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## CHAPTER 2. GENERAL ADMINISTRATION

### 2.01 MEDICAL RECORDS

a. Adequate records of both inpatient and outpatient care shall be maintained as set forth in M-1, Part I, Chapter 5.

b. Laws and regulations concerning confidentiality and release of information are found in 38 U.S.C. (United State Code) 5701 and the Privacy Act of 1974, Public Law 93-579, as set forth in MP-1, Part II, Chapter 21; and M-1, Part I, Chapter 9. NOTE: There are special regulations and laws concerning confidentiality of records of patients suffering from alcohol and drug abuse, infection with the human immunodeficiency virus, or sickle cell anemia (38 U.S.C. 7332).

### 2.02 ADMISSIONS

a. Policies regarding admission of veterans to VA (Department of Veterans Affairs) facilities are outlined in M-1, Part I. Trained mental health professionals, as determined by appropriate authority, shall be available either on duty, or on call, to assist in the admitting function during the hours of facility operation.

b. Such personnel may admit patients to inpatient or other treatment programs. If the patient (or responsible accompanying party) requests hospital admission, a nonphysician mental health professional may not refuse inpatient admission without documented consultation with a physician, preferably a psychiatrist. If appropriate treatment facilities are not available at the medical center, the Chief of Psychiatry, Medical Administration, Social Work, or Psychology Services, or designees, should be consulted concerning disposition. (See M-1, Pt. I, Ch. 4.)

c. Active Duty Military Personnel. Eligibility for VA care is described in M-1, Part I, Chapter 4.

### 2.03 INVOLUNTARY PSYCHIATRIC TREATMENT/COMMITMENT

a. This manual uses the term, "commitment," to refer to the totality of applicable state laws governing involuntary psychiatric evaluation and treatment, including involuntary outpatient treatment.

(1) VA policy with respect to commitment, retention, and discharge of committed patients is that VA will accept patients committed under the appropriate state law contingent upon:

- (a) VA eligibility criteria,
- (b) Availability of suitable facilities for the treatment of such patients, and
- (c) The clinical assessment of the patient's need for treatment.

(2) If one state commits a patient to a VA facility located in another state, the law of the state where the commitment order was issued shall govern. NOTE: There are significant variations in state laws regarding commitment procedures. VA will continue to cooperate with the courts and comply with state laws when these procedures and laws do not infringe on the functions of VA as prescribed by Federal laws (M-1, Pt. I, Ch. 13, Sec. IV).

(3) When a patient has been admitted on a voluntary basis, treatment will continue to be provided on that basis unless there is a change in clinical condition which would justify commitment of the patient under local laws.

(4) Commitment will be initiated to provide treatment when the patient, as a part of the mental illness, refuses treatment, demands discharge, and meets legal requirements for commitment.

(5) Each VA health care facility will ensure that each patient committed to its facility will not be involuntarily retained when the reasons for such commitment cease to exist. This ensurance will be accomplished by the procedure defined in paragraph b.

b. Action. The status of each such patient will be formally reviewed at least every 6 months. NOTE: If state law requires a review within a shorter period, VA will follow that requirement.

(1) The review will be conducted by a panel of at least three clinicians, including one psychiatrist, who are not directly involved in treating the patient.

(2) The patient will be notified in advance about the review and will be permitted to participate in the hearing, and to bring a relative, friend, a physician, or an attorney of the patient's choice.

(3) The review panel of clinicians will inform the patient of the purpose of the review. This panel will then address the questions as to:

(a) The current status of the patient with respect to the reasons for commitment, e.g., dangerous to self and/or others; and

(b) Whether at the time of the review the patient can exercise the degree of self control in the community necessary to meet medical criteria for termination of the commitment.

NOTE: Based on these standards alone, this panel will determine whether to continue or to terminate the commitment status.

(4) Whenever the patient's treatment team determines that continued involuntary commitment is required, it will be that team's responsibility to inform the review panel.

(5) If the panel conducting the formal administrative review is not convinced that continued commitment is required, the commitment will be terminated and the patient will be so informed.

(6) Upon terminating the patient's commitment status, the panel will further determine whether the patient will benefit from additional treatment. Based on this determination, the panel will recommend to the facility Director through the Chief, Psychiatry Service, and the Chief of Staff to:

(a) Change to a voluntary patient status if the patient's treatment team agrees that further care would be beneficial, the patient requests this, and

the patient meets eligibility requirements. Consideration will also be given to continuation of the required treatment on an outpatient basis.

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(b) Discharge of the patient from the medical center if the offer of continued treatment on a voluntary basis is refused.

(7) The specific reasons for the termination, or continuation, of the patient's involuntary commitment status will be incorporated in the patient's permanent medical record as an explicit part of the review panel's report.

(8) In those instances where continued commitment is judged by the review panel to be necessary, the reasons given will include a reference to the changes that are needed before the patient would be legally entitled to have the commitment terminated. This statement of reasons will be disclosed to the patient by the panel except in those infrequent cases where doing so would substantially destroy the continuation of successful treatment progress.

c. MAS (Medical Administration Service) Responsibilities. MAS will:

(1) Prepare and maintain a control card on each psychiatric patient on involuntary commitment.

(2) Flag the control card for panel review 6-months from date of patient's admission on involuntary commitment, or a shorter period if state law so requires.

(3) Have a control clerk send notice to the patient's ward, at least 15 calendar days prior to the 6-month or shorter period, so that the patient can be notified of the review and scheduled for the review panel within the appropriate time.

(4) Upon receipt of notice of the time the review panel is to be held, notify concerned state officials, if required in the particular state involved, and complete other related administrative details as required.

(5) Upon receipt of a request to change the patient to a voluntary status, or to discharge the patient from the medical center, notify state officials, as required in the state involved, and complete necessary administrative details to determine eligibility, determine applicability of "institutional award" procedures, etc.

d. Patient's Treatment Team. The patient's treatment team will:

(1) Either prepare a written recommendation regarding the termination of the commitment of patients who no longer require this status, or request a panel review to determine a patient's status as a committed patient whenever the team believes that the patient's condition has changed to the extent that reasons for the commitment no longer exist. All treatment teams carry out assessments of all (voluntary and involuntary) patients' clinical status as part of regular treatment plan reviews. Such reviews are most often done more frequently, but never at less than 3-month intervals.

(2) Call for a panel review to determine each committed patient's status at least at every 6-month interval from the date of each patients's admission on an involuntary commitment, or shorter period, if state law requires.

(3) Notify the patient 15 calendar days in advance in writing of the scheduled panel review as well as the purpose of the review and grounds under which commitment may be continued, consistent with laws of the State which committed the patient and, inform

the patient of the right to participate in the hearings and of the right to bring a third party. NOTE: The patient will be informed of the procedures that can be utilized to obtain legal counsel.

(4) Notify MAS prior to effecting change to voluntary status, or to discharging the patient from the medical center. This notification is required because of the need to complete administrative details, such as notifying concerned state officials or meeting specific requirements of "institutional award."

e. If a patient's commitment lapses, or is discontinued at any time, the patient's physician will document the pertinent circumstances and change of legal status in the progress notes and will ensure that the patient, relatives, or other concerned persons are notified.

#### 2.04 VETERANS UNDER CRIMINAL CHARGES

a. A veteran under criminal charges, or in custody of civil authorities, does not forfeit any right to medical care by VA. The civil authority should recognize and be informed prior to admission of the patient to the medical center or outpatient setting that VA cannot assume responsibility for custody or return of a prisoner released for treatment. (See M-1, Pt. I, Par. 16.19.)

b. VA physicians may be called upon by penal authorities to examine veterans who have filed a claim for VA compensation or pension benefits. (See M-1, Pt. I, Par. 16.18.)

#### 2.05 INFORMED CONSENT

a. Every patient applying for and/or receiving treatment at a VA facility has the right to informed participation in the decisions involving the patient's health care. All elements of the Treatment Plan, including purpose of, and possible side effects and alternatives to psychotropic medications, must be discussed with the patient. NOTE: Policies concerning consent for therapeutic or research purposes, respectively, are found in M-2, Pt. I, Ch. 23; and in M-3, Pt. I, Ch. 9.)

b. Electroconvulsive therapy, psychosurgery, aversive conditioning, or any therapy that uses painful stimuli must have special safeguards regarding peer review, patient consent, and clinical indicators. These safeguards are based on VA policy, State law, and local practice.

#### 2.06 COMPETENCY

a. Incompetency adjudicated by VA involves only the patient's ability to manage funds awarded by VA.

b. Incompetency over person or estate is a determination of a court.

c. Findings of incompetency will be reviewed at 6-month intervals, and the results of that review will be documented in the progress notes.

#### 2.07 PATIENTS' FUNDS

All patients, other than those found incompetent by the court or VA, should have responsibility for the management of their personal funds. In those instances where

patients, though not declared incompetent, demonstrate impaired judgment, their individual funds may be partially restricted, for therapeutic reasons, if documented in the Treatment Plan and with concurrence of the patient. (See M-1, Pt. I, Ch. 8, and VHA Supp. to MP-4, Pt. I, Ch. 3.)

## 2.08 COMPENSATION AND PENSION EXAMINATIONS

The establishment of accurate diagnosis and degree of disability for adjudication of disability payments and pensions is one of VA's major responsibilities. Psychiatrists and other mental health professionals assigned, or under contract, will participate in these essential VA examinations in a timely manner.

## 2.09 PTSD (POST TRAUMATIC STRESS DISORDER) EXAMINATIONS

Although the principles for all diagnoses are similar, the diagnosis of PTSD deserves special attention, particularly when the stressor is alleged to have occurred during military service. Documentation of the diagnosis and its relationship to military service must be in sufficient detail to facilitate the adjudication of disability benefit claims as well as the formulation of treatment.

a. The issue of service-connection is the sole responsibility of the rating board. The physician's responsibility is to present the clinical findings in a way that clearly demonstrates why the diagnosis of PTSD was made and, when applicable, why some other diagnosis was not made. Clinical findings which bear upon any relationship between military service and the diagnosis must be described. This diagnostic clarity should be present when the patient is found to have some diagnosis other than PTSD.

b. The diagnostic evaluation for PTSD includes review of the patient's C-file, a clinical interview and mental status exam designed to determine the presence or absence of diagnostic symptomatology and precipitants and, when indicated, psychological testing. Recent research has validated several instruments that may aid in diagnosing PTSD but do not substitute for a clinical diagnostic interview.

c. Interviews to establish a diagnosis, particularly for compensation, may be a stressful experience for the veteran, particularly for veterans with PTSD for whom issues of trust and feelings of alienation are often prominent. The veteran may be reluctant to experience the pain of relating fearful and threatening memories (e.g., of combat). For these reasons, it is vital that the interview be conducted in a sympathetic and understanding manner, and that the examiner make thorough review of the C-file and military records to provide information the veteran may not mention or to provide clues about areas or situations the examiner may wish to explore on interview.

d. The diagnosis of PTSD must be consistent with the criteria of the psychiatric diagnostic system approved by VHA (Veterans Health Administration), currently DMS-III-R (American Psychiatric Association's Diagnostic and Statistical Manual). NOTE: All criteria required for making the diagnosis must be met in order for a diagnosis of PTSD to be acceptable.

e. Specific aspects of the differential diagnosis of PTSD from other disorders, including personality disorders, substance abuse, depression, and schizophrenia, are

well described in IB 11-56, Physician's Guide for Disability Evaluation Examinations. It is possible for PTSD to co-exist with other psychiatric disorders from Axis I and Axis II (e.g., major depression, substance abuse). In some instances, the other disorder may be secondary to or associated with PTSD, while in other cases, the two disorders may be unrelated co-morbidities. The nature of the relationship of PTSD to the other disorder(s) should be clearly stated.

f. The C&P (Compensation and Pension) Evaluation Report must include the following elements:

(1) Clear and complete documentation of the diagnostic criteria that have been met to make the PTSD diagnosis. The development of symptoms since the traumatic event and the absence of these symptoms prior to the event must be noted.

(2) Clear and concretely detailed description of the stressor(s) including:

(a) A description of the event;

(b) Location in time (as best it can be recalled: year, month, season, day if possible);

(c) Geographic location (military unit, providence, town, landmarks such as river or mountain); and

(d) If possible, names of others who may have been involved in the incident.

NOTE: Often there are multiple stressors.

NOTE: The claims file and military records as well as information from the veteran may be sources of this information.

NOTE: The foregoing detail should be provided for at least one event, and descriptions of others should be provided to convey the cumulative nature of the stressful experiences.

(3) Clear and specific demonstration of the linkage between the symptoms used to make the diagnosis and the in-service stressful event, e.g., content of intrusive recollection or re-experiencing of the in-service stressor which are similar to the actual stressors experienced. NOTE: Such recollections should be of in-service stressors rather than recollection of other stressors from before or after service.

(4) Detailed description of the manner and degree to which the symptoms affect the necessary functioning of the veteran, including the effects upon:

(a) Personal relationship with family members, friends and others in social, religious, work and recreational activities (if any);

(b) Productive activity, especially employment in obtaining and maintaining effective participation; and

(c) The utilization of health services.

g. It is essential that physician examiners recognize that the value of their examination of the patient for rating purposes depends specifically on their abilities to fulfill the requirements of items f. (1), (2), (3), and (4).

(1) Rating Boards have the authority and the responsibility to return as "inadequate for rating purposes" examination reports that do not satisfy these requirements.

(2) Accurate diagnosis is a primary clinical responsibility that has major impact on the quality of care provided veterans within and outside the VA medical care system.

## 2.10 LICENSING OF PSYCHIATRIC HOSPITALS

Because they are federal facilities, VA health care facilities are not subject to state licensing requirements or certification. However, a medical center may elect to provide a state with access to the necessary information needed to make whatever determination the State wishes to make about commitment of patients to the medical center.

## 2.11 PREVENTION AND MANAGEMENT OF DISTURBED BEHAVIOR, VIOLENCE, AND SUICIDE

### a. Background

(1) Suicide and violent behavior directed at others represent serious, ongoing threats to the welfare of patients, staff and visitors at VA medical facilities.

(2) Suicide is usually ranked as tenth among the causes of death in the general population.

(3) Suicide is an even more common cause of death for veterans who are predominantly male, ranging from 40 to 65 years of age.

(4) Assaultive behavior can result in serious injury, and, in rare cases, in death, and is believed to be often under-reported in medical centers.

(5) While both suicidal and assaultive behavior in a hospital are more common on closed psychiatric units (due to patient selection for such units), both may occur throughout the medical center and among outpatients.

(6) A high incidence of violence is possible in emergency rooms, on units detoxifying substance abusers, and in areas with a heavy concentration of demented patients.

b. VA health care facilities must promote an optimal degree of safety for patients, staff, and visitors.

(1) All VA medical care facilities are expected to have an effective organizational structure to which the medical center Director delegates the

responsibility for the prevention and management of suicidal and assaultive behavior.

(2) This structure will include either a designated senior clinical staff coordinator, or an active interdisciplinary clinical committee charged with overseeing the

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implementation of a comprehensive program to deal with the many facets of suicidal and assaultive behavior. This program should include at least:

(a) The development and implementation of a tracking, or identification, system which will clearly identify high risk patients and communicate such identification to concerned staff members.

(b) An ongoing assessment of the structure and environment at the facility to ensure that the environment optimizes the safety and security of the patients, visitors and staff.

(c) Establishment of effective procedures for the local management of inevitable crisis situations, including ensuring that the roles and responsibilities are well communicated to all staff who may be involved in such incidents.

(d) Ensurance that, when instances do occur:

1. Thorough reviews of the incident are conducted as outlined in VHA supplement MP-1, Part I, Chapter 2; and M-2, Part X, G-15, Management of Suicidal and Violent Patients Program Guide; and

2. The information obtained from such reviews is clearly communicated to management and clinical staff and used at the local level to further improve the medical center's ability to prevent and manage such incidents.

(e) Ensurance that procedures are in place for providing support to staff involved in incidents of violence after the incident has been resolved.

(f) Development of an ongoing, active program of continuing education on the prevention and management of suicidal and assaultive behavior which will provide appropriate levels of training for all staff within the medical center who have contact with patients.

(g) Ensurance that the clinical assessments of patients who may be at risk for such behaviors include a careful analysis of risk potential for each patient.

(h) Ensurance that appropriate interventions are available to meet these patients' needs within the medical facility.

(i) Assistance to clinical units and services in the analysis and review of disturbed behavior incidents with the goal of improving performance and the maintenance of optimal quality care of patients. NOTE: These activities should be integrated with the quality and risk management activities of a VA facility and the clinical services involved.

(3) If a patient's disturbance can no longer be managed on any ward at a given VA health care facility, transfer should be made to a VA facility with that capability.

(a) Proper precaution must be utilized in carrying out this transfer and adequate documentation in the patient's record must accompany the patient to the receiving hospital.

(b) If the required care is not feasibly available in a VA medical facility, an inpatient may be transferred to a private facility at VA expense for the required care. Such care can only continue at VA expense until it can be provided at a VA treatment facility.

## 2.12 QM (QUALITY MANAGEMENT)

QM is a process to ensure that patients receive the most appropriate and effective mental health care services.

a. Policy. QM is an ongoing activity involving every phase of the health care delivery system. All major Mental Health Programs must develop a written QM plan which is comprehensive and integrated with the medical center's QM plan.

b. The plan should define accountability and coordination of all QM activities. The QM Program should ensure the identification, reporting and correction of problems. NOTE: The role of medical staff in ensuring quality care should be emphasized.

c. All QM Programs should include, but not be limited to:

- (1) Utilization review,
- (2) Occurrence screening,
- (3) Focused reviews,
- (4) Continuous monitors,
- (5) Clinical indicators,
- (6) Risk management,
- (7) Credentialing, and
- (8) Privileging.

d. QM monitors should be clear, simple, clinically relevant, easily defined and standardized.

e. Since QM is an area that will continue to evolve, Mental Health Service QM activities should be consistent with VA and regulatory agency, e.g., JCAHO (Joint Commission on Accreditation of Health Care Organizations) requirements.

f. Quality clinical care occurs when thorough assessment, patient-specific assets and liabilities, and thoughtful application of current professional information are combined to develop a treatment plan for each patient as a unique person. High quality clinical care can only be maintained when an ongoing effort to evaluate these plans is part of the treatment team's overall approach toward patient care.