INPATIENT MENTAL HEALTH SERVICES

1. SUMMARY OF MAJOR CHANGES: Major changes are as follows:

a. Amendment dated December 27, 2024:

(1) Provides clarification regarding service animals in the inpatient mental health setting in Appendix A, paragraph 4.

(2) Clarifies the requirement that each VA medical facility follow guidelines for involuntary hospitalization in accordance with their applicable state and local civil commitment laws in Appendix A, paragraph 5.

(3) Updates the role and responsibility for Executive Director, Office of Mental Health in paragraph 2.e.

(4) Adds role and responsibility for Executive Director, Office of Suicide Prevention in paragraph 2.h.

(5) Changes "Office of Mental Health and Suicide Prevention" to "Office of Mental Health" and "Office of Suicide Prevention" throughout.

b. As published September 27, 2023, major changes included:

(1) Clarification and updates to the roles and responsibilities for:

(a) Executive Director, Office of Mental Health and Suicide Prevention (OMHSP).

(b) National Director, Inpatient Mental Health Services, OMHSP.

(c) Veterans Integrated Service Networks (VISN) Director.

(d) VA medical facility Director.

(e) VA medical facility Chief Mental Health Lead (e.g., Mental Health Service Line Director, Associate Chief of Staff for Mental Health).

(f) VA medical facility mental health care provider.

(2) Included new roles and responsibilities for the:

(a) Executive Director, Office of Nursing Services (ONS)/Deputy Chief Nursing Officer.

(b) Executive Director, Care Management and Social Work Services (CMSW).

(c) Director of the Northeast Program Evaluation Center (NEPEC).

(d) Chair, OMHSP Inpatient Mental Health Construction Committee.

(e) VISN Chief Mental Health Officer.

(f) VA medical facility Chief of Staff.

(g) VA medical facility Associate Director, Patient Care Services (ADPCS).

(h) VA medical facility Chief of Quality.

(i) VA medical facility Chief Mental Health Nurse.

(j) VA medical facility Inpatient Mental Health Nurse Manager (IMHNM).

(k) VA medical facility Inpatient Mental Health Program Manager (IMHPM).

(l) VA medical facility Interdisciplinary Treatment Team (ITT).

(m) VA medical facility Patient Safety Manager.

(n) VA medical facility Mental Health Treatment Coordinator.

(o) VA medical facility Local Recovery Coordinator.

(3) Updates to safety and environment of care information to be in alignment with other updated policies.

(4) Updates to requirements for therapeutic programming.

2. RELATED ISSUES: VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated December 18, 2024; VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023; VHA Directive 1611(1), Safe Patient Handling and Mobility Program, dated July 11, 2023.

3. POLICY OWNER: The Office of Mental Health (11MH) is responsible for the contents of this directive. Questions regarding the content of this directive may be directed to the National Director, Inpatient Mental Health Services (IMHS) at VHAOMHInpatientMentalHealthTeam@va.gov.

4. RESCISSION: VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013, is rescinded.

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

6. IMPLEMENTATION SCHEDULE: 9 months after publication date to allow for VISNs and VA medical facilities to make necessary changes to comply with the policy.

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

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

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publication Distribution List on September 29, 2023.

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APPENDIX A

PRINCIPLES OF TREATMENT AND PROGRAM REQUIREMENTS FOR INPATIENT MENTAL HEALTH A-1

INPATIENT MENTAL HEALTH SERVICES

1. POLICY

It is VHA policy that acute inpatient mental health services (IMHS) are provided without delay to all eligible Veterans requiring this level of care. **AUTHORITY:** 38 U.S.C. § 7301(b); 38 C.F.R. § 17.38.

2. RESPONSIBLITIES

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

b. **Chief Operating Officer.** The Chief Operating Officer is responsible for:

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

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

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

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

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

e. **Executive Director, Office of Mental Health.** The Executive Director, OMH is responsible for:

(1) Communicating the contents of this directive throughout OMH.

(2) Supporting the efforts of the National Director, Inpatient Mental Health Services (IMHS), OMH by ensuring sufficient resources are available to fulfill the mission of IMHS.

(3) Establishing an OMH Inpatient Mental Health Construction Committee responsible for the national review of inpatient mental health-related construction projects. In addition to OMH representation, the Inpatient Mental Health Construction Committee must consist of representatives from VHA's National Center for Patient Safety, Office of Nursing Services (ONS), Construction and Facilities Management, and

Office of Women's Health. Other program office stakeholders may be added as necessary by the Executive Director, OMH.

(4) Coordinating with the Executive Director, Care Management and Social Work Services (CMSW) regarding the provision of national inpatient mental health services provided by VHA social workers. ***NOTE:*** *For further information, see VHA Directive 1110.02, Social Work Professional Practice, dated August 16, 2024, and VHA Directive 1198(1), Intimate Partner Violence Assistance Program, dated June 11, 2024.*

(5) Delegating responsibilities to the National Director, Inpatient Mental Health Services as needed.

(6) Coordinating with the Executive Director, Office of Suicide Prevention (OSP) regarding the provision of suicide prevention services for patients receiving inpatient mental health services. ***NOTE:*** *For further information, see VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022, VHA Directive 1160.07, Suicide Prevention Program, dated May 24, 2021, and VHA Directive 1166, Patient Record Flags, dated November 6, 2023*.

f. **Executive Director, Office of Nursing Services/Deputy Chief Nursing Officer.** The Executive Director, ONS/Deputy Chief Nursing Officer is responsible for coordinating with OMH regarding the provision of mental health nursing care and SUD services for enrolled Veterans who receive inpatient mental health care.

g. **Executive Director, Care Management and Social Work Services.** The Executive Director, CMSW is responsible for coordinating with the Executive Director, OMH regarding the provision of national inpatient mental health services provided by VHA social workers. ***NOTE:*** *For further information, see VHA Directive 1110.02 and VHA Directive 1198(1).*

h. **Executive Director, Office of Suicide Prevention**. The Executive Director, Office of Suicide Prevention (OSP) is responsible for coordinating with the Executive Director, OMH regarding the provision of suicide prevention services for patients receiving inpatient mental health services. ***NOTE:*** *For further information, see VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022, VHA Directive 1160.07, Suicide Prevention Program, dated May 24, 2021, and VHA Directive 1166, Patient Record Flags, dated November 6, 2023*.

i. **National Director, Inpatient Mental Health Services, Office of Mental Health.** The National Director, IMHS, OMH is responsible for:

(1) Developing national policy and procedures for inpatient mental health care, including updating this directive as delegated by the Executive Director, OMH.

(2) Serving as OMH's inpatient mental health services subject matter expert. This includes providing policy and operational consultation and guidance to other VHA Central Office (VHACO) program offices, VISNs and VA medical facilities regarding inpatient mental health.

(3) Monitoring VHA inpatient mental health units to ensure operational practices and clinical services provided are consistent with current standards of care. This may include review of relevant metrics, issue briefs, and survey reports from applicable internal and external regulatory, accrediting, and oversight bodies, as well as meetings with VISN and VA medical facility staff, and site visits.

(4) Reviewing VA medical facility inpatient mental health unit bed change requests and program restructuring proposals.

(5) In collaboration with the VISN Chief Mental Health Officer (CMHO), developing recommendations and monitoring VA medical facility action plans to ensure the implementation of process improvement and amelioration of operational or implementation deficiencies when such deficiencies are identified by accrediting bodies or the VISN.

j. **Director of Northeast Program Evaluation Center.** The Director of the Northeast Program Evaluation Center (NEPEC) is responsible for:

(1) Providing national program evaluation of VHA inpatient mental health units.

(2) Collecting and summarizing data related to inpatient mental health program workload, costs, and adverse events, maintaining dashboards of inpatient mental health performance data, and providing technical assistance and consultation related to these metrics to relevant stakeholders (e.g., the National Director, IMHS, OMH).

k. **Chair, Office of Mental Health Inpatient Mental Health Construction Committee.** The Chair, OMH Inpatient Mental Health Construction Committee is responsible for reviewing and participating in the planning of individual VA medical facilities' inpatient mental health-related construction or renovations projects.

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

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Communicating the contents of this directive to each of the VISN's VA medical facility Directors.

(3) Ensuring that IMHS are accessible without delay to all eligible Veterans in the VISN.

(4) Ensuring that inpatient mental health programs in the VISN comply with relevant state laws governing inpatient mental health care, hospital accreditation regulations, and VISN and facility level procedures.

(5) Ensuring that all inter-facility transfers are assessed and accomplished as indicated in VHA Directive 1094(1), Inter-Facility Transfer Policy, dated January 11, 2017.

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

(1) Ensuring that inpatient mental health policies and guidance are disseminated to the VA medical facility Chief Mental Health Leads in their VISN.

(2) Overseeing the collection of inpatient mental health data from VA medical facilities in their VISN when required.

(3) Monitoring VISN inpatient mental health units to ensure operational practices and clinical services provided are consistent with current practice standards. This may include review of relevant metrics, issue briefs, survey reports from applicable internal/external regulatory and oversight bodies, meetings with VA medical facility staff, and site visits.

(4) In collaboration with the National Director, IMHS, OMH, developing recommendations and monitoring VA medical facility action plans to ensure the implementation of process improvement and amelioration of operational or implementation deficiencies when such deficiencies are identified by accrediting bodies or the VISN.

(5) Reviewing all bed change and program restructuring requests and providing feedback to the VA medical facility prior to submission to VHACO.

(6) Participating in the planning process of individual VA medical facilities' inpatient mental health construction or renovation projects.

(7) Ensuring collaboration with the VISN Nursing Representative on all issues pertaining to inpatient mental health nursing.

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

(1) Ensuring compliance with this directive at the VA medical facility.

(2) Ensuring involuntary acute inpatient mental health treatment for Veterans is available when needed either on a locked inpatient mental health unit at the VA medical facility or through arrangements for this care to be provided at another facility or in the community. Consultation with the Office of Chief Counsel in the District is recommended due to the wide variation in state laws and procedures governing involuntary treatment.

(3) Providing appropriate support and resources, including administrative support, to ensure that the inpatient mental health program can accomplish its stated mission, goals and objectives for clinical care 24 hours a day, 7 days a week. ***NOTE:*** *VA medical facilities may wish to develop standard operating procedures (SOPs) or use service*

agreements to address timely services from other required service and program areas that provide services and care to Veterans on the inpatient mental health unit such as medicine, pharmacy, laboratory, nutrition services and environmental management.

(4) Ensuring that the elements and features in the Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities, available at https://www.cfm.va.gov/til/dGuide/dgMH.pdf, are incorporated in new units and units undergoing renovation at the VA medical facility, and that existing units meet the intent of the Design Guide to create a safe and healing environment.

(5) Ensuring that the VA medical facility Chief Mental Health Lead, inpatient mental health staff, and all VA medical facility stakeholders involved in providing care and services to Veterans and staff on the inpatient unit participate in the planning for VA medical facility inpatient mental health construction projects.

(6) Ensuring that the VISN CMHO and the OMH Inpatient Mental Health Construction Committee are consulted in the planning process of any VA medical facility inpatient mental health construction or renovation projects.

(7) Ensuring that Veterans have access to mental health evaluation and clinically appropriate treatment provided in a safe and secure environment by trained staff. This includes ensuring that all inpatient mental health units are staffed with a psychiatrist, when possible, and ensuring that Veterans are provided with necessary items for improved functioning such as appropriate clothing and treatment materials. For additional details see the **Standard Operating Procedure for Core Clinical Processes On Inpatient Mental Health Units** under this directive found at OMH's IMHS Policy Resource SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(8) Ensuring that Veterans on VA medical facility inpatient mental health units have timely access to needed medical services based upon the type and severity of the medical concern. ***NOTE:*** *VA medical facilities with larger units and more medically complex Veterans should consider having dedicated health care providers to oversee acute and complex medical conditions.* See Appendix A for additional details on Access to Care.

(9) Overseeing the tracking and reporting of VA medical facility data related to patient restraint and seclusion.

(10) Ensuring that VA medical facility practices related to informed consent for clinical treatments and procedures and forced administration of psychotropic medications align with VHA Directive 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.

(11) Ensuring that VA medical facility guidelines related to involuntary commitment align with state and local requirements.

(12) Ensuring that VA medical facility practices related to honoring Advanced Care Plans align with VHA Directive 1004.03(1), Advance Care Planning, December 12, 2023.

(13) Ensuring that the VA medical facility Quality and Patient Safety Committee reviews inpatient mental health data as required in VHA Directive 1050.01, VHA Quality and Patient Safety Programs, dated March 24, 2023.

(14) Ensuring that the unique needs of women Veterans, transgender and intersex Veterans and older Veterans with frailty or neurocognitive disorders are addressed in accordance with Appendix A of this directive.

(15) Ensuring the completion of all mandated reporting, monitoring, and applicable regulatory and oversight requirements in accordance with established timelines and requests from the VISN, OMH and other stakeholders.

o. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff (CoS) is responsible for:

(1) Ensuring that agreements between mental health and other VA medical facility services (e.g., emergency medicine, medicine, laboratory services, pharmacy, nutrition services, women's health, environmental services) clearly articulate roles and responsibilities and enhance rapid and clear communication and smooth patient flow.

(2) Ensuring collaboration between VA medical facility inpatient, outpatient and residential services so that care transitions between inpatient mental health and services at a less intensive level of care are smooth and facilitate post-discharge engagement.

(3) In collaboration with the Associate Director, Patient Care Services (ADPCS) ensuring that VA medical facility inpatient mental health units have adequate staffing to establish interdisciplinary teams, ensure access to inpatient mental health treatment for local Veterans, and fully implement the program requirements listed in Appendix A.

p. **VA Medical Facility Associate Director, Patient Care Services.** The VA medical facility ADPCS is responsible for:

(1) In collaboration with the VA medical facility COS, ensuring that VA medical facility inpatient mental health units have adequate staffing to establish interdisciplinary teams, ensure a safe and secure healing environment, and fully implement the program requirements listed in Appendix A.

(2) Ensuring that the VA medical facility Inpatient Mental Health Nurse Manager (IMHNM) completes the inpatient mental health staffing methodology and shares this information with inpatient nursing leadership in accordance with VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023.

q. **VA Medical Facility Chief Mental Health Lead.** Each VA medical facility Chief Mental Health Lead (Mental Health Service Line Director, Associate COS for Mental Health, etc.) is responsible for:

(1) Designating an Inpatient Mental Health Program Manager (IMHPM) to coordinate and promote consistent, sustained, high quality therapeutic programming for all Veterans on the VA medical facility inpatient mental health unit and ensuring that the IMHPM has adequately mapped administrative time to complete assigned tasks.

(2) Ensuring that the VA medical facility Local Recovery Coordinator (LRC) completes assigned responsibilities in accordance with this directive (see paragraph 2.r.) and provides consultation to VA medical facility IMHS staff as needed on a recovery-oriented approach to care.

(3) In collaboration with the VA medical facility IMHPM, monitoring productivity of inpatient mental health staff, ensuring labor mapping is accurate and reviewing individualized productivity targets.

(4) Ensuring that any local inpatient mental health SOPs align with national policy and SOPs.

(5) Ensuring that inpatient mental health data submitted to the VA medical facility Quality and Patient Safety Committee is reviewed and communicated to inpatient mental health staff.

(6) Collaborating with the VA medical facility IMHPM, VA medical facility IMHNM, VA medical facility ITT(s), and VA medical facility mental health care providers (e.g., outpatient) to ensure that program requirements are coordinated and provided as indicated in this directive (see Appendix A for additional details).

r. **VA Medical Facility Chief Mental Health Nurse.** The VA medical facility Chief Mental Health Nurse is responsible for:

(1) Providing mental health nursing leadership at the VA medical facility.

(2) Providing supervision and direct oversight to the VA medical facility IMHNM to ensure VA medical facility and program initiatives, goals, and operations are met, and that nursing care complies with all applicable laws, accrediting organization standards and VA and VHA policies and procedures.

(3) Collaborating with the VA medical facility IMHPM, the VA medical facility Chief Mental Health Lead, ITT(s), and VA medical facility mental health care providers (e.g., outpatient) to ensure that program requirements are coordinated and provided as indicated in this directive. (See Appendix A for additional details.)

s. **VA Medical Facility Inpatient Mental Health Nurse Manager.** The VA medical facility IMHNM is responsible for:

(1) Leading and overseeing the day-to-day delivery of professional nursing services on the VA medical facility inpatient mental health unit and ensuring the effective development and functioning of the therapeutic milieu.

(2) Ensuring safety observation occurs consistent with the level of observation ordered for each patient and the processes outlined in the **Standard Operating Procedure for Maintaining Safety And Security On Inpatient Mental Health Units** under this directive found at OMH's IMHS Policy Resource SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(3) Ensuring requests for additional staffing necessary to provide safe clinical care are submitted in a timely manner to VA medical facility leadership by completing the required staffing methodology according to VHA Directive 1351.

(4) Directing the VA medical facility nursing team's collaboration and partnership with the ITT.

(5) Setting VA medical facility inpatient mental health unit goals and measuring outcomes related to Veteran and staff safety and the quality of patient care services utilizing nursing-related outcomes and high reliability principles.

(6) Ensuring that all new VA medical facility inpatient mental health nursing staff (including float and agency staff) receive appropriate unit orientation such as ONS Psychiatric-Mental Health Nursing Orientation program, PMDB, 1:1 safety companion observation, unit safety rules, patient safety rounding and environment of care rounding procedures.

(7) Ensuring that VA medical facility nursing staff engage Veterans in recovery-oriented therapeutic programming and milieu management.

(8) Monitoring required electronic health record nursing documentation (e.g., individual meetings with Veterans, rounding documentation, documentation for critical incidents such as disruptive behavior reports or safety reports) to ensure completeness, timeliness accuracy and appropriateness.

(9) Collaborating with the VA medical facility IMHPM and VA medical facility Patient Safety Officer to consistently ensure a safe and secure environment of care at the VA medical facility. (See Appendix A for additional details.)

(10) Collaborating with the VA medical facility IMHPM to ensure appropriate mitigation strategies are in place and communicated to all VA medical facility inpatient mental health staff until repairs are completed.

(11) Collaborating with the VA medical facility IMHPM and VA medical facility staff with inpatient mental health Quality and Utilization Management knowledge and expertise to review the IMHS and program data twice a year, assess performance and determine if process improvement is needed.

(12) Collaborating with the VA medical facility Chief Mental Health Lead, the VA medical facility IMHPM, VA medical facility ITT(s), and VA medical facility mental health care providers (e.g., outpatient) to ensure that program requirements are coordinated and provided as indicated in this directive (see Appendix A for additional details).

t. **VA Medical Facility Inpatient Mental Health Program Manager.** ***NOTE:*** *The VA medical facility IMHPM was previously known as the Inpatient Program Coordinator and may continue to be the Inpatient Mental Health Program Coordinator or the Inpatient Mental Health Section Chief depending on the responsibilities assigned and the discipline selected. As the manager of an interdisciplinary unit, it is strongly recommended that the IMHPM has administrative authority (including dedicated administrative labor mapping), over the clinical staff and works in conjunction and collaboration with the ITT Leader(s) and discipline leaders.* The VA medical facility IMHPM is responsible for:

(1) Overseeing all clinical services, such as psychiatric care, case management, individual assessment, psychological evaluation, psychoeducational classes, group and individual psychotherapy services, and evidence-based psychotherapies.

(2) Ensuring that the ITT(s) meets regularly and works collaboratively with each Veteran in the development and implementation of a comprehensive inpatient mental health treatment plan.

(3) Overseeing implementation and use of the three **Standardized Operating Procedures for Inpatient Mental Health Units** under this directive found at OMH's IMHS Policy Resource SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) Serving as the VA medical facility subject matter expert in coding and documentation of inpatient mental health encounters. Encounters must be completed according to VHA Directive 1082(1), Patient Care Data Capture and Closeout, dated March 9, 2023.

(5) In collaboration with the VA medical facility Chief Mental Health Lead, monitoring productivity of inpatient mental health clinical staff, ensuring labor mapping is accurate and reviewing individualized productivity targets.

(6) Collaborating with the VA medical facility IMHNM and VA medical facility Patient Safety Manager to ensure a safe and secure environment of care at the VA medical facility. (See Appendix A for additional details.)

(7) Collaborating with the VA medical facility IMHNM to ensure appropriate mitigation strategies are in place and communicated to all VA medical facility inpatient mental health staff until repairs are completed.

(8) Reviewing Veteran and staff feedback regularly (quarterly at a minimum) such as customer satisfaction surveys, the All-Employee Survey (AES), and available inpatient

mental health data to ensure smooth operations and communicating the feedback and data to all VA medical facility inpatient mental health staff periodically.

(9) Ensuring that VA medical facility inpatient mental health staff are educated on applicable regulatory and oversight requirements and other internal oversight responsibilities.

(10) Ensuring that all new inpatient mental health non-nursing staff receive appropriate orientation (e.g., treatment planning processes, unit safety rules, tour of unit).

(11) In collaboration with the VA medical facility LRC, developing a local SOP addressing the education, staff training and implementation of recovery-oriented care. Periodic climate assessments and observations of staff interactions with Veterans in the milieu are also recommended.

(12) Conducting program evaluation in collaboration with the VA medical facility IMHNM and VA medical facility staff with inpatient mental health Quality and Utilization Management knowledge and expertise to review the IMHS and program data twice a year, assess performance and determine if process improvement is needed.

(13) Collaborating with the VA medical facility Chief Mental Health Lead, VA medical facility IMHNM, VA medical facility ITT(s), and VA medical facility mental health care providers (e.g., outpatient and residential) to ensure that program requirements are coordinated and provided as indicated in this directive (see Appendix A for additional details).

u. **VA Medical Facility Interdisciplinary Treatment Team.** The Interdisciplinary Treatment Team (ITT) is responsible for:

(1) Developing, implementing and monitoring progress on each Veteran's recovery-oriented treatment plan. This includes discussing the need, benefits and risks of family involvement in care with the Veteran, and family with the Veteran's permission.

(2) Meeting as a team at least twice a week to review the Veteran's treatment plan implementation and assess the Veteran's progress.

(3) Monitoring treatment engagement such as medication adherence and participation in therapeutic programming.

(4) Engaging in care coordination with the VA medical facility Mental Health Treatment Coordinator (MHTC) and mental health care providers (e.g., outpatient or residential) working with the Veteran post-discharge.

(5) Collaborating with the VA medical facility Chief Mental Health Lead, VA medical facility IMHPM, VA medical facility IMHNM, and mental health care providers (e.g., outpatient) to ensure that program requirements are coordinated and provided as indicated in this directive (see Appendix A for additional details).

v. **VA Medical Facility Patient Safety Manager.** The VA medical facility Patient Safety Manager is responsible for collaborating with the VA medical facility IMHPM and VA medical facility IMHNM to ensure a safe and secure environment of care at the VA medical facility. (See Appendix A for additional details.)

w. **VA Medical Facility Mental Health Treatment Coordinator.** The VA medical facility MHTC is responsible for engaging in care coordination with the VA medical facility ITT and mental health care providers (e.g., outpatient or residential) and working with the Veteran post-discharge.

x. **VA Medical Facility Local Recovery Coordinator.** The VA medical facility LRC is responsible for:

(1) Providing consultation to VA medical facility IMHS staff regarding recovery-oriented care, including education and training as needed. This includes review of policies, procedures, staff trainings, Veteran treatment materials, and other components of IMHS at a minimum of annually.

(2) In collaboration with the VA medical facility IMHPM, developing a local SOP addressing the education, staff training and implementation of recovery-oriented care on the inpatient mental health unit. Periodic climate assessments and observations of staff interactions with Veterans in the milieu are also recommended.

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

(1) Collaborating with the VA medical facility Chief Mental Health Lead, VA medical facility IMHPM, VA medical facility IMHNM, and VA medical facility ITT(s) to ensure that clinical care programming requirements are coordinated and provided as indicated in this directive.

(2) Engaging in care coordination with the VA medical facility ITT and VA medical facility MHTC working with the Veteran post-discharge.

3. MEMBERSHIP IN THE INTERDISCIPLINARY TREATMENT TEAM

a. Each VA medical facility unit must have an ITT comprised of the various disciplines that are responsible for participating in the assessment, planning and implementation of a Veteran's care. An interdisciplinary team approach is essential to providing comprehensive, coordinated, and holistic care. Comprehensive mental health services should be provided by an ITT in a healing, therapeutic and inclusive environment. ITTs are characterized by a high degree of collaboration, effective communication, and interdependence to ensure that each Veteran's needs are met. Large units may need more than one ITT although, depending on roles and responsibilities, some staff may be on more than one team.

b. ITTs are ideally comprised of a psychiatric health care provider, social worker, registered nurse, and psychotherapy provider (i.e., psychologist, licensed professional

mental health counselor (LPMHC), marriage and family therapist (MFT)). At minimum, the ITT must have a psychiatric health care provider and a registered nurse plus at least one other discipline/role from the following:

(1) Social Worker.

(2) Psychologist.

(3) Clinical Pharmacist (CP) or Clinical Pharmacy Practitioner (CPP).

(4) Peer Specialist.

(5) LPMHC.

(6) MFT.

(7) Recreation Therapist.

(8) Occupational Therapist.

(9) Medical Care Provider.

c. Other professional staff who provide care to Veterans during hospitalization and who are involved in care coordination following discharge should be invited to treatment team meetings when needed or at the Veteran's request.

4. TRAINING

Clinical and non-clinical inpatient mental health staff are required to complete mandatory PMDB training as specified in VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021, and as specified in VHA Directive 1167, Mental Health Environment of Care Checklist for Units Treating Suicidal Patients, dated November 4, 2024. ***NOTE:*** *Supervising practitioners must provide orientation and training to health professions trainees related to handling of environmental risks, emergency situations, and related VHA policies and VA medical facility procedures for the specific clinical area.*

5. RECORDS MANAGEMENT

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

6. BACKGROUND

a. VA has long provided inpatient mental health care to Veterans with acute or severe emotional or behavioral symptoms. VHA inpatient mental health care has

transformed from a long-term care model to an interdisciplinary, comprehensive, and recovery-oriented model that assists Veterans with connecting to residential or outpatient mental health care and supports so they may improve and recover.

b. For purposes of this directive, inpatient mental health care is considered acute mental health care unless otherwise noted. The guiding principles for inpatient mental health care incorporate a Veteran-centered, evidence-based, recovery-oriented approach to improve functional status, promote recovery and expedite the Veteran's transition to a less-intensive, clinically appropriate level of care. This includes evaluating and monitoring Veterans, prompt interdisciplinary mental health and medical treatment and discharge planning, adequate staffing, privacy, respect, and gender and cultural sensitivity. IMHS are the most intensive level of services that support safety and effectively manage Veteran care needs during periods of acute mental distress.

c. The primary goal of IMHS is to provide a safe and secure therapeutic environment to stabilize Veterans experiencing acute distress and improve their functional status so they no longer require acute hospitalization. This is accomplished through the provision of Services based on the guiding principles listed above, and to facilitate smooth care transitions that connect Veterans to services and supports at a less intensive level of care and facilitate post-discharge engagement.

7. DEFINITIONS

a. **Acute Mental Health Care.** Acute mental health care refers to high-intensity mental health services for Veterans with acute and severe emotional or behavioral symptoms causing a safety risk to self or others or resulting in a severely compromised functional status. This level of care is provided in a locked inpatient setting to ensure safety and provide the type and intensity of clinical observation and intervention necessary to treat the Veteran.

b. **Disruptive Behavior.** Disruptive behavior is verbal, non-verbal, physical, written, or electronic behavior by any individual that is intimidating, threatening, or dangerous; has jeopardized or could jeopardize the health, safety or security of Veterans, VA employees, or other individuals at the VA medical facility; would create fear in a reasonable person; interferes with the safe, secure and effective delivery of VA health care; compromises the ability of VA to engage in its mission of serving Veterans; or impedes the daily operation of the VA medical facility. Identifying a behavior as "disruptive" does not depend upon the actor's stated intentionality or justification for the behavior, presence of psychological or physical impairment, decision-making capacity, or later expression of remorse or apology.

c. **Mental Health Care.** Mental health care is the evaluation, diagnosis, treatment, rehabilitation and prevention of mental health and substance use disorders.

d. **Mental Health Environment of Care Checklist.** The MHEOCC is a checklist designed to help identify and abate safety hazards on mental health units and other areas treating Veterans at high acute risk for suicide. It consists of criteria applicable to

all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion/physical restraint rooms, and staff workstations. The MHEOCC can be accessed at https://dvagov.sharepoint.com/sites/vhancps. ***NOTE****: This is an internal VA website that is not available to the public.*

e. **Physical Restraint.** A physical restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a Veteran to move arms, legs, body, or head freely.

f. **Safety Observation Levels.** Safety observation levels describe both the frequency with which the inpatient mental health staff is to visually observe a Veteran admitted to an inpatient mental health unit, as well as the required staff to patient ratios and responsibilities for each level. Complete descriptions of safety observation levels (e.g., routine, direct line of sight, one to one observation) are detailed in the **Standard Operating Procedure for Maintaining Safety And Security On Inpatient Mental Health Units** under this directive found at OMH's IMHS Policy Resource SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

g. **Seclusion.** Seclusion is involuntary confinement of a Veteran alone in a room or area from which the Veteran is physically prevented from leaving.

8. REFERENCES

a. VHA Directive 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.

b. VHA Directive 1004.03(1), Advance Care Planning, dated December 12, 2023.

c. VHA Directive 1050.01, VHA Quality and Patient Safety Programs, dated March 24, 2023.

d. VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

e. VHA Directive 1082(1), Patient Care Data Capture and Closeout, dated March 9, 2023.

f. VHA Directive 1094(1), Inter-Facility Transfer Policy, dated January 11, 2017.

g. VHA Directive 1108.17(1) Clozapine Patient Management, dated May 17, 2022.

h. VHA Directive 1110.02, Social Work Professional Practice, dated August 16, 2024.

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

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

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

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

m. VHA Directive 1166, Patient Record Flags, dated November 6, 2023.

n. VHA Directive 1167, Mental Health Environment of Care Checklist for Units Treating Suicidal Patients, dated November 4, 2024.

o. VHA Directive 1178, Animal-Assisted Interventions and Services, dated February 23, 2024.

p. VHA Directive 1188(1), Animals on Veterans Health Administration (VHA) Property, dated August 26, 2015.

q. VHA Directive 1198(1), Intimate Partner Violence Assistance Program, dated June 11, 2024.

r. VHA Directive 1330.01(7), Health Care Services for Women Veterans, dated February 15, 2017.

s. VHA Directive 1340, Provision of Health Care for Veterans Who Identify as Lesbian, Gay, Bisexual and Queer, dated September 21, 2022.

t. VHA Directive 1341(4), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

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

PRINCIPLES OF TREATMENT AND PROGRAM REQUIREMENTS FOR INPATIENT MENTAL HEALTH

1. PATIENT RIGHTS

Upon the admission of any patient, the patient or their representative must be informed of the rights described in 38 C.F.R. § 17.33, must be given a copy of a statement of those rights and must be informed of the fact that the statement of rights is posted at each nursing station. All staff members assigned to work with patients must be given a copy of the statement of rights and these rights must be discussed with them by their immediate supervisor.

2. RECOVERY-ORIENTED CARE

a. A patient-centered recovery-oriented approach must be reflected in all VHA inpatient mental health units, including the services and treatments provided, language in new and existing inpatient documents and in the environment of care. With recovery-oriented care, Veterans are actively engaged in the process of defining personal goals based on their self-chosen values, interests, roles, and aspirations. A recovery-oriented approach to care also must be reflected in staff interactions with Veterans and each other. Staff must work collaboratively with Veterans and each other to foster an environment and therapeutic milieu that communicates hope and caring.

b. Veterans should be encouraged to dress in personal clothes during the day unless there is an individualized, documented reason for the Veteran to be in hospital pajamas.

3. ACCESS TO CARE

a. Admission to inpatient mental health units must be available to all eligible Veterans who require hospital level care for a mental health condition. Services must be available in the VA medical facility where the Veteran is being treated, a nearby VA medical facility, or community care. When it is determined by appropriately trained and licensed health care providers that acute inpatient mental health care is appropriate, immediate admission is necessary to ensure Veteran safety and stabilization. If immediate admission is not possible, there must be no delay in taking action to ensure safety and initiation of treatment for the Veteran.

b. **Mental Health Services for Veterans on Medical Units.** Veterans whose medical conditions require treatment on, or transfer to, a medical or surgical unit must concurrently be provided the mental health care they need as appropriate based on their medical and mental health condition. VA medical facilities must have a standardized process to ensure timely response to mental health consults and treatment as clinically indicated. Processes must be in place to arrange admission to an inpatient mental health unit as needed when medical or surgical admission is no longer indicated. The environment of care on an inpatient medicine unit can present safety

hazards due to the nature of the treatment provided which must be mitigated for patients at risk for suicide. The medical team may wish to consult with the mental health consultation team in mitigating potential hazards for Veterans including the assignment of the clinically appropriate patient safety observation level.

c. **Access to Medical Care While Hospitalized on Inpatient Mental Health Units.**

(1) Given that medical conditions are common comorbidities with psychiatric illness, all Veterans on the inpatient mental health unit must have access to necessary and timely medical care. VA medical facilities may wish to have dedicated medical care providers (e.g., general medicine doctors, PAs, nurse practitioners) who can complete admission medical assessments, monitor chronic medical concerns, treat acute medical issues and liaison as needed with the VA medical facility medical consultation team.

(2) Due to the composition and needs of the Veteran population served by a VA medical facility, the VA medical facility Director may wish to create an integrated mental health and medical unit. When establishing such a unit, the VA medical facility Director must consider and adhere to environment of care requirements, ensure adequate staffing competencies, and effectively manage patient acuity and complexity.

(3) Care for Veterans who are pregnant or lactating must be coordinated between the Veteran's mental health and medical providers, maternity care provider and community care providers if applicable. VA medical facilities must follow the VHA Office of Women's Health Guidance for Pregnant, Lactating, and Postpartum Veterans in Inpatient Mental Health and Substance Use Treatment Settings. ***NOTE:*** *This is an internal VA website that is not available to the public.*

d. **Management of Admission for Veterans in Acute Withdrawal.** Although alcohol and drug withdrawal can often be safely and effectively managed on an outpatient basis, medically monitored inpatient withdrawal management must be available, as needed, for Veterans evaluated to be at risk for moderate to severe withdrawal from alcohol, sedative/hypnotics or opioids. Location and provision of services for acute withdrawal should be based on clinical assessment of the Veteran and the program unit's ability to meet the medical and safety needs of the Veteran.

e. **Mental Health Services for Veterans with Functional and Cognitive Impairments on Inpatient Mental Health Units**. Some Veterans have medical, sensory, functional or cognitive impairments that require special care to ensure their safety (e.g., older Veterans with frailty or neurocognitive disorders). Unit design should take into account specialized care needs common among older Veterans. To prevent injury, these Veterans are to be kept safe from other Veterans demonstrating agitated behavior. Larger VA medical facilities may consider establishing a separate wing or unit for these Veterans within treatment programs designed to meet their needs. Resources for IMHS for these populations may be found on the Office of Mental Health (OMH) Inpatient Mental Health SharePoint.: ***NOTE:*** *This is an internal VA website that is not available to the public.*

f. **Mental Health Services for Women Veterans on Inpatient Mental Health Units**. Women patients treated on VHA inpatient mental health units must have access to equitable care in an environment that provides privacy, dignity and security as detailed in VHA Directive 1330.01(7), Health Care Services for Women Veterans, dated February 15, 2017.

(1) Mental health program staff members must collaborate with the Women Veteran's Program Manager, Women's Health program staff and Women's Mental Health Champion regarding inpatient mental health programming for women Veterans.

(2) VA medical facilities must ensure availability of feminine hygiene products for Veterans at no charge.

(3) VA medical facilities should not routinely restrict access to wearing personal undergarments (bras/underwear) because of elastic or support wires. When there is an individualized, documented reason to restrict use of a personal undergarments, an alternative should be provided.

g. **Mental Health Services for LGBQT+ Veterans on Inpatient Mental Health Units.** LGBTQ+ Veterans must be treated with dignity, respect and cultural sensitivity in accordance with VHA Directive 1340, Provision of Health Care for Veterans Who Identify as Lesbian, Gay, Bisexual and Queer, dated September 21, 2022, and VHA Directive 1341(4), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018. Patients must be addressed based upon their self-identified gender identity; the use of their preferred name and pronoun is required including in conversation and clinical notes, even when this is not their legal name. Room assignments and access to facilities for which gender is a consideration (e.g., restrooms) should give preference to self-identified gender, irrespective of appearance or surgical state. Additionally, LGBTQ+ Veteran Care Coordinators should be consulted and collaborated with on inpatient mental health programming for transgender, gender diverse, and intersex Veterans. Guidance for this care may be found on the VA LGBTQ+ Resources SharePoint. ***NOTE:*** *This is an internal VA website that is not available to the public.*

4. SAFETY AND SECURITY

The primary objective of inpatient mental health care is to provide the level of intensive treatment necessary for safety and stabilization in a recovery-oriented environment, and discharge to a less intensive level of care as soon as clinically appropriate and feasible based on available resources. Since Veterans are admitted due to the severity of their symptoms, all inpatient mental health units must be locked in order to accommodate involuntary Veterans and Veterans who are temporarily severely agitated or at risk of harming themselves or others, as well as to provide safety and privacy by controlling access to the unit by others. Due to the nature of the environment, service animals are not permitted in the inpatient mental health unit outside of approved animal-assisted therapy that is part of VHA therapeutic programing. Inpatient mental health units must follow VHA Directive 1167, Mental Health Environment of Care

Checklist for Units Treating Suicidal Patients, dated November 4, 2024as well as the additional details in the **Standard Operating Procedure for Maintaining Safety And Security On Inpatient Mental Health Units** under this directive found at OMH's IMHS Policy Resource SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx.
NOTE: *This is an internal VA website that is not available to the public.*
NOTE: *See definition of service animal in Directive 1188(1) Animals on Veterans Health Administration (VHA) Property, dated August 26, 2015, and Animal-assisted Therapy guidance in Directive 1178, Animal-Assisted Interventions and Services, dated February 23, 2024.*

5. COMMITMENT

As the Federal government does not have civil commitment laws, each VA medical facility must develop clear guidelines for involuntary hospitalization in accordance with applicable state and local civil commitment laws. ***NOTE:*** *Consultation with District Counsel is highly recommended because of the wide variation in state and local laws and procedures governing involuntary commitment timeframes and those with intrastate variation.*

6. SECLUSION AND RESTRAINT

a. Veterans have the right to treatment in the least-restrictive environment necessary to maintain safety (38 C.F.R. § 17.33(d)(1)). Seclusion and physical restraint are interventions to be utilized in an emergency only when de-escalation interventions and therapeutic communication are ineffective, and the Veteran's behavior presents an immediate risk of harm to self or others. Clinical programming, staffing levels, planned activities and recovery-oriented staff engagement with Veterans must facilitate a staff's ability to identify issues and intervene preemptively. Inpatient staff must continually explore ways to prevent, reduce and eliminate seclusion and physical restraint and resources to achieve this goal. Resources are located on the Zero Seclusion and Restraint page on the OMH IMHS SharePoint at https://dvagov.sharepoint.com/sites/VACOMentalHealth/MH_Inpt/SitePages/Seclusion%20&%20Restraint.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.* For reference, federal regulations governing seclusion and physical restraint include 38 C.F.R. § 17.33(d) and 42 C.F.R. § 482.13(e-f).

b. All units must always have a Mental Health Environment of Care Checklist (MHEOCC)-compliant room available for physical restraint. A VA medical facility Director (in consultation with the VA medical facility Chief Mental Health Lead) may choose to have an additional room designated specifically for seclusion or to have one room that can be used both as a seclusion and physical restraint room. See VHA Directive 1167 for additional information on MHEOCC.

c. Staff must adhere to applicable regulatory and oversight standards, state law, and federal regulations regarding seclusion and physical restraint processes, documentation, and associated training requirements.

7. THERAPEUTIC PROGRAMMING

a. All Veterans receiving IMHS must be offered a minimum of 4 hours of interdisciplinary, therapeutic and recovery-oriented programming daily including weekends and holidays, with 5 – 6 hours of programming recommended. Clinical programming should follow the **Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements** under this Directive at OMH's IMHS Policy Resource SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. Inpatient mental health programming must be available to treat Military Sexual Trauma (MST)-related conditions such as posttraumatic stress disorder (PTSD), substance use, depression or other issues, in a way that is sensitive to the unique ways MST influences the development and presentation of those conditions as detailed in VHA Directive 1115(1), Military Sexual Trauma (MST) Programming, dated May 8, 2018.

c. Psychosocial Rehabilitation and Recovery Center-provided Bridge groups for Veterans with serious mental illness (SMI) must be offered on a weekly basis at a minimum as detailed in VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019.

8. EVIDENCE-BASED PHARMACOLOGY

All Veterans receiving IMHS must be offered medication for mental health, including substance use disorders and medical conditions when clinically indicated. All inpatient mental health units must be staffed with a psychiatrist whenever possible. When significant efforts to hire a psychiatrist have failed, the inpatient mental health unit may be staffed with a psychiatric health care provider of another discipline. In these situations, all inpatient mental health units must have access to a psychiatrist for consultation when needed. ***NOTE:*** *VA medical facilities must follow guidelines for the utilization of Clozapine as outlined in VHA Directive 1108.17(1), Clozapine Patient Management, dated May 17, 2022.*

9. VISITATION

Visitation with a Veteran's social support network should be encouraged (in-person or by virtual means) during hospitalization. The VA uses a broad understanding of family, including anyone whom the patient or resident considers to be family. Infant visitation should be conducted in accordance with the VHA Office of Women's Health Guidance for Pregnant, Lactating, and Postpartum Veterans in Inpatient Mental Health and Residential Mental Health and Substance Use Treatment Settings which can be found at: https://dvagov.sharepoint.com/sites/VACOMentalHealth/MH_Inpt/SitePages/Clinical-Care.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

10. UNIT LAYOUT

a. The physical environment on an inpatient mental health unit is an element of treatment and must engender an experience of hope, healing and recovery while maintaining safety. The inpatient unit must be safely configured to promote regular interaction among staff and Veterans to facilitate building therapeutic relationships. At the same time, the physical environment must allow for staff to easily observe changes in Veteran behavior and to provide an opportunity for early staff intervention. While new VA medical facilities can more easily incorporate warm and inviting design elements into the environment, there are many design elements that can be introduced into existing units that would create such an environment. ***NOTE:*** *For more information, see the Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities (January 2021): https://www.cfm.va.gov/til/dGuide/dgMH.pdf. This is an internal VA website not available to the public.*

b. As referenced in VHA Directive 1330.01(7), for mixed gender units, the design must include safe, separate and locked sleeping rooms for women Veterans. Bedrooms and units designated for the women Veteran population must be in close proximity to staff for added oversight. It is highly recommended that women Veterans have a private and secure toilet/shower room in their room. Signage indicating the gender of the person using the shower is prohibited.

c. For VA medical facilities with a secure outdoor space that meets the standards of the MHEOCC, designated time for Veterans to be outdoors should be incorporated into the daily programming as permitted by staffing, individual Veteran interest, safety observation level of the Veteran, weather and as determined by the patient's ITT, clinical condition, and any other relevant contingency factors.