill;

5. Elderly substance abusers; and

6. Elderly patients with other psychopathology.

(b) Planning for Psychogeriatric Programs, depending upon local needs and resources, should be integrated among the seven levels of care described in Figure 1.

NOTE: *A close relationship with Geriatric Medicine, Neurology, and Extended Care Services is recommended.*

(2) Treatment Settings. Treatment settings include:

(a) Ambulatory care clinics;

(b) Day treatment centers;

(c) Home care;

(d) Community nursing homes;

(e) Residential (foster home) care;

(f) Domiciliary care;

(g) Specialized areas within NHCUs; and

(h) Long-term, intermediate, and acute hospital care.

NOTE: *Settings may be secured as well as open.*

(3) Treatment Modalities

(a) Modalities include:

1. Thorough evaluation and treatment,

2. Day and night respite,

3. Care-giver support and training,

4. Outreach, and

5. Education.

(b) Programs are often combined with:

1. Medical, rehabilitation, and nursing programs;

2. GRECCs;

3. GEMs (Geriatric Evaluation and Management Units),

4. NHCUs;

5. Domiciliaries, and

6. A variety of Community-based Programs.

(3) Staffing. Because of characteristic comorbidities and associated psychological and social issues, geriatric mental health requires an interdisciplinary approach including active contributions from:

(a) Geriatric medicine,

(b) Psychiatry,

(c) Psychology,

(d) Neurology,

(e) Rehabilitation medicine,

(f) Nursing,

(g) Social work,

(h) Denistry,

(i) Podiatry,

(j) Speech and Audiology,

(k) Pharmacy,

(l) Dietetics,

(m) Recreation therapy, and

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(n) Chaplaincy.

d. HCHV (Health Care for Homeless Veterans) Programs

The HCHV Programs include all homeless assistance programs and initiatives administered by MH&BSS. Current HCHV Programs include:

(1) HCMI Program

(a) The HCMI Program staff:

1. Seek out homeless mentally ill and substance abusing veteerans;

2. Assess the veterans multidimensional problems; and

3. Assist the veterans in obtaining comprehensive care, including community-based residential treatment.

(b) In compliance with Public Law 100-322, VA contracts with non-VA community-based Psychiatric Residential Treatment Programs to obtain the residential treatment component of the HCMI Program.

(2) VASH (VA Supported Housing) Programs

(a) In VASH Programs, VA clinicians provide ongoing case management and other needed assistance to homeless veterans in permanent housing.

(b) In the main VASH Program, a joint initiative with HUD (Department of Housing and Urban Development), VA staff provide assistance to homeless veterans in permanent housing obtained with specially-designated HUD rental assistance vouchers.

(c) In other VASH Programs, the permanent housing is obtained through partnerships with veterans service organizations and others that provide the housing component through local collaborations with public housing authorities.

(3) SSA (Social Security Administration)-VA Joint Outreach Initiative

NOTE: SSA-VA Joint Outreach Initiative is a pilot project with SSA, in which HCHV Program staff coordinate outreach and benefits cetification with SSA staff to increase the number of veterans receiving SSA benefits and to otherwise assist in the veterans's rehabilitation.

(4) The homeless-specific CWT/TR sites; and

(5) Collaborative projects between MH&BSS (Mental Health and Behavioral Science Service) homeless assistance programs and other non-VA organizations and agencies.

e. V&RS (Vocational and Rehabilitation Services)

(1) The V&RS Program endeavors to provide comprehensive and integrated services which may include any of the following elements:

(a) Vocational evaluation and testing,

(b) Educational therapy,

(c) Vocational rehabilitation therapy (formerly manual arts therapy),

(d) Work hardening and/or Work Adjustment Program,

(e) TPP (Therapeutic Printing Plant),

(f) Job placement,

(g) CWT,

(h) Transitional residences (including Independent Living Skills Training),

(i) Incentive therapy, and

(j) Vocational Rehabilitation Case Management.

(2) Overall clinical and administrative responsibility for V&RS at the VA Central Office level is provided by MH&BSS. The organizational placement at the medical center level may vary according to the case mix and resources at that medical center. At this level, the operation will be under the direction of the Chiefs of Psychology Service, Rehabilitation Medicine Service, Domiciliary Care Service, Psychiatry Service, or as otherwise designated by the Chief of Staff.

(3) Additional vocational services may be obtained from the Division of Vocational Counseling and Rehabilitation of VBA (Veterans Benefits Administration).

(4) Psychology Service provides vocational services (see subpar. 1.05c.(4)) and may coordinate such services with State Vocational Rehabilitation Programs.

f. CWT (also known as Veterans Industries). CWT Programs are a part of V&RS described in paragraph e; however, because of their prominence they are described separately. CWT Programs were established by Pub. L. 94-581 (38 U.S.C. (United States Code) 1718) to provide a Vocational Work Rehabilitation Program for inpatients, outpatients, and domiciliary patients.

(1) The major component is a work regimen with monetary incentives derived from contracts with industry and the Federal government (including VA).

(2) Monetary reimbursements are related to patient productivity. Earnings should be commensurate with wages paid in the community for essentially the same quality and quantity of work.

(3) There are two primary programs:

(a) The first program involves on-site sheltered employment where contracts are performed at the medical center or nearby in a supervised setting. Such contracts include:

1. Assembly,

2. Packaging,

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3. Carpentry, and

4. More technical work experiences.

(b) A second program includes therapeutic work for patients at a business site supervised by employees of the industry.