

Uniform Mental Health Services

Structure of Care

1. Every veteran seen in mental health services is assigned a principal MH provider.
2. All veterans receiving MH care need to be enrolled in a VA PC clinic to receive PC.
3. Facilities must offer options for needed MH services to enrolled veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible.
NOTE: *Facilities need to consider making services available by sharing agreement, contract or non-VA fee basis for other enrolled veterans when travel for VA care represents a hardship.* Page 18.
4. When veterans are discharged from inpatient or residential care settings, they must receive FU MH evaluations within 1 week of discharge. Page 19.
5. Must make SU treatment available. Pages 19-23.
6. Rural MH Care Page 40. When there are gaps between needed services, and those that are available at the VA facility nearest to the patient's home, the facility must extend the services available at the facility by: increased staffing or telemental health, referral to another nearby VA facility, making such services available through a referral for residential care when appropriate, and through referrals to community providers using sharing arrangement, contracts or non-VA fee basis care.

Outreach

7. Each VISN and each medical center must appoint MH staff responsible for liaison with State, county, and local MH systems and with community providers. Page 8. Includes serving on State's council or workgroup on suicide prevention. Page 9.
8. Outreach can involve veterans' families, as well as the veterans themselves, consistent with VHA's legislative authority to work with families.

Crisis and Acute Care

9. Facilities with locked and secure mental health inpatient units must be prepared to accept involuntary admissions. All other facilities must have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when it is appropriate. Page 11.
10. CBOCs and facilities without EDs or 24/7 urgent care must have predetermined plans for responding to mental health emergencies....during times of operation. They must also identify at least one accessible VA or community-based ED where veterans are directed to seek emergent care when necessary and: develop contracts, sharing agreements or other appropriate arrangements with them for sharing information, and develop financial arrangements for payment for authorized emergency services and necessary subsequent care. Page 11.
11. Inpatient care contracted in community. Page 12.

Ambulatory/Recovery/Residential Treatment Programs

12. Each medical center must provide access to MH RRTP for eligible veterans either at VA, regionally at VA, or by sharing agreements, contracting, or non-VA fee bases care in community facilities. Page 13. MH RRTPS must be CARF accredited. Page 14.

13. CBOCs must make all the services listed above available to eligible or enrolled veterans. For each service that they do not provide, they need to identify available sites within the VA or community to support timely referral when required. Page 23.
14. Note Rehabilitation and Recovery-Oriented Services. Includes peer support, CWT, family involvement and provision for fee basis or community contracting. Existing MOU with NAMI for Family to Family. Pages 25-29.

Evidence-Based Treatment

15. Evidence-Based Treatments. Evidence-based Psychotherapy for PTSD (CPT, PET) and Depression and Anxiety (CBT, ACT, or interpersonal Therapy). Evidence-based Somatic Therapies for mood disorders, anxiety disorders, psychotic disorders, SUD, dementia. <http://vawww.oqp.med.va.gov/CPGintro/cpg.htm>. Page 29. ECT within VA practice guidelines, and APA guidelines. Page 30.

Special Populations

16. Homeless Programs, including contracts for residential treatment of SUD, community agencies and providers. Pages 30-32.
17. Incarcerated Veterans. Pages 32-33.
18. Integrating MH into Medical Care Settings, following evidence based models, Pages 33-34.
19. Specialized PTSD Services, ambulatory, residential or inpatients in each VISN. Pages 35-37. Military Sexual Trauma, Pages 37-38.
20. Suicide Prevention. Suicide Prevention Coordinator (SPC) who tracks veterans at high risk for suicide, trains al VA staff. Pages 38-39.