

## PSYCHOSOCIAL REHABILITATION AND RECOVERY SERVICES

**1. SUMMARY OF MAJOR CHANGES:** This directive updates the previous version of VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2018, and incorporates VHA Directive 1160, Re-engaging Veterans with Serious Mental Illness, dated February 7, 2018; VHA Directive 1163.07, Services for Veterans Experiencing Early Psychosis, dated October 10, 2020; and VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016. Specific updates regarding each program or service include:

a. Removes content, terminology, and service descriptions related to the Veterans Health Administration (VHA) Vocational Rehabilitation Service (Voc Rehab Service) (see VHA Directive 1160.13, Vocational Rehabilitation Services, dated August 14, 2025, for VHA policy on the Voc Rehab Service).

b. Adds the requirement to assign a collateral VISN point of contact (POC) for Psychosocial Rehabilitation and Recovery Center (PRRC) Program Managers and a collateral VISN POC for Early Psychosis Intervention Program (EPIC). See Implementation Schedule.

c. Clarifies the following components of the Intensive Community Mental Health Recovery (ICMHR) program (see paragraph 4):

(1) Modifies the name of the primarily urban ICMHR teams from Mental Health Intensive Case Management to Mental Health Intensive Community Model (MHICM).

**NOTE:** *The acronym "MHICM" remains the same.*

(2) Addresses the need for each ICMHR MHICM team to have, through hiring or training of current staff, at least one team member with subject matter expertise and experience in evidence-based treatment(s) of substance use disorder (SUD).

(3) Adjusts the staffing requirements for psychiatrists (or other professionals who are qualified to provide psychopharmacological treatment) to 20% time for each 50 Veterans served.

(4) Clarifies the population coverage requirements for ICMHR services as 4% of the National Psychosis Registry for all VHA health care systems.

d. Updates, clarifies, and adds information for the peer specialist health care profession (see paragraphs 5, 10, and Appendix A).

e. Updates and clarifies the Local Recovery Coordinator (LRC) roles and responsibilities (see paragraphs 2.v. and 6).

f. Updates the allocation of clinical and administrative time requirements for VA medical facility LRCs based on the complexity of a health care system's mental health continuum of care (see paragraph 6.b.).

g. Updates information about re-engaging Veterans with serious mental illness in treatment (see paragraph 8).

**2. RELATED ISSUES:** VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023; VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019; and VHA Directive 1160.13, Vocational Rehabilitation Services, dated August 14, 2025.

**3. POLICY OWNER:** The Office of Mental Health (11MH) is responsible for the content of this directive. Questions should be addressed to the National Mental Health Director for Outpatient Services and Psychosocial Rehabilitation at [VHANationalPSR&RS@va.gov](mailto:VHANationalPSR&RS@va.gov).

**4. LOCAL DOCUMENT REQUIREMENTS:** ICMHR programs must develop local standard operating procedures which allow ICMHR services staff to support Veteran use of psychiatric medications in the community in a manner that is consistent with local scopes of practice for each discipline and their associated licensure (see paragraph 4.j.(6)).

**5. RESCISSIONS:** VHA Directive 1160, Re-engaging Veterans with Targeted Serious Mental Illness in Treatment, dated February 7, 2018; VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2018; VHA Directive 1163.07, Services for Veterans Experiencing Early Psychosis, dated October 7, 2020; and VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016, are rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of August 2030. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**7. IMPLEMENTATION SCHEDULE:** This directive is effective upon publication with two exceptions:

a. Within 1 year of publication of this directive, each ICMHR MHICM team must have, through hiring or training of current staff, at least one team member with subject matter expertise and experience in evidence-based treatments of SUD (see paragraph 4.d.(7)(a)).

b. VISNs have 6 months following publication of this directive to assign a collateral VISN POC for PRRC Program Managers and a collateral VISN POC for EPIC if they do not already have them in place.

August 14, 2025

VHA DIRECTIVE 1163

**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 and Chief Medical  
Officer

***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 Publications Distribution List on August 14, 2025.

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## PSYCHOSOCIAL REHABILITATION AND RECOVERY SERVICES

### 1. POLICY

It is Veterans Health Administration (VHA) policy that all eligible Veterans have access to needed mental health rehabilitation and recovery services and for all mental health services in the Department of Veterans Affairs (VA) health care system to be recovery oriented. **AUTHORITY:** 38 U.S.C. §§ 1718, 2031, 7301(b); 38 C.F.R. § 17.38.

### 2. RESPONSIBILITIES

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) Overseeing VISNs to ensure compliance with and effectiveness of this directive.

c. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for:

(1) Supporting the Office of Mental Health (OMH) with implementation and oversight of this directive.

(2) Supporting the development of mitigation or corrective actions to address noncompliance with this directive.

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

(1) Ensuring that the policy standards specified by this directive are being implemented as intended and ensuring that corrective action is taken when noncompliance is identified.

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

(3) Ensuring that sufficient resources are available both within OMH and in VISNs and VA medical facilities to support the implementation of this directive.

(4) Supporting the National Director, Outpatient Services and Psychosocial Rehabilitation (OS&PSR) and the Directors of the OMH Evaluation Centers, including the Northeast Program Evaluation Center (NEPEC), the Serious Mental Illness

Treatment Resource and Evaluation Center (SMITREC), and the Program Evaluation and Research Center (PERC), in the evaluation of OS&PSR programs and services.

e. **Executive Director, Homeless Programs Office.** The Executive Director, Homeless Programs Office is responsible for coordinating with OMH regarding provision of mental health and substance use disorder (SUD) services for Veterans who are homeless or at risk of homelessness. This includes the hiring and supervision of peer specialists and vocational rehabilitation (Voc Rehab) professionals into Homeless Services. **NOTE:** For further information, see VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, dated April 27, 2023; VHA Directive 1160.04, *VHA Programs for Veterans with Substance Use Disorders*, dated December 8, 2022; VHA Directive 1501, *VHA Homeless Programs*, dated October 21, 2016; and VHA Directive 1160.13, *Vocational Rehabilitation Services*, dated August 14, 2025.

f. **Executive Director, Office of Suicide Prevention.** The Executive Director, Office of Suicide Prevention is responsible for coordinating with OMH regarding provision of mental health and SUD services for Veterans who are at risk of suicide. This includes the hiring and supervision of peer specialists into suicide prevention programs including the Veterans Crisis Line's Peer Support Outreach Center. **NOTE:** For further information, see VHA Directive 1160.01 and VHA Directive 1160.04.

g. **Director, Primary Care Operations.** The Director, Primary Care Operations is responsible for coordinating with OMH regarding provision of mental health and SUD services for Veterans in receipt of primary care services. This includes championing and supporting the integration of peer support staff in accordance with the Supporting the Resiliency of our Nation's Great Veterans Act (STRONG Veterans Act) of 2022, Section 401 and SUD funding initiatives.

h. **National Director, Outpatient Services and Psychosocial Rehabilitation.** The National Director, OS&PSR section in OMH is responsible for:

(1) Developing and communicating national policy and procedures for psychosocial rehabilitation services which are consistent with evidence-based practice and promising practices literature; VHA's mission, goals, and objectives; and VHA Directive 1160.01.

(2) Providing subject matter experts (SMEs) for consultation and guidance to VISNs and their VA medical facilities in the development and operation of comprehensive psychosocial rehabilitation clinical programs.

(3) Maintaining VHA mental health services as a recovery-oriented system of care.

(4) Collaborating with OMH Evaluation Centers, including NEPEC, SMITREC, and PERC, to monitor and evaluate VHA mental health services and programs.

(5) Facilitating efforts to re-engage Veterans with serious mental illness (SMI) in treatment along with the SMITREC.

(6) Analyzing reports from NEPEC, SMITREC, and PERC about the operations of OS&PSR programs and working with SMEs to remediate issues identified.

(7) In accordance with VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024, approving or not approving waivers to VHA national policy requests from any VA medical facility or VISN unable to comply with this directive as it relates to the implementation, provision, or oversight of OS&PSR programs and services. **NOTE:** For OMH's waiver process, see the [OMH Official Policy Waivers SharePoint](#). This is an internal VA website that is not available to the public.

i. **National Director, VHA Vocational Rehabilitation Service.** The National Director, VHA Voc Rehab Service in OMH is responsible for developing national policies, practices, and guidance pertaining to the delivery of Voc Rehab services by members of the Voc Rehab health care professions. **NOTE:** For policy on the VHA VOC Rehab Service, see VHA Directive 1160.13.

j. **National Director, Intensive Community Psychosocial Rehabilitation.** The National Director, Intensive Community Psychosocial Rehabilitation in OMH is responsible for:

(1) Serving as the national lead for Intensive Community Mental Health Recovery (ICMHR) and Early Psychosis Intervention Coordination (EPIC) programs. This role includes developing responses to inquiries from internal and external stakeholders (e.g., Office of the Inspector General (OIG), Government Accountability Office (GAO), Congress). For more information on ICMHR and EPIC programs, see paragraphs 4 and 7.

(2) Developing national policy and procedures on matters relating to VHA ICMHR programs and to guide the delivery of mental health services to Veterans with early psychosis through EPIC.

(3) Ensuring the availability of training for ICMHR and EPIC team members via virtual or face-to-face training to ensure staff are prepared to meet all program standards and the evolving clinical needs of the Veterans served. For training requirements and recommendations, see paragraph 10.

(4) Providing consultation, technical assistance, and mentoring via national ad hoc training calls, conferences, for cause and ad hoc site visits, and individual consultation to VISN Chief Mental Health Officers (CMHOs), VA medical facilities, and ICMHR and EPIC team members.

(5) Collaborating with NEPEC, PERC, and SMITREC to evaluate the effectiveness of ICMHR and EPIC services and make recommendations to VISNs or VA medical facilities as needed.

(6) Reviewing and approving or denying clinical restructuring requests for ICMHR programs and EPIC.

(7) Collaborating with the Department of Defense and other national entities responsible for the delivery of clinical services for Service members with early psychosis, when transitioning to VA care.

(8) Collaborating with the National Director, VHA Voc Rehab Service for the delivery of Voc Rehab services for Veterans enrolled in ICMHR programs. **NOTE:** For policy on the VHA Voc Rehab Service, see VHA Directive 1160.13.

**k. National Director, Psychosocial Rehabilitation and Recovery Centers and Local Recovery Coordinators.** **NOTE:** For more information on Psychosocial Rehabilitation and Recovery Centers (PRRCs), see paragraph 3. For more information on the Local Recovery Coordinator (LRC) program, see paragraph 6. The National Director, PRRCs and LRCs in OMH is responsible for:

(1) Serving as the national lead for PRRCs and LRCs. This includes developing responses to inquiries from internal and external stakeholders including, but not limited to, national program offices, OIG, GAO, Veteran Service Organizations, and Congress.

(2) Developing national policy and procedures on matters relating to PRRCs, as well as the roles and responsibilities of LRCs across the enterprise. This includes maintaining the advanced Inpatient Mental Health Recovery Checklist which can be found on the [LRC Policy Support Page](#). **NOTE:** This is an internal VA website that is not available to the public.

(3) Ensuring the availability of ad hoc training for PRRC and LRC staff as needed via virtual or face-to-face training on clinical and administrative practices.

(4) Providing consultation and assistance via national Community of Practice (CoP) calls, ad hoc training conferences, for cause or ad hoc site visits, and individual consultation to VISN CMHOs, VA medical facilities, and PRRC and LRC staff and managers to guide PRRC and LRC services across the enterprise.

(5) Collaborating with NEPEC, PERC, and SMITREC to evaluate the effectiveness of PRRC and LRC services and make recommendations to VISNs or VA medical facilities as needed.

(6) Supporting the development and implementation of new PRRCs, as well as the transformation of existing Day Treatment Centers (DTCs) and analogous programs to formally designated PRRCs, and managing the evaluation and approval process for VA medical facility PRRC formal designation applications.

(7) Collaborating with the National Director, VHA Voc Rehab Service for the delivery of Voc Rehab services for Veterans enrolled in PRRC programs. **NOTE:** For policy on the VHA Voc Rehab Service, see VHA Directive 1160.13.

**l. National Director, Peer Support Services.** **NOTE:** For more information on the peer specialist profession, see paragraph 5 and Appendix A. The National Director, Peer Support Services in OMH is responsible for:

(1) Serving as the national lead for the peer specialist health care profession within VHA. **NOTE:** *Peer specialists are members of a profession, not a single program. Peer specialists can be integrated into interdisciplinary teams in multiple settings.*

(2) Developing responses to inquiries from internal and external stakeholders (e.g., VA Secretary, VHA upper-level leadership, VHA national program offices, VHA field staff, Congress, White House, community mental health agencies).

(3) Developing national policies pertaining to the delivery of peer support services by members of the VHA peer specialist health care profession and retaining prior versions of associated documents for records. This includes requirements regarding job qualifications, hiring practices, training, and supervision requirements. For peer specialist profession requirements, see Appendix A.

(4) Ensuring the availability of ad hoc trainings for peer support staff and peer support supervisors as needed via webinars, conferences, and Talent Management System (TMS) courses that focus on their expected roles and responsibilities and relevant VHA policies. For additional information on peer support staff training, see paragraph 10 and Appendix A.

(5) Providing consultation and assistance via national calls, conferences, for cause and ad hoc site visits, and individual consultation to VISN CMHOs, VHA national program offices, VA medical facilities, and VHA peer support staff and supervisors to guide the implementation of the peer specialist health care profession and the delivery of peer support services.

m. **Director, Northeast Program Evaluation Center.** The Director, NEPEC in OMH is responsible for:

(1) Providing national program monitoring, evaluation, and reporting for services provided by PRRCs and ICMHR programs. For more information, see paragraphs 3.f. and 4.f.

(a) These reports are designed to guide operations and national policy development and are distributed to the following: Executive Director, OMH; National Director, OS&PSR; National Director, PRRCs and LRCs; National Director, Intensive Community Psychosocial Rehabilitation; VHA leadership; and VISN Directors. Further information is available on the [NEPEC Dashboard](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(b) These responsibilities include, but are not limited to, monitoring compliance with evaluation data requirements; monitoring the use of relevant stop codes and workload coding; communicating information to stakeholders; and providing technical assistance related to all evaluation performance measures, monitoring, and capacity targets.

(c) In collaboration with OS&PSR, NEPEC may also provide consultation to sites that demonstrate an inability to maintain the elements of services as defined in this directive.

(2) Overseeing NEPEC staff who lead the evaluation efforts for PRRC and ICMHR services and who are the primary points of contact (POCs) for program monitoring and evaluation.

(3) Ensuring the accuracy and completeness of all data and reports developed by NEPEC associated with OS&PSR programs and services and communicating to the National Director, OS&PSR when any data integrity issues may impact oversight or operations.

(4) Collaborating with OS&PSR, SMITREC, and PERC to promote the sharing of information pertinent to these services and the Veterans served.

n. **Director, Serious Mental Illness Treatment Resource and Evaluation Center.**  
The Director, SMITREC in OMH is responsible for:

(1) Providing national program monitoring and evaluation for the Re-Engaging Veterans with Serious Mental Illness in Treatment (SMI Re-Engage) and the EPIC programs. For more information, see paragraphs 7 and 8.

(2) Collaborating with OS&PSR programs to develop metrics regarding service provision in target populations of Veterans who likely are experiencing early psychosis, who may be at increased risk of suicide, or who have been lost to follow-up care.

(3) Providing a dashboard and lists of Veterans to support VISN CMHOs, VA medical facilities, and LRCs in identifying Veterans in target populations who likely are experiencing early psychosis, who might benefit from enhanced care coordination, or who have been lost to follow-up care.

(4) Evaluating service utilization of Veterans experiencing early psychosis to ensure they receive adequate services, including identifying unmet needs and assessing the effectiveness of VHA services to this population.

(5) Producing reports based on available clinical and administrative data to OMH, evaluating the state of service delivery to Veterans in VHA, and identifying opportunities for improvements in these services.

(6) Providing support for LRCs re-engaging Veterans with SMI in the following ways:

(a) Maintaining reporting tool(s) for the LRCs to record their initial contact with the Veterans on their list.

(b) Ensuring the availability of ad hoc training and orientation for the LRCs on processes and protocols.

(c) Providing technical assistance to VISN CMHOs, VA medical facilities, and LRCs on re-engagement and reporting processes.

(d) Providing OMH, VISN CMHOs, VA medical facilities, and LRCs reports to monitor and evaluate the effectiveness of these re-engage efforts. For more information about the LRC reports related to the SMI Re-engage program, see paragraph 8.

(e) Continuing process improvements through refining the evaluation algorithms and obtaining feedback from the LRCs to improve the process of contacting and re-engaging Veterans in services.

o. **Director, Performance Evaluation and Resource Center.** The Director, PERC, is responsible for:

(1) Maintaining metric and staffing dashboards to support monitoring of performance metrics by OS&PSR.

(2) Collaborating with OS&PSR to promote the sharing and updating of information pertinent to these services and the Veterans served.

p. **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 to ensure that psychosocial rehabilitation services are provided and available as specified, and informing the Assistant Under Secretary for Health for Clinical Services and the Chief Operating Officer when barriers to compliance are identified.

(2) Overseeing corrective actions to address operational noncompliance at the VISN and VA medical facilities within the VISN.

(3) Ensuring that OS&PSR services (e.g., ICMHR, EPIC, PRRCs, peer support services) are available to eligible Veterans living in areas distant from the parent VA medical facility.

(4) Establishing strategies to provide Veterans with timely access to psychosocial rehabilitation services sufficient to meet their needs (e.g., ensuring that telehealth services, when appropriate, are available and utilized).

(5) Ensuring the VISN CMHO, in collaboration with VA medical facility leadership, appoints VA medical facility team leaders to serve as VISN POCs to OMH, based on criteria identified by OS&PSR, for the following OS&PSR positions, services, or programs: EPIC, ICMHR, LRC, PRRC Program Manager, Peer Specialist, and Peer Support Supervisor. VISN POCs coordinate service teams and serve as champions for implementation of this directive and other psychosocial rehabilitation services across each VISN (see paragraph 2.s.).

(6) Ensuring that VHA points of service submit formal written requests (waivers) for local modifications or exceptions to clinical service requirements and direct them to OMH through the VISN for decision to approve or not approve. ***NOTE: For further information about the waiver process, see VHA Directive 1023 and a description of***

OMH's waiver process on the [OMH Official Policy Waivers SharePoint](#). This is an internal VA website that is not available to the public.

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

(1) Providing oversight and support to VA medical facilities and all their associated points of service within the VISN in the organization, direction, coordination, evaluation, review, and improvement of OS&PSR services, data collection, and participation in for cause and consultative site visits, and informing leadership when barriers to compliance are identified.

(2) Consulting with OMH prior to program changes that may affect Veteran access to OS&PSR services, in accordance with VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.

(3) In collaboration with VA medical facility leadership, appointing VISN POCs that meet experience and qualification standards for each of the following positions, services, or programs: EPIC, ICMHR, LRC, PRRC Program Manager, Peer Specialist, and Peer Support Supervisor. The duties of the VISN POCs are supplemental to their current duties and do not require a promotion.

r. **Veterans Integrated Service Network 5 Mental Illness Research, Education, and Clinical Center Director.** The VISN 5 Mental Illness Research, Education, and Clinical Center (MIRECC) Director is responsible for collaborating with the National Director, OS&PSR to facilitate as needed the Psychosocial Rehabilitation Fellowships offered at several VA medical facilities and the Psychosocial Rehabilitation Fellowship Administrative Hub Site at the VISN 5 MIRECC. See the [Office of Academic Affiliations Advanced Fellowships & Professional Development website](#) for more information.

s. **Veterans Integrated Service Network Points of Contact.** *NOTE: Designated VA medical facility team leaders serve in collateral roles as VISN POCs to OMH, generally needing no more than 2 to 4 hours a month and based on criteria identified by OS&PSR, for the following OS&PSR positions, services, or programs: EPIC, ICMHR, LRC, PRRC Program Manager, Peer Specialist, and Peer Support Supervisor.* The VISN POCs are responsible for:

(1) Coordinating communications, information, and resources to their programs and services within their VISN. This includes:

(a) Maintaining the VISN email distribution lists of program staff.

(b) Acting as the first level of consultation for questions or concerns from VA medical facilities within the VISN.

(c) Communicating position changes within their VISN's VA medical facilities' specific program or services, including vacancies, backfills, and new hires to OMH and the VISN CMHO as required.

(d) Actively engaging with the VISN CMHO in any collaborations with OMH or across VA medical facilities within the VISN.

(e) Attending national ad hoc trainings and conference calls with OMH.

(f) Relaying information between VA medical facility leadership, the VISN CMHO, OMH, and staff within their VISN, and obtaining feedback when required to address questions or concerns pertaining to implementation of national policies.

(g) Welcoming new VA medical facility staff in their VISN and assisting with general orientation such as the location of program information and resources.

(h) Coordinating VISN-wide conferences, ad hoc trainings, and meetings as requested by VISN or VA medical facility leadership on behalf of the VA medical facility, VISN, or OMH.

(2) Meeting specific qualifications and expectations of the OS&PSR program throughout the duration of their appointment as the VISN POCs. This includes:

(a) The VISN EPIC POC must meet specific qualifications and expectations related to EPIC on the [EPIC Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(b) The VISN ICMHR POC must meet specific qualifications and expectations related to ICMHR on the [ICMHR Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(c) The VISN LRC POC must meet specific qualifications related to LRCs. See the frequently asked questions (FAQ) section on the [LRC Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(d) The VISN PRRC Program Manager POC must meet specific qualifications related to PRRCs. See the FAQ section of the [PRRC Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(e) The VISN Peer Support Supervisor POC(s) and VISN Peer Specialist POC(s) must meet specific qualifications and expectations as listed in the VISN Peer Support Points of Contact folder that is located within the Human Resources section's Position Descriptions folder on the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

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

(1) Ensuring overall VA medical facility compliance with this directive and that appropriate action is taken if noncompliance is identified.

(2) Ensuring that staff in OS&PSR programs and services have adequate resources to fulfill their responsibilities and flexibility required to be able to respond to immediate

Veteran needs as they arise (e.g., staffing, clinic capacity, vehicles, equipment, administrative support, office space).

(3) In accordance with VHA Directive 1043, consulting with OMH prior to implementing the expansion, reduction, or elimination of OS&PSR services or programs that may change or impact the delivery of care provided to Veterans.

(4) Ensuring that every VA medical facility and very large Community-Based Outpatient Clinic (CBOC) (i.e., CBOCs serving 10,000 or more unique Veterans each year) hires multiple permanent peer specialists to provide peer support services in selected programs and meet mandated peer specialist hiring requirements from other VHA directives (e.g., VHA Directive 1160.01), Executive Orders, and legislation (e.g., STRONG Act of 2022, Section 401), and ensuring supervision of peer specialists in accordance with paragraph 5 and Appendix A. Details about legislatively mandated peer specialist staffing requirements can be found in the Official Guidance section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(5) Ensuring the completion of all data requests, reporting, monitoring, and accreditation requirements by the applicable due dates for all OS&PSR programs, positions, or services.

(6) Ensuring the use of national stop codes to record OS&PSR activity for approved programs. **NOTE:** *For additional and service-specific resources, see the [Mental Health Business Operations SharePoint](#). This is an internal VA website that is not available to the public.*

(7) Ensuring resource allocation for the VA medical facility SMI Re-engage program to provide re-engagement services to Veterans in the targeted populations who have been lost to follow-up care. This includes:

(a) Ensuring clinic capacity, processes, and collaboration across services that allows Veterans to be re-engaged in treatment within 10 business days of contact unless the Veteran requests a later date.

(b) Ensuring that VA medical facility LRCs complete outreach activities in accordance with paragraph 2.v. of this directive.

(c) Promoting collaboration between program coordinators for VA and community-based outreach programs (including, but not limited to, primary care leaders, Suicide Prevention Coordinators, Veteran Justice Outreach Coordinators, Homeless Program leaders, and VA medical facility Schedulers), and the VA medical facility LRCs to re-engage Veterans in treatment.

u. **VA Medical Facility Mental Health Leader.** The VA medical facility Mental Health Leader (e.g., Mental Health Service Line Chief, Associate Chief of Staff–Mental Health, depending on the VA medical facility) is responsible for:

(1) Overseeing implementation of OS&PSR programs and services at the VA medical facility in compliance with this directive and OS&PSR program guidance to ensure the provision of high-quality services.

(2) Completing all mandated reporting, monitoring, evaluation, and accreditation requirements relevant to OS&PSR services at the VA medical facility. Reporting requirements may vary by OS&PSR service.

(3) Appointing the following positions and collateral roles:

(a) VA medical facility EPIC POC collateral role (see paragraph 2.x.).

(b) ICMHR program Team Leader and staffing to meet the staffing requirements based on the ICMHR team staffing model(s) used. **NOTE:** See paragraphs 2.y. and 4.c of this directive.

(c) 1.0 full-time equivalent (FTE) VA medical facility LRC to serve as a system-wide consultant on implementation and sustainment of a recovery-oriented mental health system of care (see paragraph 2.v.). See paragraph 6.b.(1)(a-c) for requirements of mapped administrative and clinical time for LRCs. **NOTE:** Outreach activities associated with the SMI Re-Engage program are considered clinical time and must be taken into consideration as such when considering the clinical workload.

(d) 1.0 FTE PRRC Program Manager and support staffing to meet the staffing requirements and ratios for PRRC. While a 1.0 FTE Program Support Assistant is recommended, at least a 0.5 FTE Program Support Assistant is necessary to minimally support scheduling requirements and to provide general administrative assistance to the PRRC Program Manager and PRRC clinical staff. Without this support, clinicians assigned to the program will be pulled away from clinical work to complete administrative tasks. **NOTE:** See paragraphs 2.w. and 3.c. of this directive.

(4) Ensuring that the VA medical facility EPIC POC:

(a) Develops and updates annually a plan for delivery of services to Veterans with early psychosis that is consistent with the practices and principles of Coordinated Specialty Care (CSC).

(b) Develops an EPIC clinical care team with no less than three members from three different clinical programs to advise on the therapeutic and psychosocial needs of individual Veterans identified as experiencing early psychosis. For additional information about EPIC clinical care team activities, see paragraph 7.b.(2).

v. **VA Medical Facility Local Recovery Coordinator.** **NOTE:** VHA Directive 1160.06, *Inpatient Mental Health Services*, dated September 27, 2023, has additional responsibilities listed for VA medical facility LRCs regarding collaboration with inpatient mental health. See the [LRC Policy Support Page](#) for information on how the responsibilities detailed below relate to each other. This is an internal VA website that is not available to the public. The VA medical facility LRC is responsible for:

(1) Promoting and sustaining the integration of recovery principles and recovery-oriented services into mental health provided at all points of service throughout the health care system, including consultation and collaboration with inpatient and outpatient settings.

(2) Consulting on updates to VA medical facility mental health standard operating procedures and guidance documents to ensure that recovery principles and the voice of the Veteran are represented, and that mental health services are reflective of VA's commitment to Veterans' health care.

(3) Providing consultation to VA medical facility Inpatient Mental Health Services (IMHS) staff regarding recovery-oriented care, including ad hoc education and training as needed. This includes review of procedures, staff trainings, Veteran treatment materials, and other components of IMHS at least annually.

(4) Developing, implementing, monitoring, reviewing, and updating a VA medical facility-level Recovery Transformation/Sustainment Strategic (RTSS) plan in collaboration with their leadership and relevant stakeholders. Specifically, documented input from the following stakeholders must be part of the RTSS plan: Veterans, Patient Advocate, VA medical facility Mental Health Leader or equivalent, Chief of Staff, Chief Nurse, Associate Director for Patient Care Services, VA medical facility Director. Progress on the RTSS plan must be reviewed by the LRC and VA medical facility mental health leadership at least twice a year and the plan must be updated at least annually with review and concurrence by VA medical facility executive leadership.

**NOTE:** *The RTSS plan is a multi-year local plan to direct and maintain recovery transformation in collaboration with local mental health leadership to continually improve the local recovery transformation. The RTSS is a living document and requires dedicated time by the LRC for ongoing recovery transformation and sustainment. Refer to the [LRC Policy Support Page](#) for additional information. This is an internal VA website that is not available to the public.*

(5) Advocating for Veterans, particularly Veterans with SMI, to establish treatment plans that allow them to pursue and be responsible for their own life goals, to plan for their own recovery, and to seek enhanced community participation.

(6) Participating in VHA national conference calls, LRC Community of Practice calls, and ad hoc training programs related to OS&PSR; sharing innovative, strong, and best practices across VA medical facilities to assist with new or changing initiatives, directives, priorities, and metrics.

(7) Promoting the effective and appropriate use of peer support staff in OS&PSR and other programs across the VA medical facility through advocacy for peer support services, consultation on the effective and appropriate use of peer support staff, and education about recovery practices and principles.

(8) Promoting activities and events emphasizing the importance of community inclusion, upstream suicide prevention, stigma elimination, and increasing social capital.

(9) Providing training, education, and consultation to VA medical facility staff, Veterans, families, and the community to ensure that services are treating the whole person and that programs are collaborative and integrated. Staff training, education, and consultation may include ad hoc, virtual, and formal training opportunities as requested or needed.

(10) Implementing and maintaining an SMI Re-Engage program to provide outreach to Veterans with SMI that have been lost to VA care for over 1 year, including facilitation of the Veteran's return to care, and reporting outreach outcomes and re-engagement efforts to SMITREC. For details on outreach and re-engagement services provided by LRCs as part of the SMI Re-Engage program, see paragraph 8.d. **NOTE:** See *paragraph 6.b.(1)(a-c) for requirements of mapped administrative and clinical time for LRCs. Engagement in these activities constitutes part of the VA medical facility LRC's clinical time.*

(11) Collaborating with the VA medical facility Veterans Justice Program Specialist(s) as needed, to address the needs of Veterans who are identified through the SMI Re-Engage program.

(12) Providing recovery-oriented clinical services according to the requirements of mapped administrative and clinical time in paragraph 6.b.(1)(a-c).

(13) Serving as a champion for mental health system redesign and performance improvement projects to better serve underserved Veteran populations.

(14) Leading and participating in VA medical facility and community committees as a SME on SMI and psychosocial rehabilitation and recovery.

(15) Coordinating community outreach and serving as a consultant for community organizations providing mental health services to Veterans or their families.

(16) Serving as a mentor for new VA medical facility LRCs, peer specialists, and other staff seeking mentorship.

(17) Serving as liaison to the Veterans Mental Health Councils (VMHCs) to ensure that the Veteran's voice is represented in VA medical facility leadership decisions affecting mental health care. When a VA medical facility does not have a VMHC, the LRC may incorporate the Veterans' voice through VA medical facility mental health town halls, facilitating mental health focus groups, or other strategies to hear from the Veterans about their care. **NOTE:** *For additional information on VMHCs, see VHA Directive 1160.01.*

(18) In collaboration with the Inpatient Mental Health Program Manager, develop a local standard operating procedure 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. Additionally, LRCs may participate in VA medical facility workgroups addressing inpatient mental health units, environment of care, and

transformation to ensure recovery-oriented practices. **NOTE:** Refer to the [LRC Policy Support Page](#) for additional information. This is an internal VA website that is not available to the public.

w. **VA Medical Facility Psychosocial Rehabilitation and Recovery Center Program Manager.** The VA medical facility PRRC Program Manager is responsible for:

(1) Overseeing day-to-day program operations of the PRRC and PRRC staff. This includes ensuring the quality and regularity of all scheduled programming (see paragraph 3) and overseeing PRRC teams who evaluate Veterans for participation in PRRC programs, complete an initial assessment of Veterans admitted to the PRRC program, and develop recovery plans.

(2) Ensuring PRRC staff submit program monitoring data to NEPEC when requested.

(3) Designing and implementing quality improvement initiatives to improve PRRC services.

(4) Ensuring compliance with internal and external regulatory bodies, monitoring protocols, national PRRC procedures, and guidance.

(5) Coordinating with other physical, mental health, or psychosocial services in the provision of services for Veterans enrolled in or referred to PRRC.

x. **VA Medical Facility Early Psychosis Intervention Coordination Point of Contact.** **NOTE:** EPIC POCs are appointed by the VA medical facility Mental Health Leader and may be chosen from those working in programs such as PRRC, ICMHR, Voc Rehab, inpatient mental health, or the LRC. This person must demonstrate a strong interest and expertise in providing services to individuals with early psychosis or more broadly to those with SMI. The VA medical facility EPIC POC is responsible for coordinating outreach and clinical services to Veterans with early psychosis, including:

(1) In consultation with the VA medical facility Mental Health Leader, developing and leading an EPIC clinical care team with no less than three members from three different clinical programs to advise on the therapeutic and psychosocial needs of individual Veterans identified as experiencing early psychosis. For additional information about EPIC clinical care team activities, see paragraph 7.b.(2). **NOTE:** These Veterans have a clinical home in an existing clinical program, with EPIC efforts focused on ensuring access to additional clinical services as indicated in the treatment plan.

(2) Developing and updating annually a VA mental health service-level plan for delivery of services to Veterans with early psychosis that is consistent with the practices and principles of CSC. Please see the [EPIC Policy Support Page](#) for resources related to this plan. **NOTE:** This is an internal VA website that is not available to the public.

(3) Creating an electronic health record (EHR) referral system to the EPIC clinical care team (e.g., EHR e-consult for chart review) for facilitating identification of Veterans.

(4) Utilizing national OMH analytics, including dashboards such as the National Psychosis Registry (NPR) Patient-Level Dashboard and the SMI Care Management National Dashboard, identifying Veterans with a high likelihood of early psychosis.

(5) Facilitating and promoting educational opportunities to VA medical facility staff about early psychosis and CSC.

y. **VA Medical Facility Intensive Community Mental Health Recovery Program Team Leader.** The VA medical facility ICMHR program Team Leader is responsible for:

(1) Overseeing the provision of ICMHR services and coordinating care across ICMHR teams and disciplines in accordance with the requirements in paragraph 4.

(2) Overseeing ICMHR teams in evaluating Veterans for enrollment in ICMHR services and developing shared recovery plans for Veterans simultaneously enrolled in an ICMHR program and a PRRC.

(3) Ensuring ICMHR teams build and maintain competencies to deliver ICMHR services and help Veterans with SUD.

(4) Ensuring that ICMHR teams meet requirements related to the use of prescribed psychiatric medications.

(5) Ensuring development of memoranda of understanding (MOUs) with community organizations, as needed, when ICMHR staff complete clinical visits with Veterans in community settings. For details, see location of community visits in paragraph 4.

(6) Implementing quality improvement initiatives to improve ICMHR services.

(7) Ensuring ICMHR staff submit program monitoring data to NEPEC when requested.

### **3. PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTER PROGRAMS**

#### **a. Background.**

(1) VHA Directive 1160.01 requires that all VA medical facilities with 1,500 or more Veterans across all sites of care included on the NPR dashboard have a PRRC. DTCs, day hospitals, partial hospitals, or analogous programs are prohibited and have been transitioned to PRRCs, and new PRRCs must be established where they are needed. VA medical facilities with 1,000 to 1,499 current (fiscal year (FY) 2006 and later) Veterans across all sites of care included on the NPR are strongly encouraged to have a PRRC.

#### **(2) Characteristics of Psychosocial Rehabilitation and Recovery Centers.**

(a) PRRCs are intensive outpatient specialty mental health transitional treatment and learning centers designed to support recovery and integration into meaningful self-

determined community roles for Veterans challenged with SMI and severe functional impairment. Programming is multimodal (e.g., curriculum-based classes, evidence-based psychotherapies and psychosocial interventions, counseling and in-vivo exercises) and is specifically designed to capitalize on each Veteran's skills, strengths, and talents. Programming additionally focuses on building skills and accessing resources to define and realize Veterans self-chosen roles and goals in all domains of wellness. PRRC services are part of the mental health continuum of care and are coordinated with other services in the VA medical facility and in the community.

(b) PRRC services are coordinated, accessible, and readily available as long as needed. Following the evaluation and treatment planning process, Veterans voluntarily participate in the program as often as clinically indicated and consistent with the Veteran's needs and preferences. It is expected that participation in the PRRC declines over time as the Veteran becomes more integrated into the community.

(c) PRRC staff recognize family members and other natural supports as vital contributors to the Veteran's recovery. With the consent of the Veteran, family members and other natural supports are involved in the Veteran's treatment planning and recovery in every situation where it is appropriate.

(d) PRRCs offer a menu of daily treatment alternatives detailed on the weekly schedule with sufficient variety to support meaningful choice. Treatments offered include, but are not limited to, group offerings, individual interventions and community-based activities as clinically indicated. Veterans participate in specific programming alternatives based on their perception of how their programming choices will assist them with personal goal attainment.

(e) PRRC staff constantly strive to learn and offer innovative recovery-oriented practices and skills. PRRC staff actively encourage and support program participants, regardless of symptom severity, to engage in community activities throughout their involvement in the rehabilitation process.

(f) PRRC staff embrace the mantra of "all advocacy, all the time." Specifically, PRRC staff advocate and help Veterans advocate for full rights and equal opportunities for Veterans served in the PRRC.

(g) PRRC staff regularly solicit Veteran feedback and input into the development and improvement of PRRC services. These data are analyzed and used as part of a robust continuous quality improvement process.

b. **Target Population.** PRRC services provide necessary specialty mental health treatment and support for Veterans who meet the following criteria:

(1) The primary target population for PRRC services is Veterans with severe manifestations of psychosis, mood disorders, or post-traumatic stress disorder (PTSD) whose functional status is severely impaired. To maintain an overall emphasis on services for Veterans with psychosis and bipolar disorder, PRRC Program Managers are strongly encouraged to serve at least a 75% minimum proportion of Veterans

meeting the diagnostic criteria established for the NPR. Veterans with severe manifestations of other SMI and similar impairments in functional status may be admitted when there is capacity to do so without impacting access for Veterans with severe manifestations of psychosis or bipolar disorder.

(2) Other conditions such as Mild Traumatic Brain Injury (mTBI), SUD, or personality disorders may coexist as secondary diagnoses. While PRRC services are not designed to serve Veterans who have these accompanying diagnoses as the primary problem for which services are required, these diagnoses do not exclude Veterans from PRRC services. PRRC services can be provided simultaneously with treatment for accompanying diagnoses, with PRRC staff working to ensure coordination, non-duplication of services, and linking of all services to an overall recovery-oriented treatment plan.

**c. Staffing and Panel Sizes.**

(1) Staffing in each program is determined by the number of Veterans served, severity of impairment, and the services provided (i.e., as the number of Veterans enrolled in the PRRC program increases, the number of PRRC staff who provide direct services to Veterans needs to increase as well.) Specifically, a 1:6-10 staff Veteran ratio is necessary to ensure that specialty mental health services as defined in VHA Directives 1160.01 and this directive can be delivered effectively.

(2) Recommended interdisciplinary staffing for PRRCs generally includes:

(a) 1.0 FTE Program Manager;

(b) 1.0 FTE Masters prepared Social Worker, Licensed Professional Mental Health Counselor, or Marriage and Family Therapist;

(c) 1.0 FTE Masters prepared Advanced Practice Registered Nurse or Physician Assistant;

(d) 1.0 FTE Occupational Therapist;

(e) 1.0 FTE Psychologist;

(f) 1.0 to 2.0 FTE Peer Specialists; and

(g) 0.5 FTE Program Support Assistant. **NOTE:** *While a 1.0 FTE Program Support Assistant is recommended, at least a 0.5 FTE Program Support Assistant is required to support scheduling requirements and to provide general administrative assistance to the PRRC Program Manager and PRRC clinical staff. This Program Support Assistant position should be included when calculating staff to patient ratios.*

(3) PRRC teams are encouraged to utilize a variety of professional disciplines both as team members and as collateral partners. Team members need to routinely collaborate with these professionals and with other related VHA programs. If not directly

represented on the team or in regular team meetings, team members must routinely collaborate as required to meet the needs of Veterans with professionals in other related VHA programs such as the VHA Voc Rehab Service, Chaplain Service, Health Care for Homeless Veterans (HCHV), Women's Health, Veteran Justice Outreach, and Housing and Urban Development-VA Supportive Housing (HUD-VASH), as appropriate for the Veteran.

d. **Core Services.** PRRCs offer a minimum set of core services which cultivate a therapeutic and supportive learning environment for Veterans that is designed to maximize functioning in all domains of health. A minimum array of services available to Veterans through a PRRC must include:

(1) Treatment for Veterans with co-occurring SUD.

(2) Development of a recovery plan for each Veteran admitted to the PRRC program, or a shared recovery plan for each Veteran simultaneously enrolled in a PRRC and ICMHR program. For details, see paragraph 3.m.

(3) Individual recovery planning and recovery coaching by PRRC staff should be offered to Veterans and ideally occurs initially at least every 2 weeks to meet the clinical needs of the Veteran. As the Veteran makes progress toward their recovery goals, the interval may increase to a minimum of once monthly, as clinically indicated.

(4) Individual recovery services (e.g., evidence-based psychotherapy, supportive therapy, recovery coaching, or other individual psychiatric rehabilitation services) to assist with defining and realizing the Veteran's preferred life roles and goals identified during PRRC treatment.

(5) Addressing health literacy needs, as many Veterans recovering from SMI may have difficulty understanding and acting on health information relevant to their mental and physical health.

(6) Group psychotherapy (e.g., cognitive behavioral therapy for depression and other evidence-based group psychotherapies) to assist with meeting therapeutic treatment goals.

(7) Social skills training classes.

(8) Psychoeducational classes (e.g., Wellness Recovery Action Plan (WRAP)).

(9) Illness Management and Recovery (IMR) classes.

(10) Wellness programming to promote an active and healthy lifestyle (e.g., spiritual health, nutrition, importance of regular meals, sleep hygiene, exercise, smoking cessation, healthy leisure activities, weight management, pain management, chronic disease management). Helpful resources for these and other health conditions can be found on [VHA's National Center for Health Promotion and Disease Prevention \(NCP\) website](#). **NOTE:** Please refer to the [My Recovery Plan website](#) for tailoring to Veterans.

(11) Family psychoeducational and educational programs.

(12) Peer support services (see paragraph 5 and Appendix A).

(13) PRRC Bridge Groups provided by PRRC staff at least once weekly on acute inpatient mental health units for all Veterans, regardless of the type or severity of mental health challenges. It is highly recommended that PRRCs coordinate the implementation of Bridge Groups with the acute inpatient mental health unit staff to minimize overlap with existing group programming in the milieu. PRRC Bridge Groups may also be offered in VHA Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs).

(a) The purpose of the PRRC Bridge Group is to provide education about PRRC programs and recovery, and to assist with the transition to PRRC or other recovery-oriented services following discharge from the inpatient mental health unit.

(b) Topics to cover include, but are not limited to: the definition and principles of recovery; use of goal setting to establish purpose and meaning; exploration of strengths and barriers; instillation of hope; introduction to community integration and community inclusion as integral aspects of recovery; and introduction to peer support services, preferably through peer specialists as facilitators or co-facilitators.

(14) A facilitated transition to the PRRC in coordination with the acute and non-acute inpatient mental health treatment teams and as desired by the Veteran.

(15) Care coordination across the VHA continuum of care (e.g., primary care, homeless services, SUD treatment, Behavioral Health Interdisciplinary Program Teams (BHIP), ICMHR, Chaplain Service, NCP, and other services).

(16) Education for Veterans on the importance and process of completing mental health advance directives. **NOTE:** *For more information, see VHA Directive 1004.03(1), Advance Care Planning, dated December 12, 2023.*

e. **Clinical Documentation.** Program involvement and progress for each Veteran towards accomplishing their recovery plan must be documented in the EHR. Detailed guidance is provided in the Mental Health Coding Guide found on the [Mental Health Business Operations SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

f. **National Psychosocial Rehabilitation and Recovery Center Monitoring, Data Collection, and Quality Improvement.**

(1) The Northeast Program Evaluation Center (NEPEC), in collaboration with OS&PSR, is responsible for developing and implementing program evaluation and outcome measures for PRRCs, analyzing the data submitted by PRRCs, and communicating the findings to the VA medical facilities and VISN leadership. PRRC staff are required to actively participate, including timely submission of all required information requested. This requirement includes PRRC staff participating in a Veteran-

centered shared decision-making process that tailors the selection of data collection and data entry methodology based on Veterans' preferences and a robust list of key factors to consider to ensure validity and reliability of the data.

(2) PRRC coding guidance (e.g., clinic set up, stop codes, and Clinical Procedural Codes) is detailed in the Mental Health Coding Guide. This document can be found on [Mental Health Business Operations SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(3) PRRCs must have organized, regular, and planned quality improvement initiatives to systematically improve their services. PRRCs should utilize the NEPEC PRRC program monitoring and evaluation data for their PRRC program and input from Veterans served as part of this process.

g. **Use of Federal Vehicles.** PRRC staff may need to use Federal vehicles to perform their job duties and, therefore, may need to transport Veterans in those vehicles. Per 38 U.S.C. § 111A, any person may be transported to or from a VA facility or other place for the purpose of examination, treatment, or care. Each use of Federal vehicles to transport Veterans in the delivery of PRRC services must be documented in the clinical chart, with clear linkage established to specific recovery goals and objectives in the Veteran's recovery plan. Part of that plan must include efforts to help the Veteran progress over time towards independence in transportation, when possible. **NOTE:** *For information regarding medical clearance of incidental motor vehicle operators, see the fact sheet located on the [VA Fleet Management SharePoint](#). This is an internal VA website that is not available to the public.*

h. **Accreditation.** Endorsement from external accreditation agencies is an important aspect of ensuring ongoing, high-quality programming. Information related to accreditation requirements can be found on the [PRRC Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

i. **Psychosocial Rehabilitation and Recovery Centers Program Structure.**

(1) **Virtual Programming.** For formally designated "brick and mortar" PRRC programs, PRRC services may be offered virtually utilizing VHA-approved virtual platforms when indicated. It is required that Veterans in PRRC programs have access to the full array of PRRC services whether services are provided in-person or by a combination of in-person and virtual care. A solely virtual PRRC program is not permitted.

(2) **Hours of Operation.** Hours of operation are typically Monday through Friday from 8:00 a.m. to 4:30 p.m. However, the actual hours of operation can vary according to the number of Veterans served and their clinical needs. During evening and weekend hours, all Veterans are encouraged to develop and make use of natural community opportunities (e.g., social activities, parks, libraries, museums, preferred houses of worship) and relationships (e.g., family, friends, social groups). Programs are

encouraged to offer evening and weekend program hours on an as-needed basis to support Veterans' emerging skill development and integration in the community.

**(3) Location.**

(a) PRRCs are ideally located in the community with readily accessible public transportation. When PRRCs are on VA medical facility property, efforts must be made to locate the PRRC in an outpatient area which is separate from the mental health clinic and separate from where other traditional mental health services are provided. Regardless of the location, adequate space as detailed in the most recent version of the Mental Health Outpatient Services Design Guide or equivalent guidance document and in the PRRC Implementation Checklist must be available to support PRRC program operations. **NOTE:** See the [Office of Construction & Facilities Management Mental Health Outpatient Services Design Guide](#). The PRRC Implementation Checklist can be found on the [PRRC Policy Support Page](#). This is an internal VA website not available to the public.

(b) Safety of PRRC staff and Veterans is of critical importance. PRRC staff who provide community interventions must have access to cellular telephones with a data plan, Microsoft TEAMS application, and weather application. **NOTE:** *These cellular phones are issued to PRRC staff by VA in accordance with VA medical facility procedures and resources.*

j. **Supervision of Unlicensed Staff.** Unlicensed PRRC staff (e.g., mental health profession trainees and other non-licensed providers) must be supervised to ensure the delivery of safe and effective clinical services. Appropriately credentialed health care professionals (e.g., licensed independent practitioners (LIPs), licensed practitioners, supervisory peer specialists) must readily be available to supervise unlicensed PRRC staff in person, by phone, or by a VHA-approved video-telecommunication platform. Additionally, supervision of peer support staff on the PRRC team must comply with Appendix A. Supervision of mental health profession trainees must follow guidelines outlined in the Office of Academic Affiliations' supervision policies: VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019, and VHA Directive 1400.04(1), Supervision of Associated Health Trainees, dated March 19, 2015.

k. **Drug and Alcohol Screening.**

(1) Substance use must never be an insurmountable barrier for treatment of Veterans with mental health conditions. All individuals with a co-occurring alcohol or other SUD are screened for current use prior to admission to the program.

(a) Individuals are prohibited from participating in PRRC services if attempting to attend while under the influence of alcohol or other non-prescribed drugs, since this limits their ability to benefit from the program and may interfere with the progress of other Veterans in the program.

(b) PRRCs unable to provide the appropriate treatment objectives and therapies for Veterans with active (untreated) SUD must make efforts to partner with the Veteran and the primary treatment team to identify therapeutic services that would meet the Veteran's current needs. PRRC programming will be made available when the Veteran is more likely to benefit from the array of PRRC services.

(2) Veterans receiving PRRC services must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their personal recovery plans. Individuals who do not adhere to this monitoring policy are subject to discharge from the PRRC with continuing services provided in appropriate alternate levels of care.

### **I. Admission Criteria.**

(1) PRRC teams provide an evaluation for service participation for Veterans who are referred to or who personally request PRRC services. Referrals and PRRC team responses must be documented using the consult procedure. The process of evaluation for PRRC service participation must be guided by these principles:

(a) Each referral is considered on an individual basis for admission, giving the greatest possible consideration for participation in the program to Veterans who have needs that have not been met by traditional outpatient mental health services.

(b) Veterans cannot be denied services solely due to the number of previous treatment episodes, legal history, homelessness, the diagnosis of a personality disorder or SUD, or previous treatment non-adherence. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.

(2) Because PRRC services provide unique clinical services for Veterans with SMI, PRRC teams must make every possible effort to accept referred Veterans who meet the definition of the target population and who desire PRRC services.

(3) While respecting the Veteran's right to refuse specific treatment options, PRRC teams must exert additional efforts to reach out to those who initially are reluctant to participate to ensure that they make an informed decision.

(4) Referred Veterans may be excluded from participation in the program if the behaviors associated with their mental health condition would significantly impair learning for themselves or others in a curriculum-based environment, as determined by PRRC staff.

(5) When a PRRC decides against providing services to a referred Veteran, the PRRC team must partner with the Mental Health Treatment Coordinator (MHTC) or referring provider (if an MHTC has not yet been designated) to ensure that the mental health needs of the referred Veteran are met (e.g., suggesting alternative services). PRRC programming will be made available when the Veteran is more likely to benefit from the array of PRRC services.

**m. Initial Assessment and Strength-Based Recovery Plans with Focus on Community Inclusion and Integration.**

(1) An initial assessment and preliminary recovery plan must be completed with each Veteran admitted in the program for 10 participating days or longer (i.e., the number of days in which the Veteran is participating in some aspect of the PRRC program). Completion of the initial assessment and preliminary recovery plan will formally establish admission to the PRRC. The initial assessment must be completed by an appropriately credentialed and trained provider on the PRRC team who is assigned based on the staffing mix at the PRRC.

(2) Full recovery plans must be entered into the EHR within 20 participating days after admission to the PRRC and after completion of the initial assessment and preliminary recovery plan. The recovery plans must focus on helping Veterans identify environments in which to live, work, learn, and socialize that are all based on their unique strengths, needs, abilities, preferences, and personal goals. In connection with this, PRRC staff ensure that the 14 Recovery Domains are considered and addressed to the extent that these are pertinent to the Veteran's goals in the recovery plan for each Veteran served in the PRRC. These 14 Recovery Domains can be found on the [PRRC SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(3) The recovery plan is jointly completed by the Veteran and their clinical care team. The recovery plan reflects an organized approach toward assisting the Veteran with identifying specific, meaningful roles and goals. If a Veteran is simultaneously enrolled in PRRC and ICMHR programs, the PRRC team must collaborate with ICMHR team members to develop a shared recovery plan. Partnerships between PRRCs and the ICMHR program are important to the continuum of care provided to Veterans with SMI.

(4) There must be a clear link between the Veteran's participation in specific elements of PRRC programming and accomplishing specific goals and objectives detailed in the recovery plan.

(5) Efforts to promote community involvement and integration/inclusion emphasize independent, self-directed engagement in community activities and roles. PRRC staff do not foster community institutionalization. Staff must attempt to avoid community linkages or hosted activities that are led or facilitated by PRRC staff in an ongoing manner that do not move to quickly foster an individual's ability to transition to self-directed, independent participation in their community using natural supports. PRRCs are designed to minimize dependency and expedite independent involvement in the community by guarding against elongated periods of preparation and transitional supports. Staff-directed activities must be kept at a minimum and only be used when clinically indicated. The emphasis of staff-led community-based activities or interventions must be on providing the individual(s) with the skills needed to overcome the barriers to participation and succeed in that role or activity on their own.

**n. Transition to Lower Intensity Services.** PRRC services must be delivered in a manner which promotes increasing Veteran independence. While services are available

as long as necessary, discharge from the program is mutually determined by Veterans in treatment and the PRRC treatment team. Transition to lower intensity treatments (e.g., BHIP and specialty outpatient mental health services) are clinically appropriate for Veterans after they have met their most significant recovery goals and no longer need intensive specialty mental health services to maintain their progress, or for those who have embarked on a self-directed plan to achieve goals with less intensive clinical support. Those Veterans who no longer need PRRC core services must be transferred to standard mental health outpatient care (i.e., BHIP) or another appropriate level of care. Decisions related to the intensity of care must be made in collaboration with the Veteran and based upon regular review of the Veteran's needs. Characteristics of readiness for standard outpatient mental health care or other appropriate treatments may include:

- (1) Clinically stable and not relying on extensive inpatient or emergency services.
- (2) Has met the treatment and personal recovery goals (including community integration/inclusion goals) identified as necessary for discharge from the program in collaboration with the PRRC team.
- (3) Maintaining stable community living in a residence of the Veteran's own choosing and having the means to sustain this stable housing.
- (4) Has had access to PRRC-related SUD services as needed and is ready to work on the recommended interventions at the next level of care based on clinical assessment.
- (5) Independently participating in necessary treatments.
- (6) Expressing a desire to receive less frequent clinical contacts or utilize a different treatment modality.

**o. Post-Discharge Psychosocial Rehabilitation and Recovery Center Services.**

Following successful discharge from the program, Veterans may be readmitted to the PRRC to participate in any element of the program on an as-needed basis. The Veteran's current level of functioning cannot prevent readmission to the PRRC, regardless of whether it differs from the Veteran's functioning at initial admission. A new assessment and recovery plan must be completed when Veterans are readmitted to the PRRC.

**p. Meal Preparation Support.** It is not a requirement of PRRC programming to provide meal preparation skills to Veterans. If PRRC staff provide meal preparation skills to Veterans in a PRRC kitchen, there needs to be a clear, psychosocial rehabilitation rationale written by the PRRC staff member in the participating Veteran's recovery plan. The rationale must include a clear path to ultimate independence in this area to reduce the risk of fostering dependency over time.

**q. Development of Public Transportation Skills.** When clinically indicated, PRRC staff should be available to assist Veterans with learning skills to effectively use public

transportation (e.g., local bus, train, subway). This may include PRRC staff accompanying Veterans during skill acquisition. Each staff-assisted use of public transportation in the delivery of PRRC services must be documented in the Veteran's medical record, with clear linkage established to specific recovery goals or objectives in the Veteran's recovery plan. Part of that plan must include efforts to help the Veteran progress over time towards independence in transportation.

#### **4. INTENSIVE COMMUNITY MENTAL HEALTH RECOVERY PROGRAM**

##### **a. Background.**

(1) SMI is a significant problem among Veterans. In 2024, VA provided care for 236,513 Veterans with SMI diagnoses (i.e., schizophrenia spectrum disorders, bipolar spectrum disorders, related disorders with psychosis as a core feature) at an estimated cost of \$11.5 billion (Bowersox et. al, 2024). ICMHR services are an adaptation of Assertive Community Treatment (ACT) designed to address the unique needs of Veterans with SMI within VHA while ensuring access to additional medical, mental health, and specialty medicine providers. The ICMHR services model has demonstrated significant positive outcomes for the target population, including a reduction of inpatient mental health hospitalizations, improved patient satisfaction with care, increased housing stability, and improved treatment retention.

(2) ICMHR services provide clinical community-based, psychosocial rehabilitation services to Veterans with SMI, severe functional impairment, and high inpatient mental health unit utilization, in coordination with existing community and VA services.

(3) A health care system's ICMHR program provides services through three types of teams: ICMHR Mental Health Intensive Community Model (MHICM), serving primarily urban and suburban areas; ICMHR Rural Access Network for Growth Enhancement (RANGE), serving primarily rural areas; and ICMHR Enhanced RANGE (E-RANGE), serving primarily rural areas with a special emphasis on homeless Veterans.

(4) ICMHR services are cost-effective interventions, despite the high resource intensity associated with them. When the ICMHR service elements have been rigorously maintained (i.e., appropriately high frequency and intensity of services, low Veteran to staff ratios, team structure) and when the service is offered to Veterans in the defined target population, reductions in utilization of interventions, including inpatient mental health units, outpatient clinics, emergency rooms, and others have more than offset the costs of ICMHR services. According to data collected by NEPEC, ICMHR services are associated with improvements in satisfaction with mental health services, housing independence, quality of life, and mental health symptoms.

(5) Evaluations by NEPEC indicate compelling evidence for the effectiveness of the intervention with Veterans who experience psychotic symptoms. ICMHR services may also be useful for Veterans who experience significant impairments in independent and community functioning as a result of severe affective disorder, severe PTSD, or other SMI.

(6) NEPEC has produced comprehensive reports that document adherence of ICMHR services to VHA policy, identify outliers, and document clinical outcomes using standardized and other accepted measures.

b. **Target Population.** ICMHR services provide necessary mental health treatment and support for Veterans who meet all of the following criteria:

(1) The primary target population for ICMHR services is Veterans with SMI and severe functional impairment. (See paragraph 11.r. for the definition of SMI.)

(a) To maintain an overall emphasis on services for Veterans with psychosis and bipolar disorder, ICMHR programs are expected to serve a minimum proportion of Veterans meeting the diagnostic criteria established for the NPR (i.e., 75% of MHICM teams and 65% for RANGE and E-RANGE teams). Veterans with severe manifestations of other SMI and similar impairments in functional status may be admitted when there is capacity to do so without impacting access for Veterans with severe manifestations of psychosis or bipolar disorder.

(b) While ICMHR services are not designed to serve Veterans with primary diagnoses of traumatic brain injuries, SUD, neurocognitive disorders, or personality disorders, these diagnoses do not exclude Veterans from ICMHR services when comorbid with SMI. ICMHR services can be provided simultaneously with treatment for accompanying diagnoses, with ICMHR staff working to assure coordination, non-duplication of services, and linking of all services to an overall recovery-oriented treatment plan.

(2) **Inadequately Served.** Veterans inadequately served by conventional, clinic-based, outpatient treatment or case or care management programs (e.g., unable to maintain successful and stable community integration through the use of conventional services, even with augmented services such as PRRC).

(3) **High Resource Use.** This requirement includes Veterans with over 30 days of VA and non-VA inpatient mental health unit care or three or more episodes of mental health hospitalization over the past year. Veterans who meet the inpatient mental health unit care criteria must be given priority consideration for admission to ICMHR services. Veterans who do not meet inpatient mental health care criteria may be considered appropriate for ICMHR services when other indicators of high resource use or high vulnerability exist, including, but not limited to, frequent Emergency Department visits, frequent contacts with law enforcement, frequent use of crisis support services, frequent contact with emergency responders, or homelessness that consistently impairs their ability to maintain adequate housing or community function.

(4) **Clinically Appropriate for Outpatient Status.** The positive aspects of ICMHR services must not be used to justify moving Veterans to a community-based model, if they would be better served by inpatient care or another higher level of

care. Veterans who are more appropriately served clinically on inpatient mental health units must remain in the inpatient setting.

**c. Staffing and Population Focus of Intensive Community Mental Health Recovery Teams.**

(1) VA health care systems with 1500 or more Veterans on the NPR are required to have at least one ICMHR MHICM team. All VA health care systems should have the capacity to provide ICMHR services for at least 4% of the number of Veterans on the NPR; therefore, a mix of ICMHR team types (i.e., ICMHR MHICM, ICMHR RANGE, and ICMHR E-RANGE) may be needed to provide full population coverage. **NOTE:** For more information, see the [ICMHR Policy Support Page](#). This is an internal VA website that is not available to the public.

(2) Adequate staffing for models of ICMHR services is guided by the number of Veterans served, the severity of impairment of Veterans served, and logistical considerations in offering the type of services provided.

(a) Veterans served by ICMHR services must have access to recovery-oriented clinical psychosocial rehabilitation services, psychotherapy, and pharmacological treatment as appropriate for their needs. Staffing of ICMHR programs is expected to include multiple disciplines, reflecting the interprofessional nature of psychosocial rehabilitation and recovery-oriented services. ICMHR services are strongly encouraged to include peer specialists on their teams.

(b) Based on the number of Veterans needing services and their locations, VA health care systems can choose ICMHR team models where the Veteran to staff ratio is appropriate for the location of the Veterans needing services to address population coverage. For example, smaller Veteran to staff ratios are necessary in more rural areas, given the increased time needed for travel when providing direct patient care.

(3) Provision must be made in each ICMHR program for adequate team leadership (i.e., sufficient administrative time) based on the number of teams and clinical staff members, the intensity of the work, the need for communication and collaboration among team members, the need to ensure staff safety, support and development, and the completion and submission of all required reports.

(4) Each ICMHR program must have a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment) at 20% time for each 50 Veterans served. Each team must include two or more appropriately trained and licensed health care providers for the provision of these intensive outpatient services. Additionally, staffing of each type of ICMHR team is guided by the following:

(a) ICMHR Mental Health Intensive Community Model Team Staffing. ICMHR MHICM teams serve primarily Veterans living in more densely populated urban or suburban areas.

1. The ICMHR MHICM team staffing plans include a minimum of 4.0 FTE ICMHR primary clinicians and must be adjusted to include additional FTEs as the numbers of Veterans potentially served grows to maintain the appropriate ICMHR primary clinician-to-Veteran ratio (1:7-15).

2. Each ICMHR MHICM team must have a full-time registered nurse.

(b) ICMHR RANGE Team Staffing. ICMHR RANGE teams serve Veterans living in less densely populated or rural areas. The staffing pattern for these teams includes a minimum of 2.0 FTE ICMHR primary clinicians and must be adjusted to include additional FTEs as the numbers of Veterans potentially served by the team grows, in order to maintain the appropriate ICMHR primary clinician-to-Veteran ratio (1:7-10), as clinically indicated by the needs of the Veterans served, or as practically indicated by geographical distance or travel time.

(c) ICMHR E-RANGE Team Staffing. ICMHR E-RANGE teams are ICMHR RANGE teams enhanced by a special emphasis on homelessness. The staffing pattern for these teams includes a minimum of 3.0 FTE ICMHR primary clinicians and must be adjusted to include additional FTEs as the numbers of Veterans potentially served by the team grows to maintain appropriate staff to Veteran ratio (1:7-10), as clinically indicated by the needs of the Veterans served, or as practically indicated by geographical distance or travel time.

d. **Core Service Elements.** ICMHR services are delivered by an integrated, interdisciplinary team. See paragraph 4.c. for team staffing models. Fidelity to these service elements is essential to ensure desired program outcomes and positive results for Veterans. The core service elements are:

(1) **Provision of Psychosocial Rehabilitation Services.** ICMHR services utilize psychosocial rehabilitation as the primary service modality. ICMHR services are driven by a recovery-oriented care-planning process that incorporates the Veteran's goals, preferences, and strengths. It includes interventions for building adaptive and social skills, increased self-care, independent living, employment, crisis resolution, and practical problem solving.

(a) Psychosocial rehabilitation in ICMHR services focuses on all aspects of the physical and social environment through the utilization of community experiences as in-vivo treatment opportunities (e.g., therapy, skill building) to facilitate Veterans' recovery. While services through telehealth modalities and office-based visits may be part of ICMHR services, the in-person, community-based psychosocial rehabilitation visit is the core method of service delivery. ICMHR services provide psychosocial rehabilitation and mental health treatment directly to Veterans.

(b) To address the many facets of psychosocial rehabilitation and to promote Veteran recovery, ICMHR programs are encouraged to utilize a variety of professional disciplines (e.g., psychiatrists, psychologists, social workers, pharmacists, mental health counselors, marriage and family therapists, nurses,

occupational therapists, recreation therapists, rehabilitation counselors, vocational specialists, peer specialists), both as team members and as collateral partners.

(c) If not directly represented on the team or in regular team meetings, team members must routinely collaborate as required to meet the needs of Veterans with professionals in other related VHA programs such as VHA Voc Rehab Service, Chaplain Services, Health Care for Homeless Veterans (HCHV), Women's Health, Veteran Justice Outreach, and Housing and Urban Development-VA Supportive Housing (HUD-VASH), as appropriate for the Veteran.

(d) Strong partnerships between ICMHR programs and PRRCs are important to the continuum of care provided to Veterans with SMI. In support of this partnership, a shared recovery plan must be in place for each Veteran simultaneously enrolled in an ICMHR program and a PRRC.

(e) Care management and case management are not the primary clinical service modality of ICMHR programs. ICMHR staff may be considered to serve in the role of Lead Coordinator in the Care Coordination and Integrated Case Management (CC&ICM) initiative only where a Veteran is enrolled in ICMHR services and receiving services from additional clinical programs (beyond the Patient Aligned Care Team (PACT)) that offer care management or case management. In this way, not every Veterans receiving ICMHR services will have a Lead Coordinator. ICMHR staff serve as the Lead Coordinator for many, though not all, Veterans enrolled in ICMHR programs who require a Lead Coordinator. ICMHR staff collaborate as clinically appropriate with all health care services in VHA and the community.

**(2) Focus on Community Integration.** Helping Veterans with SMI to achieve integration into their communities is a major goal of ICMHR services. ICMHR services help Veterans learn skills in linking to community environments in which to live, work, learn, and socialize based on individual goals and preferences. Consistent with this principle, efforts to promote community integration must emphasize work with individual Veterans over group outings. When desired by Veterans, assisting Veterans in connecting or reconnecting with family members and other natural supports can be helpful in promoting community integration.

**(3) High Frequency and Complexity.** ICMHR services are both frequent (i.e., high intensity of service) and clinically intense (i.e., complex clinical encounters). Veterans receive on average a minimum of one visit face-to-face per week plus additional contacts as needed based on shared decision making with the Veteran and clinical judgment.

(a) The term "visit" refers to an in-person, individual interaction, though visits may also include a limited number of VA Video Connect (VVC) visits. Virtual visits using tele video technology may be used in lieu of in-person visits for "face-to-face visits" up to 35% of the time (up to the point where minimum visit requirements are met) and only as clinically appropriate for and agreed upon by the Veteran.

(b) The broad term “contacts” includes the full range of clinical interactions (e.g., in-person, VVC, group, and telephone).

(c) For some Veterans, clinical contacts may need to be as often as two to three times per week or more. This level of service intensity is typically not required for the entire time the Veteran receives ICMHR services, and Veterans may have contacts more or less frequently as warranted by their clinical needs, recognizing that recovery is a non-linear process. Events such as VA medical facility discharges, transitions in living environments, initiation or changes in psychopharmacological treatment, or times of loss often require increased intensity of contact for periods of time.

(d) All Veterans enter the ICMHR program at the level of service intensity described in this paragraph, referred to as Regular Intensity. As clinically appropriate, some Veterans may transition to low intensity services as described in paragraph 4.m. Changes in the intensity of services must be documented in the EHR. Additional information on requirements for documentation can be found on the [ICMHR Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(4) **Selection of Clinical Service Delivery Modality.** Clinical contacts are anticipated to be complex and typically are primarily conducted in-person. While services through telehealth modalities and office-based visits may be part of ICMHR services and consistent with evidence-based practice and the promotion of in-vivo skill building, the in-person, community-based visit is the core service modality in ICMHR services. ICMHR clinicians must consider Veteran needs and preferences when choosing clinical service delivery modalities for each contact. Contacts may be with the Veteran alone or may also involve other individuals of the Veteran’s choosing, such as the Veteran’s caregivers, family members, and other natural supports.

(5) **Low Veteran to Clinician Ratios.** To provide intense and frequent contact with Veterans served, ICMHR services must have low Veteran to clinician ratios. Low Veteran to clinician ratios are also necessary to allow time for regular travel to Veterans’ homes and communities. Veteran to clinician ratio ranges are provided to allow for the consideration of the individual level of needs of the Veterans served by the ICMHR program. For example, Veterans with complex needs who may experience specific challenges such as homelessness or active substance abuse may have more frequent need of clinical contact than those approaching readiness for a lower intensity of care. When Veteran to clinician ratios in ICMHR programs approach the specified upper limits, ICMHR Team Leaders must work with local VA medical facility leadership to increase staffing. (See paragraph 4.c., Staffing and Population Focus of ICMHR Teams, below for ratios by team type).

(6) **Clinical Responsibility.** While each Veteran in ICMHR services has an ICMHR primary clinician, ICMHR programs use shared caseloads so that the Veteran can benefit from the clinical skills of each team member and so that the Veteran has consistent access to ICMHR services, uninterrupted by staff absences.

This approach provides continuous service by team members known to the Veteran and provides enrolled Veterans with access to the expertise of each discipline on the interdisciplinary team, as well as to specific competencies various team members have in delivering additional evidence-based treatments or interventions. The ICMHR program is identified as being a “fixed point of clinical responsibility,” providing continuity of care for each Veteran across treatment settings for the duration of the Veteran’s participation in ICMHR services. This responsibility lasts as long as necessary based on the Veteran’s needs and preferences, utilizing shared decision making between the Veteran and the ICMHR team.

**(7) Services for Veterans with Co-Occurring Substance Use Disorders.** Given the high rates of comorbidity of SUD among Veterans with SMI, serving Veterans with these co-occurring disorders is an important priority. The ICMHR services team must work to build clinical competence in helping Veterans with SUD.

(a) Within 1 year of publication of this directive, each ICMHR MHICM team must have, through hiring or training of current staff, at least one team member with subject matter expertise and experience in evidence-based treatment(s) of SUD.

(b) ICMHR RANGE and ICMHR E-RANGE teams are strongly encouraged to also meet this standard.

(c) All ICMHR programs must have a written plan in place for ensuring access to treatment for SUD when clinically indicated and in accordance with VHA Directive 1160.04, including medications for the treatment of SUD, through both direct provision of such services and referral to local SUD services.

**(8) Services for Veterans Experiencing Early Episode Psychosis.** Delay between the onset of psychotic symptoms and the initiation of treatment during a first psychotic episode is known to correlate with poor clinical outcomes. Early intervention can help to improve the longitudinal course of psychotic disorders and prevent or mitigate the initial negative social, economic, and medical impact of these illnesses. While many Veterans who experience a first psychotic episode will recover with less intensive interventions, services provided to Veterans experiencing early episode psychosis within ICMHR services should be guided by the principles and practices of Coordinated Specialty Care (CSC). ICMHR staff should confer with the EPIC clinical team, when available, in the care of these Veterans to ensure optimal access to the components of CSC.

**(9) Provision of Holistic Care.** ICMHR staff work to enhance overall health care quality both by direct provision of mental health services and by coordinating health care and social service needs across the entire VHA system and beyond. ICMHR staff work to ensure timely access to medical care services for both routine and acute visits, assist Veterans in receiving recommended preventive services, and assist Veterans in accessing and adhering to recommended medical treatments (within the clinical privileges or the scope of practice of each professional).

(10) **Flexibility and Community Orientation.** Most services are provided in community settings and include collaboration with available support systems (e.g., family members, landlords, employers) whenever possible and with the consent of the Veteran. Flexibility of ICMHR staff is critical to respond to the anticipated, unanticipated, and ongoing acute needs of Veterans. ICMHR staff may need to adjust their schedules throughout the course of any given day in response to Veterans who are in crisis, especially when support persons and resources in the community are unavailable, and to adjust for weather, traffic, and other situational demands related to providing community-based services to vulnerable persons. VA medical facility mental health leaders must have plans and systems in place to accommodate a high degree of flexibility and to ensure the integrity of the program and safety of team members and Veterans. Scheduling processes must support the need for flexibility in timing of visits, including that some visits may occur prior to appointments being scheduled.

(11) **Location of Community Visits.** The majority of clinical visits take place in the community, often where the Veteran lives. When Veterans are housed, temporarily or ongoing, in settings other than private residences (e.g., hospitals, rehabilitation centers, skilled nursing facilities, family care homes), ICMHR staff must work with the local VA medical facility business office to ensure appropriate billing practices. Additionally, clinical care must be coordinated with these partner entities.

(12) **Focus on Advocacy and Supporting Veteran Autonomy.** ICMHR services staff seek to elicit and document Veterans' preferences for clinical care during potential episodes of diminished decision-making capacity and to identify, when desired by the Veteran, individuals who need to be consulted about clinical care decisions on behalf of the Veteran at these times. The ICMHR services staff advocate for the Veteran during these times and work with other health care providers and the Veteran's designated surrogate decision maker to ensure that the treatment(s) chosen balances the Veteran's wishes, or best interests if the Veteran's wishes are unknown, with the Veteran's safety. ICMHR services teams provide education on advance directives and assistance to Veterans who wish to complete them. For additional information on advance directives, see VHA Directive 1004.03(1).

e. **Clinical Documentation.**

(1) **Stop Codes.** The definitions of the stop codes for the ICMHR workload (546, 552, and 567) can be found in the Coding Guide located on the [Mental Health Business Operations SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.* ICMHR services provided under stop code 552 are the primary determinant of the patient classification within the VHA Veterans Equitable Resource Allocation (VERA) system. For RANGE, RNNX is added to these stop codes. RNNY is added for E-RANGE.

(2) ICMHR staff are required to meet all requirements for the timely documentation of their clinical services in the Veteran's EHR and for the timely

completion of all forms required for the ICMHR MHICM, ICMHR RANGE, and ICMHR E-RANGE performance evaluation and monitoring systems administered by OMH, including NEPEC. ICMHR staff must abide by all applicable laws, regulations, and VHA policies related to privacy, confidentiality, and information security.

f. **Program Monitoring and Quality Improvement Initiatives.** ICMHR programs must maintain service standards consistent with this directive, as monitored by NEPEC and OS&PSR. Additionally, ICMHR services must have organized, regular, and planned quality improvement initiatives to systematically improve their services. Quality improvement efforts may also be initiated by OMH.

g. **Use of Federal Vehicles.** Provision of ICMHR services requires use of Federal vehicles for the delivery of community-based services, including times when Veterans may ride with VA clinical staff in Federal vehicles. Per 38 U.S.C. § 111A, any person may be transported to or from a VA facility or other place for the purpose of examination, treatment, or care. Use of Federal vehicles in the delivery of ICMHR services must be documented in the clinical chart, with clear linkage established to specific goals and objectives in the Veteran's recovery plan. Part of that plan must include efforts to help the Veteran progress over time towards independence in transportation, when possible. **NOTE:** *For information regarding medical clearance of incidental motor vehicle operators, see the fact sheet on the [VA Fleet Management SharePoint](#). This is an internal VA website that is not available to the public.*

h. **Accreditation.** Endorsement from external accreditation agencies is an important aspect of ensuring ongoing high-quality programming. Information related to accreditation requirements can be found on the [ICMHR Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

i. **Enrollment in Intensive Community Mental Health Recovery Programs.** ICMHR staff provide an evaluation for service participation for Veterans who are referred to or who personally request ICMHR services. The process of evaluation for ICMHR services participation must be guided by the following principles:

(1) Each referral must be considered on an individual basis for enrollment, giving the greatest possible consideration for participation in the program to Veterans who have needs that have not been met by traditional services.

(2) Veterans who otherwise meet the definition of the target population for ICMHR services cannot be denied service participation based solely upon the length of current abstinence from alcohol or non-prescribed controlled substances, the use of prescribed controlled substances, the number of previous treatment episodes, legal history, homelessness, personality disorder, or previous treatment non-adherence. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.

(3) Because ICMHR programs provide unique clinical services, ICMHR staff must make every possible effort to enroll referred Veterans who meet the definition of the target population and who desire ICMHR services. While respecting the Veteran's right to refuse specific treatment options, ICMHR staff must exert additional efforts to reach out to those who initially are reluctant to enroll to promote engagement and informed decision making about treatment options.

(4) Safety of ICMHR staff and of Veterans is a highly important consideration. Because they primarily deliver services in the community, ICMHR staff work in settings that cannot be controlled in the same manner as the VA medical facility or clinic. In addition to general considerations of safety in the community, accommodations such as conducting initial evaluation visits in pairs or in the VA medical facility or clinic may be used to facilitate completion of the evaluation for ICMHR service participation. In support of safe practice while working in the community, ICMHR staff must have access to cellular telephones. **NOTE:** *Workplace Violence Prevention resources are located on the [Workplace Violence Prevention Program SharePoint](#). This is an internal VA website that is not available to the public.*

(5) When a referred Veteran is not enrolled in ICMHR services, ICMHR staff must communicate with the MHTC or the referring health care provider (if an MHTC has not yet been designated) to support care coordination and identification of appropriate resources.

(6) Referrals and ICMHR program responses must be documented using the consult procedure in the EHR.

**j. Use of Psychiatric Medications.**

(1) Each ICMHR program must have a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment) at 20% time for each 50 Veterans served. Given that ICMHR services provide care to Veterans with complex clinical histories and often treatment refractory illnesses, a psychiatrist is the preferred discipline for this clinical role.

(2) Appropriate use of psychiatric medications is among the evidence-based tools which can be used to support recovery in Veterans with SMI. Availability of a primary psychiatric provider with time dedicated to each ICMHR team assures that use of psychiatric medications is recovery-oriented, person-centered, and team-based. As a full ICMHR team member and in addition to the provision of clinical care, expected activities include attendance at regular team meetings and ongoing consultation to ICMHR staff.

(3) While most Veterans served by ICMHR services would transfer psychopharmacological care to the ICMHR team's primary psychiatrist (or other pharmacotherapy provider), a small number of Veterans may be better served by their relationship with a provider in another program. This arrangement is considered

on a case-by-case basis. Within their appropriate clinical privileges or scopes of practice, all ICMHR services staff can contribute to optimal implementation of the use of psychiatric medications.

(4) ICMHR services staff must collaborate to ensure that Veterans have continuous access to prescribed psychiatric medications (i.e., physical possession of medications where oral medications are prescribed).

(5) An ICMHR primary clinician must review refill records and discuss medication access with Veterans regularly to ensure there are no gaps in the ability of Veterans to access prescribed psychiatric medications. When there is a current or upcoming gap in medication access, ICMHR primary clinicians must utilize real-time, closed loop communication to ensure continuous access to medications is maintained. Programs must have a detailed contingency plan for Veteran access to medications during emergencies such as natural disasters, pandemics, or other events which could create obstacles to Veterans receiving and taking psychiatric medications, including long-acting injectables.

(6) ICMHR services staff should assist Veterans in increasing their ability to take prescribed psychiatric medications independently. However, Veterans may require increased levels of support with psychiatric medications. Support (including administration of injectable medications) may often ideally be provided in the community. ICMHR services must work with VA medical facility administration to develop local standard operating procedures which allow ICMHR services staff to support Veteran use of psychiatric medications in the community in a manner that is consistent with local scopes of practice for each discipline and their associated licensure. For more information, see the [ICMHR Policy Support Page](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(7) The use of clozapine in the treatment of refractory psychotic disorders is an underutilized evidence-based practice with clinical advantages over other antipsychotic medications for refractory symptoms and suicidality. Where clinically appropriate, ICMHR services should support Veterans in gaining access to this treatment.

k. **Life Goals as the Primary Clinical Service Offering.** Life Goals is an intervention developed within VA to help Veterans with SMI. This intervention has been shown to result in positive clinical outcomes (e.g., symptom reduction, improved role functioning, improved patient satisfaction, improved health-related quality of life) when fully implemented. Life Goals is the primary psychosocial intervention offered to Veterans receiving ICMHR services. See paragraph 10.b. for additional information on training.

l. **Delivery of Additional Evidence-Based and Recovery-Oriented Practices.** To fully facilitate recovery, Veterans served by ICMHR services must also have access to additional evidence-based and recovery-oriented practices. While linking Veterans to health care providers outside of ICMHR services may be necessary, provision of these practices in the community directly by ICMHR services staff is ideal. This approach

takes best advantage of Veterans' community environment to tailor services to individual needs and to help Veterans build skills in the settings where they will be applied. ICMHR services staff must work to develop competence among team members in multiple established evidence-based and recovery-oriented practices for Veterans with SMI. Examples of some practices that may be provided in the context of community visits include: Illness Management and Recovery, Wellness Recovery Action Planning, Motivational Interviewing, Cognitive Behavioral Therapy, and Integrated Dual Disorders Treatment.

m. **Transition to Lower Intensity Services.** ICMHR services are Veteran-driven and promote increasing the Veteran's independence. Lower intensity services are clinically appropriate for Veterans after they have met their most significant recovery goals and no longer need intensive services to maintain their progress or for those who have embarked on a self-directed plan to achieve goals with less intensive clinical support. Those Veterans may be transferred either to standard mental health outpatient care or, in some cases, may continue to be treated by the ICMHR services team for a limited time at a lower level of service intensity (e.g., fewer than one community in-person or virtual visit per week and typically no less than one contact every 2 weeks). However, given the tendency of this population of Veterans to occasionally drop out of care for extended periods of time, it is vital that ICMHR services remain flexible with Veterans' needs. **NOTE:** *Additional guidance on the management of Veterans in Low Intensity status may be found on the [ICMHR Policy Support Page](#). This is an internal VA website that is not available to the public.*

(1) Decisions related to the intensity of care must be made in collaboration with the Veteran and based upon regular review of the Veteran's needs. Given the target population for ICMHR services, typically no more than 20% of Veterans served by each ICMHR program should consist of Veterans receiving low intensity ICMHR services.

(2) Characteristics of readiness for a lower intensity of care often include the following:

- (a) Clinically stable and not relying on extensive inpatient or emergency services;
- (b) Has met the treatment goals identified in collaboration with the ICMHR services staff;
- (c) Maintaining stable community living in a residence of the Veteran's own choosing, and having the means to sustain this stable housing;
- (d) Abstinence from use of substances or achievement of substantial harm reduction;
- (e) Independently participating in necessary treatments;
- (f) Expressing a desire to receive less frequent contacts or utilize a different treatment modality; and

(g) Increased ability to utilize self-management skills, such as those learned in Life Goals.

## 5. PEER SPECIALIST PROFESSION

### a. Background.

(1) The peer specialist profession is an integral part of VA health care and is delivered by trained and certified peer support staff who are members of the profession. Peer support staff and the peer support services they deliver are not a singular program. As members of the peer specialist mental health care profession, peer support staff work as part of interdisciplinary treatment teams in many different programs across VHA. Regardless of where in VHA peer support staff are employed, all members of the profession are required to abide by this directive.

(2) Peer support services support Veteran patients pursuing recovery and enhanced personal wellness related to various mental health conditions, addictions, and chronic physical health conditions. This recovery approach recognizes that individuals with mental illnesses and addictions as well as those managing and recovering from chronic physical health conditions, may achieve their goals for healthy and productive lives more readily when individualized services are delivered by and in collaboration with peer support staff.

(3) Peer support services in VHA are specifically designed to offer hope for Veteran recovery, and peer support staff serve as role models for that recovery, health, and wellness. Peer support staff help Veterans develop skills to manage their recovery from illness, improve their quality of life, support their individualized goals, facilitate support from others, and achieve independence from institutional settings.

### b. Staffing Requirements for Peer Support Staff.

(1) The first VHA-funded peer support staff positions were filled in 2005. In 2013, 800 peer specialist positions were added to the VHA workforce as a result of Executive Order 13625, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, which directed VA to hire and train these new staff by the end of calendar year 2013. VISNs and VA medical facilities were assigned a total number of peer specialists based on the proportion of Veterans projected to receive mental health services at each VA medical facility in FY 2013. All VA medical facilities in each VISN must maintain their initial allocation of peer specialist positions in order to maintain the requirement of a peer specialist workforce strength of at least 800 positions as set forth in Executive Order 13625. **NOTE:** *VISNs and VA medical facilities were assigned a total number of peer support staff based on the proportion of Veterans projected to receive mental health services at each facility in FY 2013. These FY 2013 staffing requirements are available from the VHA OMH's Peer Support Services Section.*

(2) Additionally, VA medical facilities are required to abide by peer specialist hiring requirements mandated by other Executive Orders, VHA directives (e.g., VHA Directive

1160.01), and legislation (e.g., Supporting the Resiliency of our Nation's Great Veterans (STRONG) Veterans Act of 2022, Section 401). **NOTE:** *Details about legislatively mandated peer specialist staffing requirements can be found in the Official Guidance section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.*

**c. Methods of Delivering Peer Support Services.**

(1) At VA medical facilities, peer support services must be available for all Veterans for whom this service is clinically indicated and must be included in the Veteran's treatment plan in the electronic health record (EHR). Peer specialists working in the Veterans Crisis Line (VCL) Peer Support Outreach Center (PSOC) document contact with Veterans and Veterans' goals.

(2) Each VA medical facility must assess the needs of the Veterans and the availability of high-quality resources to provide peer support services. The following methods of delivering peer support services are typical of those in use in VHA:

(a) Peer Support Staff Positions. Peer support staff positions include the following list. Any VHA setting that has one or more of these positions must abide by the policies applicable to the peer specialist health care profession that are discussed in this directive. **NOTE:** *Appendix A contains the qualification standards for each VHA-employed peer support staff member and information about their scope of practice.*

1. Peer support apprentices.
2. Peer specialists.
3. Lead peer specialists.
4. Supervisory peer specialists.
5. Without compensation (WOC) peer support employees (volunteers).

(b) Outreach Services for Veterans Not Currently Using VHA Services. Peer support staff may provide outreach in person or via phone to educate Veterans about VA services and resources and offer support to connect Veterans to those resources and services that interest them. These outreach services should focus on the Veterans' current needs and experiences to identify available resources or services from which the Veteran may benefit.

1. Peer support staff's outreach services cannot include any clinically-based practices, such as administering clinical assessment tools, gathering clinical information or history of mental health or substance use treatment for the purposes of clinical assessment or treatment, or contacting a Veteran for the purpose of conducting a risk screening. If a Veteran discloses clinically-based information during the interaction with the peer support staff, then this information may be documented by the peer support

staff. However, it is not the peer support staff's role to probe for or purposefully gather any clinical history.

2. During the outreach encounter, if a Veteran says or does something concerning where a risk screening would be beneficial, the peer support staff member must use the Columbia Suicide Severity Rating Scale (C-SSRS) Screener to screen the Veteran. Then, the peer support staff member must engage an LIP or other appropriately credentialed health care professional for a further risk evaluation if needed. If the C-SSRS Screener is administered, the peer support staff member must document the results of the C-SSRS Screener and what occurred during the encounter, including what actions were taken to help the Veteran, in the Veteran's EHR. **NOTE:** *Peer specialists working in the Veterans Crisis Line's Peer Support Outreach Center, where they have specialized training and frequent supervision, may have additional responsibilities when engaging in outreach activities specific to the work in that program.*

d. **Settings.**

(1) Peer support services may be provided in a variety of VA health care programs, including, but not limited to, substance use treatment services, inpatient mental health, outpatient mental health, ICMHR programs, PRRCs, RRTPs, VHA Voc Rehab services, Veterans Integration to Academic Leadership, primary care, Women's Health Services, homeless programs, Veterans Justice Program, and the VCL PSOC. Peer support staff are continuing to be hired in additional types of VHA programs. Peer support services can be delivered individually or in a group format, and they can be delivered in person, via telephone, or via VA Video Connect (VVC).

(2) Any VHA program that hires peer support staff using one of the official position descriptions/functional statements for "peer support apprentice," "peer specialist," "lead peer specialist," or "supervisory peer specialist" must abide by this directive, including Appendix A, and the additional guidance found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

e. **Qualifications and Standards.** Because peer support staff serve in a variety of settings throughout the VA medical facility, it is important to ensure peer support staff are qualified, certified, and supervised appropriately. See Appendix A for scope of practice for peer support staff and standards for peer support staff hiring, supervision, promotion, training, documentation, and ethics.

f. **Documentation of Need.**

(1) When referring a Veteran to receive peer support services at a VA medical facility, the need for peer support services must be documented in the Veteran's existing plan of care. Documentation must specify how peer support services will be delivered, in what context, for what duration, and the goals of the intervention. Peer specialists working in the VCL PSOC document Veteran contact and goals.

(2) VA medical facility peer support staff must never be the primary or only VA health care professionals in a treating service who provide health care services for any Veteran. Peer support services do not occur in isolation but are a component of the overall VHA services that the Veteran is receiving. Related to this point, VA medical facility peer support staff do not serve as the lead author of a Veteran's treatment plan in the Veteran's EHR. Instead, peer support staff add the peer support service goal(s) to a Veteran's existing treatment plan in the Veteran's record that was previously developed by the Veteran's other health care service provider(s). **NOTE:** *This directive does not prohibit peer support staff from providing outreach services to VHA-enrolled and non-enrolled Veterans where their role is to educate Veterans about, and connect them to, available services, resources, and support. Peer support staff can participate in these types of outreach services.*

(3) Within the operations of the VCL PSOC, peer support staff collaborate and coordinate with clinical program coordinators, supervisory peer specialists, VCL call responders, and other staff regarding the services that the PSOC provides for Veterans. PSOC peer support staff document their work with Veterans.

g. **Additional information.** For additional information about scope of practice for peer support staff and standards for peer support staff hiring, supervision, promotion, training, documentation, and ethics, see Appendix A.

## 6. LOCAL RECOVERY COORDINATOR

### a. **Background.**

(1) The development of VHA's LRC position was part of an enterprise-wide response to the President's New Freedom Commission on Mental Health in July 2003 (Executive Order 13263) and the VHA Mental Health Strategic Plan. This plan detailed VHA's commitments to evidence-based practices, consumer and family-driven care, and a recovery-oriented mental health system, where all those with mental illnesses have the essential services and supports necessary to live, work, learn, and participate fully in the community.

(2) As part of this transformation, VA medical facility LRCs were tasked with developing and coordinating the change processes necessary for all mental health services to become recovery-oriented and to sustain these changes across the continuum of care and at every entry point. VHA empowered LRCs to lead the charge to address the shifts in culture necessary not to just transform the health care system, but also to sustain these improvements.

(3) This directive and VHA Directives 1160.01 and 1160.06 emphasize the actions required of every member of VA's health care system to sustain the transformation to a recovery-based system. Additionally, these national policies detail the growing responsibilities of VA medical facility LRCs, who continue to lead local transformation and sustainment efforts. The work of mental health recovery transformation and sustainment is an ongoing responsibility, requiring the full attention of the LRC and

continuous commitment on the part of Mental Health and VA medical facility leadership at all levels.

**b. Local Recovery Coordinator Role.**

(1) Each VA health care system must have at least 1.0 FTE LRC position reporting to the VA medical facility Mental Health Leader or equivalent position. This cross-cutting leadership position serves as a consultant across their health care system dedicated to recovery transformation and sustainment and leading continuous process improvement based on the unique needs of the health care system. The LRC has varying portions dedicated to administrative time and clinical time based on the complexity of the health care system's mental health continuum of care, given less administrative time is generally needed at lower complexity VA medical facilities with fewer mental health programs to transform and sustain. In considering the responsibilities of the LRC, the mapped clinical time is not only applied to direct patient care activities, but also applies to outreach services (e.g., SMI Re-Engage Program), clinical consultation, development and sustainment of recovery programming, clinical and technical supervision, and other duties that require clinical expertise. Specifically, the following administrative and clinical time parameters are required:

(a) In health care systems that have neither a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) nor an acute inpatient mental health unit, the LRC must be mapped at least 50% administrative time and no more than 50% clinical time.

(b) In health care systems that have an MH RRTP, but no acute inpatient mental health unit, the LRC must be mapped at least 65% administrative time and no more than 35% clinical time.

(c) In health care systems that have an acute inpatient mental health unit, the LRC must be mapped at least 75% administrative time and no more than 25% clinical time.

(2) For information about VA medical facility LRC responsibilities, see paragraph 2.v.

(3) See the [LRC Policy Support page](#) for additional resources. **NOTE:** *This is an internal VA website that is not available to the public.*

## **7. SERVICES FOR VETERANS EXPERIENCING EARLY PSYCHOSIS: EARLY PSYCHOSIS INTERVENTION COORDINATION PROGRAM**

**a. Background.**

(1) Though schizophrenia and related psychotic disorders can have illness onset throughout the lifespan, these disorders most often emerge in the late teenage years to mid-twenties for males and mid-to late twenties for females, near common ages of military service. Therefore, many individuals who eventually develop these conditions may experience their first psychotic symptoms during military service and may ultimately separate from service due to these symptoms. Other individuals who are

eligible for VA health care may develop these conditions after separation from the military.

(2) The period surrounding the first emergence of psychotic symptoms, or early psychosis, is often extremely stressful for Veterans and family members, regardless of age of onset. This period is associated with significantly elevated risk of death by suicide. In one study, VA patients with early episode psychosis were shown to be at a higher risk for suicide mortality and self-harm 1 year after initial diagnosis than other Veterans with mental health conditions, even after accounting for other risk factors.

(3) Active-duty Service members or Veterans who experience early psychosis often do not connect with VA health care services rapidly after illness onset. These individuals receive variable types and degrees of treatment across the private and non-VA public sector that is often poorly coordinated. Therefore, many Veterans who eventually receive care for psychosis from VHA present for services long after their illness onset, already exhibiting significant clinical, functional, and biological deterioration. Early intervention for psychotic conditions provides opportunities to mitigate the extent of immediate (e.g., suicide) and longer-term (e.g., skill and functional deterioration) consequences associated with inadequate treatment.

(4) VHA provides comprehensive inpatient and outpatient mental health services, with all the key components of effective early psychosis programs provided in various clinical settings, though not necessarily in a coordinated manner at each VA medical facility. Early Psychosis Intervention Coordination (EPIC) facilitates active-duty Service members with early psychosis in transitioning to VHA health care and provides early interventions to Veterans who experience a new onset of psychosis.

(5) Multiple clinical trials have demonstrated the effectiveness of Coordinated Specialty Care (CSC) in individuals with first episode psychosis. As such, EPIC provides services to Veterans with early psychosis consistent with the practices and principles of CSC. In doing so, eligible Veterans who experience these difficulties will be provided with services designed to assist them in leading full and meaningful lives, limiting to the greatest extent possible the morbidity and mortality associated with early psychosis. For the purposes of this directive, early psychosis is the period lasting for 4 years after the first appearance of primary psychotic symptoms, regardless of the age of onset. **NOTE:** *Given the difficulty of determining retrospectively whether a first episode of psychosis has resolved, the term “early psychosis” is used in this directive to allow for more uniformity in defining the target population.*

b. **Core Services.** The following EPIC program core services must be implemented in all VA medical facilities that have both an existing ICMHR MHICM team and PRRC program. Other sites are strongly encouraged to implement this initiative as well.

(1) Each VA medical facility must appoint an appropriately credentialed or privileged practitioner who is actively engaged in clinical service delivery to Veterans with SMI as an EPIC POC. **NOTE:** *EPIC POCs may be chosen from those working in programs such as PRRC, ICMHR, VHA Voc Rehab, inpatient mental health, or the LRC. This*

*person must demonstrate a strong interest and expertise in providing services to individuals with early psychosis or more broadly to those with SMI.*

(2) Each VA medical facility must create an EPIC clinical care team to advise on the therapeutic and psychosocial needs of Veterans identified as experiencing early psychosis. **NOTE:** *The EPIC clinical care team is led by the VA medical facility EPIC POC and composed of clinicians whose duties are already focused on Veterans with SMI. The EPIC initiative therefore represents increased efforts to engage a subset of Veterans with SMI rather than assignment of new duties. These Veterans have a clinical home in an existing clinical program, with EPIC efforts focused on ensuring access to additional clinical services as indicated in the treatment plan.* This team's activities include:

(a) Working with the EPIC POC to ensure timely referral to indicated clinical services for each Veteran experiencing early psychosis.

(b) Meeting at least monthly to coordinate and facilitate care for Veterans with early psychosis.

(c) Developing a VA medical facility-level plan with the EPIC POC to deliver services consistent with CSC to Veterans experiencing early psychosis across the VA medical facility, as described above. Please see the [EPIC Policy Support Page](#) for resources related to this plan. **NOTE:** *This is an internal VA website that is not available to the public.*

(3) The appropriate amount of FTE dedicated to the duties for the EPIC POC will vary based on the size of the VA medical facility but is generally expected to be a minimum of 0.20 FTE. Membership of other clinicians on the EPIC clinical care team may be through dedicated FTE or collateral duty based on overlap of the duties of their current assignment with those of the EPIC clinical care team (e.g., outreach to Veterans with early psychosis is an appropriate work activity for employees working in programs serving individuals with SMI).

(4) Each VA medical facility must develop a VA mental health service-level plan for delivery of services to Veterans with early psychosis that is consistent with the practices and principles of CSC and incorporates the services available within that VA medical facility's continuum of care or through community care. The plan must include:

(a) Provision of (or coordination of) evidence-based therapeutic treatments, both pharmacologic and non-pharmacologic. Non-pharmacologic treatments must include Supported Employment (SE) and educational services, cognitive therapy, individual resiliency training, family support, and other therapies as needed by the individual.

(b) Provision of SUD services.

(c) Provision of psychoeducation about mental illness for the Veteran and their family.

(d) Utilization of existing clinical resources such as the VA medical facility LRC or those individuals working in other programs like PRRC, ICMHR, Voc Rehab, mental health crisis services, and inpatient mental health.

(e) Standards for involving the Veteran and, as warranted and desired by the Veteran, the Veteran's family members.

(f) Coordination with primary care services.

## 8. RE-ENGAGING VETERANS WITH SERIOUS MENTAL ILLNESS

### a. Background.

(1) A substantial number of Veterans with SMI of schizophrenia and bipolar disorder have medical comorbidities that require ongoing medical care. Research demonstrates that disengagement from care is relatively common among Veterans with SMI and is associated with adverse outcomes.

(2) In 2010, VHA's Under Secretary for Health accepted recommendations from a quality improvement assessment by the Office of the Medical Inspector to institute outreach services to Veterans with schizophrenia and bipolar disorder who were lost to follow-up care. Prior directives established VHA policy that Veterans in the target population with schizophrenia and bipolar disorder who have been lost to follow-up care must be identified on an ongoing basis and that the local treating VA medical facility must assess these Veterans' need for continued treatment, actively seek and re-engage the Veterans in treatment as warranted, and accurately maintain contact information for these Veterans.

(3) Evaluations of the outcomes of the SMI Re-Engage program by the SMI Treatment Resource and Evaluation Center (SMITREC) have shown the following:

(a) Longitudinal assessments of selected cohorts indicate that Veterans who were contacted were more likely to return to care (42%) than Veterans who were not contacted (27%).

(b) Comparative evaluations of VA medical facilities with higher versus lower percentages of Veterans who were contacted and re-engaged in care identified specific outreach practices associated with better outcomes. VA medical facilities with clinicians who made at least four attempts to contact Veterans using strategies including telephone calls and certified letters have more success contacting Veterans and facilitating their return to care.

(c) Longitudinal assessments of care retention following re-engagement in VHA care for selected cohorts found that 93% of Veterans are retained in care for 2 years following an initial return-to-care appointment.

(4) The SMI Re-Engage program uses a population-based management approach to identify Veterans with schizophrenia and bipolar disorder who have not received VHA

care for 12 months to conduct outreach to assess their needs, invite their return to care, and facilitate re-engagement in VHA services if desired.

b. **Target Population.** The target population for the SMI Re-Engage program is a subset of Veterans with SMI, specifically those who have been diagnosed with schizophrenia-spectrum or bipolar-spectrum disorder and who have been identified as not receiving any VHA services for at least 1 year. SMITREC identifies Veterans meeting the target population and provides the names and contact information for these Veterans to the LRC at the local treating VA medical facility.

c. **Staffing.** VA medical facility LRCs are designated to carry out the SMI Re-Engage program. LRCs' duties include direct, recovery-oriented clinical services to Veterans with SMI. The activities associated with the SMI Re-Engage program are to be considered as part of LRCs' clinical time.

(1) LRCs' workload productivity target must reflect that the LRCs work in the SMI Re-Engage program is counted as clinical services even if some services are not billable. See paragraph 6.b.(1)(a-c) for requirements of mapped administrative and clinical time for LRCs.

(2) The LRC may employ the assistance of other clinicians and Health Professions Trainees (HPTs). HPTs may participate in SMI Re-Engage activities aligned with their training programs and must be supervised by the LRC for SMI Re-Engage-related work. All individuals who are part of assisting the LRC with the SMI Re-Engage program must be oriented by SMITREC to carry out the work. **NOTE: Orientation requests can be made at the [SMITREC SharePoint](#). This is an internal VA website that is not available to the public.**

(3) Peer specialists may also be involved in a more circumscribed and restricted role. Peer specialists can be involved with the SMI Re-Engage program under the following conditions:

(a) If the Veteran's individual needs have been initially evaluated by a clinician and the clinician has determined the Veteran would likely benefit from peer support services. For example, the VA medical facility LRC could facilitate the scheduling of appointments with peer specialists following the Veteran's return to VHA care, as a part of the mental health treatment team addressing the needs of the Veteran. Alternatively, after being in contact with the Veteran, the LRC could request that a peer specialist maintain regular contact with a Veteran if the Veteran's appointment is scheduled in the future, as a part of the mental health treatment team addressing the needs of the Veteran. As an additional option, the LRC may determine that a conversation with a peer specialist may help a Veteran resolve ambivalence about returning to VHA care, in which case the peer specialist is supporting the Veteran's engagement in collaboration with the LRC.

(b) Peer specialists are not permitted to perform the core duties of the SMI Re-Engage program, including the following: chart reviews, sending letters, conducting outreach calls, and scheduling appointments.

d. **Core Services.** All VA medical facilities are required to have an SMI Re-Engage program with the following core services:

(1) **Outreach and Re-Engagement.** This includes:

(a) Upon receipt of the list of Veterans disseminated from SMITREC, VA medical facility LRCs initiate outreach and re-engagement services to contact the Veteran and to assist the Veteran in returning to treatment for mental or physical health care or psychosocial services. LRCs must complete their efforts to contact and re-engage the Veterans on their list no later than 90 days from the date of receipt of the list.

(b) LRCs' outreach must include a minimum of four contact attempts to reach the Veteran, unless the Veteran is contacted with fewer attempts. These attempts should include direct contact with the Veteran (typically through a phone call). If the Veteran cannot be contacted directly, a letter must be sent to the Veteran. Evaluation data demonstrates that Veterans are more likely to be contacted if they receive a certified letter instead of a conventional letter. Thus, if a conventional letter does not result in successful contact with the Veteran, it is strongly recommended that a certified letter is sent. Other methods for attempting to contact a Veteran or obtain their current contact information include contacting next of kin and contacting recent providers.

1. Veterans who are engaged in community care (including VA-paid community care) should receive outreach.

2. If a Veteran is determined to be incarcerated, outreach attempts are not necessary.

3. LRCs and other qualified clinicians carrying out re-engagement services for Veterans with SMI may check inmate locator websites to determine the location of a Veteran for outreach visit purposes only. LRCs should contact the local Health Care for Reintegrating Veterans (HCRV) and the Veterans Justice Program at their VA medical facility.

(c) Re-engagement activities performed by the LRC start when the Veteran is reached and include:

1. Determining the Veteran's need for continued treatment services.

2. Coordinating with clinical scheduling to make appointments for all Veterans who desire to continue mental and physical health care or psychosocial treatment services. Given the importance of engaging this population of Veterans, appointments must occur within 10 business days unless a later date is requested by the Veteran. Use of mental health same-day services or the Emergency Department or Urgent Care should be facilitated for Veterans with urgent mental health or medical needs. **NOTE: Due to the high vulnerability of these Veterans, the timeliness of these appointments is critical and must be prioritized to meet this standard.**

3. Coordinating the Veteran's appointment with the appropriate mental health and primary care clinicians to assist the receiving clinician or team with developing a list of treatment options.

4. Assisting with contacting the Veterans when appointments are not kept.

5. Documentation by the VA medical facility LRC in the Veteran's EHR the contact efforts and outcomes (e.g., return to care, retention), services provided, appointments, and referrals made.

(2) **Orientation and Technical Assistance.** SMITREC provides ad hoc training to VA medical facility LRCs, maintains documentation on processes and protocols, and provides technical assistance to LRCs and VA medical facilities on the re-engagement and reporting processes outlined in this directive. LRCs receive the appropriate training from SMITREC regarding the procedures prior to conducting outreach for this program.

e. **Data Reporting.** VA medical facility LRCs complete and submit to SMITREC the contact and summary information for all Veterans contacted and returned to care, and those who were not able to be contacted, within 90 days of receipt of the Veterans' names. The data reported by the LRCs are used for program quality monitoring and program evaluation.

f. **Program Quality Monitoring and Evaluation.** SMITREC completes program quality monitoring and evaluation for the SMI Re-Engage program. **NOTE:** For more information, see the Director, SMITREC responsibilities in paragraph 2.n.

## 9. OVERSIGHT AND ACCOUNTABILITY

a. **Internal Controls.** The internal controls in this directive are:

(1) Oversight responsibilities for the Executive Director, OMH; Executive Director, Homeless Programs Office; Executive Director, Office of Suicide Prevention; Director, Primary Care Operations; National Director, OS&PSR section in OMH; National Director, Intensive Community Psychosocial Rehabilitation in OMH; National Director, PRRCs and LRCs in OMH; National Director, Peer Support Services in OMH; Director, NEPEC in OMH; Director, SMITREC in OMH; and the Director, PERC as outlined in paragraph 2 of this directive.

(2) NEPEC, SMITREC, and PERC monitoring and evaluation of OS&PSR programs and services.

b. **Metrics.** The metrics in this directive that assess the directive or program effectiveness are:

(1) Metrics aggregated by NEPEC for PRRC programs (e.g., stigma of mental illness, community participation) and ICMHR programs (e.g., recovery, wellbeing) to evaluate the effectiveness of services.

(2) Metrics aggregated by SMITREC for SMI Re-Engage programs (e.g., return to care, retention) to evaluate the effectiveness of services.

(3) All pre-existing Day Treatment Centers (DTCs), day hospitals, partial hospitals, or analogous programs have been transitioned to PRRCs.

## 10. TRAINING

a. The following training is **required** for all peer support staff: Congressionally Mandated Trainings for Peer Support Staff (Talent Management System (TMS) VHA-269). **NOTE:** *Details about mandated peer specialist training requirements can be found in Appendix A and in the Training section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.*

b. The following training is **strongly recommended** for ICMHR services staff:

(1) For all ICMHR services staff:

(a) The Life Goals Program for Self-Management Skills: Training Level 1 (TMS VA 37843). This training is available online and on-demand and is accessible without charge to all VA staff.

(b) All ICMHR services staff are strongly encouraged to complete higher levels of training beyond minimal requirements.

(2) For ICMHR Team Leaders:

(a) RS: Life Goals Virtual Training: Training Level 2 (TMS VA 131017358).

(b) ICMHR Team Leaders are strongly encouraged to complete Level 3 training. The Level 3 Life Goals training provides opportunity for one-on-one case consultation with a member of the Life Goals faculty and can be accessed at the conclusion of Level 2 training in TMS.

c. The following training is **recommended** for non-clinical staff working in OS&PSR programs or those new to the concept of mental health recovery: Mental Health Recovery: An Introduction (TMS VA 29476).

d. The following training is **recommended** for clinical staff working in Mental Health and OS&PSR programs or those who want a deeper dive into recovery-oriented practices: Mental Health Recovery: How to Transform Principles into Practice (TMS VA 33942).

## 11. DEFINITIONS

a. **Administrative Supervision.** For the purposes of this directive, administrative supervision is assigning and evaluating the work of subordinate staff; resolving complex problems to ensure Veteran needs are met; evaluating performance and taking

disciplinary action when necessary. The supervisor has full administrative and professional responsibility for planning and directing the work of others.

b. **Community Inclusion.** Community inclusion refers to active efforts made by communities to welcome people with differences into society and enable full participation and interaction with community members. Community inclusion is closely tied to community integration but expands the focus to communities that foster a sense of belonging for all individuals. Community inclusion with reference to PRRC is cultivated through partnership, education, and advocacy among Veterans, PRRCs, VA medical facilities, and community members. Additional information and resources on community inclusion can be found on the [Temple University Collaborative on Community Inclusion website](#).

c. **Community Institutionalization.** Community institutionalization is linkages or PRRC activities that are led or facilitated by PRRC staff in an ongoing manner that do not foster an individual's ability to transition to self-directed, independent participation in the larger community using natural opportunities and supports. Examples of community institutionalization include program-based Tai Chi, Arts Workshops, newsletters, or bowling groups, without a clear path to transferring involvement to similar activities in the community.

d. **Community Integration.** Community integration is the opportunity to live in the community and to be valued for one's uniqueness and abilities, like everyone else. These include opportunities for participating in meaningful, socially valued roles (e.g., volunteer, employee, friend, student, family member, parent, religious community participant, athlete, hobbyist) within the Veteran's communities of choice. It does not include participation that occurs as a patient within a VA mental health program (e.g., PRRC, Compensated Work Therapy (CWT)) or any other authorized VA health care program or therapy. While community integration programs are important and valuable components of mental health rehabilitation and treatment, community integration is maximized when the participation that results is:

(1) Self-directed and individualized (e.g., not necessarily group-based unless proactively desired by the person) rather than staff-directed.

(2) Occurs in the community rather than on-station.

(3) Promotes opportunities for interactions with people who do not necessarily experience mental health issues versus a VA group outing into the community that limits opportunities to interact with others. **NOTE:** *Additional information and resources on community integration can be found on the [Temple University Collaborative on Community Inclusion website](#).*

e. **Coordinated Specialty Care.** CSC is a team-based, recovery-oriented approach to providing treatment to individuals with first episode psychosis. The team provides, as warranted, the following services: medication management, psychotherapy, case management, VHA Voc Rehab, individual resiliency training, and family education and

support. For additional information, see the [National Institute of Mental Health Recovery After an Initial Schizophrenia Episode \(RAISE\) website](#).

f. **Dual Relationships**. Dual relationships are relationships in which VA staff concurrently participate in two or more role categories with a Veteran. Similarly, a dual relationship can occur between two VA employees. Such dual relationships may be benign (as when both are members of the same social group) or exploitive (e.g., a sexual relationship), but all dual relationships have the potential to cause harm and violate the necessary boundaries between employees or between an employee and a Veteran receiving VA services, which may have ethical and legal implications.

g. **Early Psychosis**. For the purposes of this directive, early psychosis is the period lasting for 4 years after the first appearance of primary psychotic symptoms, regardless of the age of onset. ***NOTE: Given the difficulty of determining retrospectively whether a first episode of psychosis has resolved, the term “early psychosis” is used in this directive to allow for more uniformity in defining the target population.***

h. **First Episode Psychosis**. First episode psychosis is the period from the first appearance of primary psychotic symptoms until significant symptomatic remission is achieved. A first episode of psychosis is one in which no other period of psychotic symptoms appeared in one’s past and resolved.

i. **Local Treating VA Medical Facility**. The local treating VA medical facility is the most recent VA medical facility where a Veteran in the target population received inpatient or outpatient mental health care.

j. **Lost to Follow-Up Care**. Lost to follow-up care refers to any living Veteran in the target population who received any outpatient or inpatient care within VHA in the past 13 to 24 months but has not received treatment services within the past 12 months (i.e., no outpatient visits or no inpatient stay longer than 2 days).

k. **Natural Supports**. Natural supports are supports provided to an employee with a disability from their supervisors and co-workers, such as mentoring, providing feedback on job performance, or learning a new skill together.

l. **Peer**. For the purposes of this directive, a peer is a Veteran who has had similar life experiences in terms of illnesses, life events, treatments for mental illnesses, SUD, or other health conditions as other Veterans being served.

m. **Points of Service**. Points of service within the VA health care system are distinct places, usually defined by an address or a continuous range of addresses, that identify the physical location where a Veteran interacts with VA health care providers, which are sufficiently distinct that they can be geocoded and mapped for the purposes of calculating drive times, mileage, and access standards. ***NOTE: For further information, see VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.***

n. **Psychosocial Rehabilitation.** Psychosocial rehabilitation in VA is equivalent to psychiatric rehabilitation, which is the promotion of recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. (See, e.g., the [Psychiatric Rehabilitation Association website](#).) Psychosocial rehabilitation services are collaborative, person-directed, individualized, evidence-based, and an essential element of any health care system.

o. **Re-Engaging Veterans.** For the purposes of this directive, re-engaging Veterans includes contacting Veterans who have been lost to follow-up care; determining their need for mental health, medical, and psychosocial services; facilitating new appointments for those Veterans who need continued treatment; and following up to determine that the Veteran attended the appointment.

p. **Recovery.** Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The Substance Abuse and Mental Health Services Administration (SAMHSA) has delineated four major dimensions to support a life in recovery:

(1) **Health.** Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.

(2) **Home.** A stable and safe place to live.

(3) **Purpose.** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.

(4) **Community.** Relationships and social networks that provide support, friendship, love, and hope. **NOTE:** For further information, see [SAMHSA's Recovery and Recovery Support website](#).

q. **Recovery-Oriented Care.** Recovery-oriented care is personalized care provided to meet the Veterans' needs and to promote hope and encouragement to Veterans. Recovery-oriented care is strengths-based, focuses on Veterans' self-chosen goals and preferences, and is founded in shared decision making.

r. **Serious Mental Illness.** For the purposes of this directive, SMI is a mental, behavioral, or emotional disorder (excluding cognitive and developmental disorders and disorders due to a general medical condition) listed in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that meets all the following criteria. **NOTE:** For further information, see SAMHSA's working definition of SMI, located on [SAMHSA's Managing Life with SMI website](#).

(1) Single unremitting episode of symptoms or with frequently recurring or prolonged episodes of symptoms.

(2) Symptoms result in impairments in mood, thinking, family or other interpersonal relationships, behavior (often resulting in socio-legal consequences) or self-care, which substantially interfere with or limit major life activities.

(3) The impact of these symptoms results in a significant functional impairment using any valid and reliable measure which has norms for a Veteran population.

s. **Shared Caseload.** Shared caseload is a concept that emphasizes the health care team as a whole being responsible for consumers receiving the care they need.

t. **Shared Decision Making.** Shared decision making is a formal communication process for consensus building between a health care provider and patient when multiple evidence-based treatment alternatives exist to treat the patient's condition or problem. The provider and patient jointly participate in the process to arrive at a clinical decision or treatment plan. SDM requires three components: 1) clear, accurate and unbiased medical evidence about reasonable alternatives, including no intervention and the risk and benefits of each; 2) clinician expertise in communicating and tailoring the evidence for individual patients and 3) patient values, goals, informed preferences and concerns, which may include treatment burden. This communication process facilitates Veterans and clinicians working together to make optimal health care decisions that align with what matters most to Veterans. This is a vital component to recovery-oriented care.

u. **Technical Supervision.** For the purposes of this directive, technical supervision is supervisory review to improve the peer support staff's work with Veterans; ensure Veteran welfare; support staff in relation to their work and support their professional development. This includes overseeing subordinate peer support staff's documentation in the electronic health record and supervising an individual as they work towards obtaining peer specialist certification.

v. **Wellness Programming.** Wellness programming is educational programming composed of psychoeducational interventions that teach skills necessary to acquire an active and healthy lifestyle in the community.

## 12. 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.

## 13. REFERENCES

a. P.L. 110-387 § 405.

b. 38 U.S.C. §§ 101, 111A, 1718, 2031, 7301(b), 7402(b)(13).

- c. 5 C.F.R. § 2635.101(b).
- d. 38 C.F.R. § 17.38.
- e. [Executive Order 13263, President's New Freedom Commission on Mental Health](#), dated April 2002.
- f. [Executive Order 13625, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families](#), dated August 31, 2012.
- g. VHA Directive 1004.03(1), Advance Care Planning, dated December 12, 2023.
- h. VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024.
- i. VHA Directive 1030(2), VHA Integrity and Compliance Program, dated December 29, 2020.
- j. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- k. VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.
- l. VHA Directive 1160.01, Uniform Mental Health Services in VHA Points of Service, dated April 27, 2023.
- m. VHA Directive 1160.04, VHA Programs for Veterans with Substance Use Disorders, dated December 8, 2022.
- n. VHA Directive 1160.05, Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions, dated June 2, 2021.
- o. VHA Directive 1160.06, Inpatient Mental Health Services, dated September 27, 2023.
- p. VHA Directive 1160.13, Vocational Rehabilitation Services, dated August 14, 2025.
- q. VHA Directive 1199, Reporting Cases of Abuse and Neglect, dated September 3, 2024.
- r. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.
- s. VHA Directive 1400.04(1), Supervision of Associated Health Trainees, dated March 19, 2015.
- t. VHA Directive 1501, VHA Homeless Programs, dated October 21, 2016.

u. U.S. Department of Veterans Affairs. [Office of Academic Affiliations Advanced Fellowships & Professional Development website](#).

v. U.S. Department of Veterans Affairs. [Office of Construction & Facilities Management Mental Health Outpatient Services Design Guide](#).

w. U.S. Department of Veterans Affairs. [My Recovery Plan website](#).

x. U.S. Department of Veterans Affairs. [National Center for Health Promotion and Disease Prevention \(NCP\) website](#).

y. VHA Intranet: [EPIC Policy Support Page](#). **NOTE:** This is an internal VA website that is not available to the public.

z. VHA Intranet: [EPIC SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

aa. VHA Intranet: [ICMHR Policy Support Page](#). **NOTE:** This is an internal VA website that is not available to the public.

bb. VHA Intranet: [LRC Policy Support Page](#). **NOTE:** This is an internal VA website that is not available to the public.

cc. VHA Intranet: [Mental Health Business Operations SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

a. VHA Intranet: [NEPEC Dashboard](#). **NOTE:** This is an internal VA website that is not available to the public.

b. VHA Intranet: [OMH Official Policy Waivers SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

c. VHA Intranet: [OMH Policy Support Pages](#). **NOTE:** This is an internal VA website that is not available to the public.

d. VHA Intranet: [Office of Quality and Patient Safety External Accreditation website](#). **NOTE:** This is an internal VA website that is not available to the public.

e. VHA Intranet: [Peer Support Services SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

f. VHA Intranet: [PRRC Policy Support Page](#). **NOTE:** This is an internal VA website that is not available to the public.

g. VHA Intranet: [PRRC SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

h. VHA Intranet: [SMI Re-Engage SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

- i. VHA Intranet: [VA Fleet Management SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*
- j. VHA Intranet: [Workplace Violence Prevention Program SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*
- k. National Institute of Mental Health. [National Institute of Mental Health RAISE website](#).
- l. Substance Abuse and Mental Health Services Administration. [SAMHSA Managing Life with SMI website](#).
- m. Substance Abuse and Mental Health Services Administration. [SAMHSA Recovery and Recovery Support website](#).
- n. Bowersox NW, Smith CM, Austin K, Bradford DW, Browne J, Nelson SM, Szymanski BR, Glynn SM. Mortality and suicidality in Veterans Health Administration patients with newly-identified early episode psychosis. Schizophrenia Research. 2024 Feb 1;264:362-9. <https://pubmed.ncbi.nlm.nih.gov/38219412/>.
- o. [Psychiatric Rehabilitation Association website](#).
- p. [Temple University Collaborative on Community Inclusion website](#).

## PEER SPECIALIST PROFESSION REQUIREMENTS

### 1. PEER SUPPORT STAFF POSITIONS

a. All Veterans Health Administration (VHA) peer support staff must meet the definition of Veteran in 38 U.S.C. § 101(2). The 38 U.S.C. § 101(2) definition of Veteran is not a basis for determining Veterans' preference for those found qualified. They must have at least 1 year of recovery from a mental health condition (mental illness and or substance use disorder (SUD)) and have resided outside of an inpatient or residential treatment setting for at least 1 year. Successful recovery is exemplified by one who manages symptoms of illness and pursues a healthy lifestyle; lives independently; is employed or volunteers significant time approximating at least a part-time employment schedule; has meaningful relationships with family members and friends; and is socially involved in the community through clubs, hobby groups, religious communities, civic organizations, or Veteran organizations in which the individual provides a service to others.

b. Only full, current, and unrestricted peer specialist certifications from a state-issued agency or a VHA-contracted not-for-profit peer specialist certification training vendor are accepted to meet the peer specialist certification requirement for peer support staff positions. The peer specialist certifications VHA accepts are listed in the VHA-Approved Peer Specialist Certifications Guide that can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal Department of Veterans Affairs (VA) website that is not available to the public.*

c. Specialized experience for each General Schedule (GS) level and other qualification requirements as well as guidance on hiring and promoting peer support staff can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

d. For the purposes of this directive, the peer support staff designation includes all peer support apprentices, peer specialists, lead peer specialists, supervisory peer specialists, without compensation (WOC) peer support employees, and peer support technicians. **NOTE:** *Peer specialists are members of a profession, not a single program. It is a mental health care profession that can be integrated into interdisciplinary teams in multiple settings.*

(1) **Peer Support Apprentice.** A GS-5 peer support apprentice is a 1-year, time-limited appointment for a peer support staff member who is new to the peer specialist profession and does not yet have the required peer specialist certification or the specialized experience to qualify for a peer specialist position. A peer support apprentice is required to obtain their VHA-approved full, current, and unrestricted peer specialist certification from a state-issued agency or a VHA-contracted not-for-profit peer specialist certification training vendor before the end of their 1-year time-limited

appointment. The duties of a GS-5 peer support apprentice are specified in the VHA nationally standardized position description/functional statement.

(2) **Peer Specialist.** In VHA, a peer specialist assists Veterans who are receiving health care services by serving as a recovery role model. The peer specialist engenders hope, models recovery, and teaches advocacy skills among other valuable psychosocial rehabilitation and wellness self-management practices. Peer specialists are GS-6, GS-7, GS-8, or GS-9 employees, with GS-9 being the full performance level that all peer specialists are expected to achieve. The duties of GS-6, GS-7, GS-8, and GS-9 peer specialists are specified in the VHA nationally standardized position descriptions/functional statements.

(a) A peer specialist is required to have obtained a full, current, and unrestricted peer specialist certification before hiring. Candidates with a provisional (temporary) state-issued peer specialist certification can be hired as a GS-5 peer support apprentice. Additional qualification requirements for each peer specialist GS level can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(b) All peer specialists are required to keep their peer specialist certification active as a condition for their continuing employment in the peer specialist occupation in VHA. Failure to maintain the peer specialist certification as required will result in immediate removal from patient care activities as a peer specialist and may result in termination of employment.

(3) **Lead Peer Specialist.** A GS-10 lead peer specialist leads a team of peer support staff and facilitates, coordinates, coaches, and problem solves with members of the peer support staff team. The lead peer specialist also acts as the recognized liaison to and from the peer support staff team and the supervisor. The duties for a lead peer specialist are specified in the VHA nationally standardized position description/functional statement.

(a) A lead peer specialist is required to have obtained a full, current, and unrestricted peer specialist certification before hiring. Additional qualification requirements for the lead peer specialist position can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(b) All lead peer specialists are required to keep their peer specialist certification active as a condition for their continuing employment in the peer specialist occupation in VHA. Failure to maintain the peer specialist certification as required will result in immediate removal from patient care activities as a lead peer specialist and may result in termination of employment.

(4) **Supervisory Peer Specialist.** A GS-11 supervisory peer specialist is a leadership position within the VHA peer specialist profession. As the supervisor of a team of paid peer support staff, the supervisory peer specialist ensures that peer

support services are delivered to Veterans in an effective manner and coordinated with other treatment services as part of holistic, recovery-oriented, best health care practices. The work of the position ensures that local and national VHA policies and procedures are properly employed, which enables the peer support staff team to deliver improved quality, quantity, and timely services to Veterans. The duties of a supervisory peer specialist are specified in the VHA nationally standardized position description/functional statement.

(a) A supervisory peer specialist is required to have obtained a full, current, and unrestricted peer specialist certification before hiring. Additional qualification requirements for the supervisory peer specialist position can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

(b) All supervisory peer specialists are required to keep their peer specialist certification active as a condition for their continuing employment in the peer specialist occupation in VHA. Failure to maintain the peer specialist certification as required will result in immediate removal from patient care activities as a supervisory peer specialist and may result in termination of employment.

(5) **Without Compensation Peer Support Employee.** Peer support services may be provided by Veterans who wish to work as peer specialists without being paid for their services. These Veterans must go through the formal WOC registration and orientation process, and they are required to obtain and maintain a VHA-approved peer specialist certification. WOC peer support employees are volunteers. They do not receive payment or compensation for their services.

(6) **Peer Support Technician.** Peer support technician is a term that was a human resources (HR) job classification for peer support staff that was in effect before the peer specialist job classification was developed in 2012 in association with 38 U.S.C. § 7402(b)(13). In the previous job classification, peer support technicians were often non-Veterans. The peer support technician job series is no longer used to hire peer support staff in VHA. Any remaining peer support technicians on staff must abide by all policies pertaining to peer support staff and peer support services.

## 2. RECRUITMENT

a. Any VHA program that hires peer support staff using one of the official position descriptions/functional statements for “peer support apprentice,” “peer specialist,” “lead peer specialist,” or “supervisory peer specialist” must abide by this directive, including Appendix A. Peer support staff must have VHA nationally standardized position descriptions or functional statements. These position descriptions meet the legislative mandates written in P.L. 110-387 § 405. VA medical facilities hiring peer support apprentices, peer specialists, lead peer specialists, or supervisory peer specialists must use the VHA nationally standardized position description/functional statement for the position. **NOTE:** *The official position descriptions/functional statements along with other*

hiring guidance can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.

b. VHA's Office of Mental Health (OMH) no longer supports hiring of peer support technicians and requires facilities to use the peer specialist classification when hiring peer support staff.

c. Veterans who meet the statutory requirements to be peer support apprentices, peer specialists, lead peer specialists, or supervisory peer specialists are the only eligible candidates to be recruited for these paid positions. WOC peer support employees must also meet statutory requirements.

d. The peer specialist classification, defined by legislation, allows interviewers to ask specific questions about one's personal experience of recovery from a mental illness or SUD. However, the legislation did not change the prohibitions on asking candidates to share their diagnosis or treatment regimens concerning their care.

e. OMH and VHA Workforce Management and Consulting have developed Structured Oral Interview (SOI) Guides that are utilized for all peer support staff positions. These guides incorporate all the legal and HR requirements that pertain to peer support staff positions and contains approved interview questions that must be used for interviewing and hiring peer support staff. The SOI guides can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

f. Local VA medical facility program managers may conduct interviews by adding questions to the existing SOI Guides, if every candidate applying for the specific position is asked the same questions.

### 3. APPOINTMENTS AND PROMOTIONS

Hiring managers and supervisors must work with their local VA medical facility's HR office to determine the best recruitment strategy. They must discuss the use and benefits of various hiring authorities and appointments, as well as strategies and requirements for transitioning peer support apprentices to peer specialist positions and GS-6, GS-7, and GS-8 peer specialists to higher grades until the staff reaches the target GS-9 peer specialist full performance level. For additional information about qualification requirements for hiring and grade promotions for peer support staff, please refer to guidance in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

### 4. PEER SUPPORT STAFF SCOPE OF PRACTICE

a. Peer support staff provide peer support services to Veterans. They also provide outreach services that focus on educating Veterans about available VA and community

services and resources. They support Veterans' connection to those services and resources when needed. The scope of practice for peer support staff includes:

(1) Providing recovery-oriented services by sharing their personal recovery stories and using psychosocial rehabilitation tools and interventions in individual and group-based meetings to support Veterans' goals. **NOTE:** *Examples of psychosocial rehabilitation tools and wellness interventions that peer support staff use include but are not limited to Wellness Recovery Action Plan (WRAP), My Recovery Plan, Personal Health Inventory, Introduction to Whole Health, Taking Care of My Life and Health, Illness Management Recovery (IMR), Honest Open Proud (HOP), Veteran X Model Programs, Social Skills Training, and Veterans Outreach Into the Community to Expand Social Support (VOICES) Veterans Socials.*

(2) Instilling hope by providing opportunities for Veterans to observe peer support staff who are further along in their recovery and participating in positive, productive roles of their choosing.

(3) Educating Veterans by role modeling successful management of health conditions and demonstrating the ability to function independently within their environment.

(4) Teaching Veterans skills to advocate for themselves both in and outside of the VA health care system. Examples of advocacy skills include self-assertiveness and tactfulness.

(5) Advocating to reduce stigma associated with mental illnesses and other health conditions.

(6) Educating VHA-enrolled and non-enrolled Veterans about available VA and community services and resources and supporting Veterans to connect with those services and resources if needed.

b. The parameters of peer support staff's work in the following areas are defined as:

(1) Peer support staff are part of interdisciplinary teams that provide health care services for Veterans. Peer support staff do not serve as the primary or only health care professional for treatment planning, provision of health care services, or discharge planning with Veterans. The services provided by peer support staff to Veterans are a part of the overall health care services that the Veteran receives from their treatment team.

(2) If a VA medical facility's Facility Consult Management Steering Committee grants the needed consult privileges, peer support staff can place and respond to consults about peer support services. Peer support staff do not place nor respond to consults about clinical services or equipment. If a Veteran asks a peer support staff member for assistance with accessing a clinical service or equipment, the peer support staff member collaborates with the Veteran's clinical treatment provider(s) to have a consult submitted for the clinical service requested.

(3) At VA medical facilities, peer support staff do not serve as the lead author of a Veteran's treatment plan in the Veteran's electronic health record (EHR). Peer support staff add the peer support service goal(s) to a Veteran's existing treatment plan in the EHR. Peer support staff working in the Veterans Crisis Line (VCL) Peer Support Outreach Center (PSOC) document Veteran contact and goals.

(4) Peer support staff do not complete any clinical reminders.

(5) Peer support staff administer the Columbia Suicide Severity Rating Scale (C-SSRS) Screener when there is a concern about a Veteran based upon the Veteran's words or actions during their interaction. Peer support staff do not complete the routine annual clinical reminder for the C-SSRS Screener. Further guidance about peer support staff's role with the C-SSRS Screener can be found in the [Frequently Asked Questions \(FAQ\) section](#) of the [VHA Peer Support Services SharePoint](#). **NOTE:** *These are internal VA websites that are not available to the public.*

(6) Peer support staff do not gather clinical history information from Veterans that would be used to diagnose a Veteran or determine the severity of a current health condition. Peer support staff do not administer nor interpret results of clinical assessment tools such as those used in measurement-based care.

(7) Peer support staff do not diagnose Veterans, but they do add a Veteran's diagnosis of record in their documentation as part of the encounter. Further guidance about adding the diagnosis of record to peer support staff's encounters can be found in the Mental Health Coding Guide found on the [Mental Health Business Operations SharePoint](#). **NOTE:** *This is an internal VA website not available to the public.*

(8) Peer support staff do not serve as case managers. They collaborate with other members of a Veteran's interdisciplinary treatment team to support the Veteran in connecting with services and resources. For further clarification, please refer to the definition of case management in VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019, as well as the [FAQ about peer support staff's scope of practice](#) that is located in the FAQ section on the [VHA Peer Support Services SharePoint](#). **NOTE:** *These are internal VA websites that are not available to the public.*

(9) Peer support staff do not provide clinical counseling, nor do they facilitate evidence-based psychotherapy protocols for Veterans (e.g., cognitive behavioral therapy, cognitive processing therapy, motivational enhancement therapy, prolonged exposure). Correspondingly, VHA does not refer to peer support staff's work as "peer counseling." Peer support staff can collaborate with clinicians to support Veterans' engagement and retention in clinical treatments (e.g., sharing examples from the peer support staff member's personal experiences of overcoming challenges with engaging in a clinical treatment service such as an evidence-based psychotherapy). For further guidance about how peer specialists can support Veterans' engagement and retention in clinical treatments, please refer to the [FAQ about peer support staff's scope of](#)

[practice](#) that is located in the FAQ section on the [VHA Peer Support Services SharePoint](#). **NOTE:** *These are internal VA websites that are not available to the public.*

(10) With appropriate training, peer support staff can facilitate evidence-based psychosocial interventions such as motivational interviewing, social skills training, and problem solving training among others discussed in VHA Directive 1160.05, Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions, dated June 2, 2021. For details on training, see Appendix A, paragraph 7 below.

(11) Peer support staff do not participate in therapeutic containment activities when those types of activities are needed with Veterans.

(12) Peer support staff do not make the required outreach calls for the Serious Mental Illness (SMI) Re-engage program. Peer support staff can participate in outreach calls where the purpose is to educate Veterans about available VHA services and resources and support Veterans connecting with the VHA services and resources if needed.

(13) Peer support staff are mandated reporters, and they are expected to report allegations of abuse and neglect of protected populations (e.g., children, older adults). If there is an instance where a mandated report is needed, the peer support staff must work with their supervisor and follow the local VA medical facility's procedures for making the mandated report to the appropriate state office. The peer support staff must then follow the VA medical facility's procedures for documenting that the mandated report occurred. See VHA Directive 1199, Reporting Cases of Abuse and Neglect, dated September 3, 2024. Peer specialists working in the VCL PSOC are required to follow VCL PSOC standard operating procedures related to reporting and disclosures.

(14) Peer support staff are required to comply with VHA policies and procedures that apply to all VHA employees, including confidentiality, documentation, and dual relationships. Such information is provided in mandatory new employee orientation, annual mandatory training, and supervisory guidance pertaining to VHA culture and policies.

(15) Peer support staff must use their official VHA job title (i.e., "peer support apprentice," "peer specialist," "lead peer specialist," "supervisory peer specialist") in their verbal and written communications with others, including in their Outlook address and email signature block.

(16) All peer support staff must demonstrate VHA's competencies expected for peer support staff to provide peer support services. **NOTE:** *The specific domains of competence that must be demonstrated are found in the Human Resources section on the [VHA Peer Support Services SharePoint](#). This is an internal VA website not available to the public.*

(17) Peer support staff are required to maintain these competencies and their peer specialist certification through ongoing continuing education (CE). VHA requires a

minimum of 12 hours of CE directly related to the work of peer specialists every year, where 1 hour of CE must be in the domain of ethics relevant to the work of peer specialists and 1 hour of CE must be on the topic of providing peer support services to Veterans who have experienced military sexual trauma. Peer specialists with state-issued peer specialist certifications must also comply with their state's requirements for maintaining their state-issued peer specialist certification over time. Failure to maintain a full, current, and unrestricted status for the peer specialist certification over time will result in immediate removal from patient care activities as a peer specialist and may result in termination of employment. It is the discretion of the local facility to decide whether a grace period may be given for the peer specialist to reobtain the required peer specialist certification or if the peer specialist will be terminated.

(18) VA medical facility peer support staff must join the Veterans Integrated Service Network (VISN) mail group for peer support staff that the VISN Peer Support Points of Contact (POCs) maintain to ensure that peer support staff receive all messages that the VISN Peer Support POCs and the OMH Peer Support Services Section disseminate regarding national policies and upcoming ad hoc training opportunities. VA medical facility peer support staff should participate in monthly VISN conference calls for peer support staff and peer support supervisors that are facilitated by the VISN Peer Support POCs. Peer support staff working within the VCL PSOC have a PSOC-specific mail group and PSOC communication mechanism for obtaining relevant national policy and training information.

## 5. SUPERVISION OF PAID AND WITHOUT COMPENSATION PEER SUPPORT STAFF

Supervision is required for all paid and WOC peer support staff. Supervision must be consistent with the following guidelines.

a. **Supervisor Qualifications.** Technical supervision of the peer support staff member's work with Veterans in a program must be provided by a licensed independent provider (LIP) or other appropriately credentialed health care professional (e.g., supervisory peer specialist, physician assistant, rehabilitation counselor). Supervisory peer specialists can serve as the expected co-signer of EHR documentation for paid peer support staff and WOC peer support employees who they are supervising.

b. **Supervisor Roles and Responsibilities.**

(1) Supervisors of paid and WOC peer support staff are responsible for:

(a) Ensuring compliance with position qualifications and experience requirements for all peer support staff under their supervision.

(b) Using the VHA nationally standardized position descriptions/functional statements and complying with all HR policies for recruiting peer support staff. **NOTE:** *The nationally standardized peer support staff position descriptions/functional statements and HR policy guidance for hiring and promoting peer support staff can be*

found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.

(c) Conducting interviews using the SOI for Peer Support Staff Guides provided by OMH, which ensures questions that address the mental health recovery experience aspect of the job qualifications are asked in a legal and tactful manner. **NOTE:** *Only employees who supervise peer support staff and are members of the national mail group for peer support supervisors ([vhaomhpeersupervisors@va.gov](mailto:vhaomhpeersupervisors@va.gov)) can access the SOI for Peer Support Staff Guides. The SOI for Peer Support Staff Guides are located in the Human Resources section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.*

(d) Ensuring discussion of peer specialist certification requirements occurs during the onboarding process and that the related Condition of Employment form is signed by the peer support staff member. **NOTE:** *The Condition of Employment form must be kept in the peer support staff member's employment file. Condition of Employment forms are located in the Human Resources section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.*

(e) Within 1 month of the peer support apprentice's selection date, notifying the National Director of Peer Support Services and the Institute for Learning, Education, and Development (ILEAD) representative to initiate the process for obtaining the required full, current, and unrestricted peer specialist certification from the VHA-contracted not-for-profit peer specialist certification training vendor. **NOTE:** *The peer specialist certifications that VHA accepts are listed in the VHA-Approved Peer Specialist Certifications Guide which is located in the Human Resources section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.*

(f) Assisting peer support apprentices as needed to obtain travel funding from the VA medical facility and make the appropriate arrangements needed for the peer support apprentice to travel to the required in-person portion of the VHA-contracted peer specialist certification training course. **NOTE:** *The VHA-contracted peer specialist certification training course is delivered with a combination of in-person and virtual training components. While OMH funds the registration for the VHA-contracted peer specialist certification training course, the VA medical facility where the peer support apprentice is employed is responsible for funding the travel cost involved with participating in the in-person portion of the course.*

(g) Ensuring that the peer support apprentice has adequate time dedicated solely to the completion of the virtual components of the peer specialist certification training course during the peer support apprentice's work schedule, or make appropriate arrangements if training is required outside the peer support apprentice's work schedule.

(h) Ensuring that all documentation, including all documentation entered by peer support staff, meets standards found in the local setting's (VA medical facility or VCL

PSOC) established business rules and co-signing peer support staff's documentation in the approved record where a co-signature is required. **NOTE: Documentation by VA medical facility peer support staff must be completed according to the most current documentation guidance provided in the [Mental Health Coding Guidance SharePoint](#). This is an internal VA website that is not available to the public.** Refer below to Appendix A, paragraph 8, Documentation Requirements, for specific requirements for co-signature of documentation.

(i) Ensuring that paid peer support staff and WOC peer support employees are operating within their scope of practice and position description/functional statement (see Appendix A, paragraph 4).

(j) Ensuring high-quality performance and conduct of peer support staff.

(k) Providing technical supervision for peer support staff focused on the peer support services delivered by peer support staff to Veterans receiving health care services in VHA.

1. Technical supervision must be delivered in face-to-face individual supervision for a minimum of 1 hour per week for each GS-5 peer support apprentice and GS-6 peer specialist for 1 year. The assigned supervisor must work on station with the peer support apprentices and GS-6 peer specialists.

2. At VA medical facilities, technical supervision must be delivered in face-to-face individual supervision for a minimum of 1 hour per week for peer support technicians, GS-7/8/9 peer specialists, GS-10 lead peer specialists, and GS-11 supervisory peer specialists during their first year of entry into the peer specialist occupation in VHA and thereafter until the peer support staff member demonstrates the need for less frequent supervision based upon their experience and competencies.

3. At VA medical facilities, after their first year of entry in the peer specialist occupation in VHA, at a minimum, technical supervision for the work of peer support technicians and peer specialists at the GS-7 level or above must be delivered in individual supervision meetings via in-person face-to-face or video technologies no less than 1 hour per month.

4. Due to the VCL PSOC being a virtual national program, all individual supervision meetings with the PSOC peer support staff are conducted via use of video technologies.

5. Group supervision, while encouraged as an additional resource for consultation and learning, does not substitute for the individual supervision requirement.

6. At VA medical facilities, in addition to the supervision meeting requirement, there must be an identified LIP or other appropriately credentialed health care professional (e.g., supervisory peer specialist, physician assistant, rehabilitation counselor) who is available on-station for consultation when needed during the work

hours of peer support staff. In the VCL PSOC, clinical program coordinators and VCL call responders are available for the PSOC peer support staff to consult when needed.

7. Technical supervision is distinct from administrative supervision. Providing administrative supervision includes overseeing work schedules, leave requests, and performance appraisals for peer support staff. Administrative supervision can be provided by the same supervisor who provides the technical supervision of the peer support staff member's work, or the administrative supervision can be provided by a different staff member who meets the requirements to serve as a supervisor of peer support staff.

(l) Monitoring peer support staff's attendance at team meetings and communicating instructions on how to provide feedback to other team members during supervisory meetings to ensure that peer support staff function as full members of the interdisciplinary team and are fully integrated in all health care services and planning activities.

(m) Providing and supporting ongoing education and training for peer support staff to obtain and maintain their peer specialist certification and meet annual CE requirements discussed below in Appendix A, paragraph 7.

(n) Developing and communicating performance standards for all paid peer support staff at the beginning of the rating period, verifying that all paid peer support staff meet required competencies, and developing performance plans including relevant training when necessary.

(o) Consulting with the local VA medical facility's HR office when peer support staff performance issues arise and as a means of becoming knowledgeable about reasonable accommodation and its applications.

(p) Participating in monthly VISN calls for VA medical facility peer support supervisors and peer support staff that are facilitated by the VISN Peer Support POCs to learn about relevant national policies, ad hoc training opportunities for peer support supervisors and peer support staff, and other national guidance. In the VCL PSOC, the supervisors have a PSOC-specific mail group and PSOC communication mechanisms for obtaining relevant national policy guidance and training information.

(2) In addition to all of the above supervisory roles and responsibilities for all peer support staff, supervisors of WOC peer support employees are responsible for:

(a) Following all local VA medical facility procedures pertaining to WOC peer support employees.

(b) Verifying that all Veterans appointed as WOC peer support employees have obtained their full, current, and unrestricted peer specialist certification from a VHA-approved peer specialist certification body prior to their WOC appointment. **NOTE:** *The peer specialist certifications that VHA accepts are listed in the VHA-Approved Peer Specialist Certifications Guide that can be found in the Human Resources section of the*

[VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.

(c) Developing written position descriptions for WOC peer support employees using the peer specialist position descriptions as a model but modifying as necessary to fit the job as developed for a WOC peer support employee.

(d) Establishing a work schedule with the WOC peer support employee that fits the needs of the Veterans in the program(s) served.

(e) Orienting the WOC peer support employee to their assigned program and to all relevant VHA policies.

(f) Ensuring that local VA medical facility business rules governing the use of the EHR (e.g., coding, clinics, encounters) are in compliance with guidance provided in the [Mental Health Coding SharePoint](#). **NOTE:** This is an internal VA website that is not available to the public.

(g) Ensuring that WOC peer support employees can obtain a personal identity verification (PIV) card and have access to a work computer and needed supplies and resources to perform their duties.

(h) Ensuring that WOC peer support employees can make entries in the EHR, and that all documentation entered by WOC peer support employees meets standards and is completed according to the local VA medical facility's established requirements. **NOTE:** All documentation written by WOC peer support employees must be co-signed by an appropriately credentialed health care professional (e.g., LIP, supervisory peer specialist, physician assistant, rehabilitation counselor) who is directly supervising the WOC peer support employee.

(i) Providing face-to-face individual technical supervision for the WOC peer support employee's work for a minimum of two times per month during the first year. After their first year, technical supervision for the work of WOC peer support employees must be delivered in face-to-face individual supervision meetings no less than 1 hour per month.

(j) Group supervision, while encouraged as an additional resource for consultation and learning, does not substitute for the individual supervision requirement.

1. Technical supervision is distinct from administrative supervision. Administrative supervision includes overseeing work schedules, leave requests, and performance reviews for WOC peer support employees.

2. Administrative supervision can be provided by the same supervisor who provides the technical supervision of the WOC peer support employee's work, or the administrative supervision can be provided by a different staff member who meets the requirements to serve as a supervisor of peer support staff.

(k) Providing and supporting ongoing education and training. WOC peer support employees must meet the same requirements that peer specialists, lead peer specialists, and supervisory peer specialists must meet for the maintenance of the VHA-approved peer specialist certification and annual CE. Details about the CE requirements are discussed in this Appendix below in paragraph 7.d.

(l) Developing and communicating performance standards for WOC peer support employees at the beginning of their assignment, verifying that they meet required competencies, and developing appropriate performance plans to include relevant training when necessary.

## 6. WORK PERFORMANCE STANDARDS AND COMPETENCIES

All VHA peer support staff, including WOC peer support employees, must adhere to the same regulations as all other VHA employees, including performance standards, ethics, and competencies.

a. All peer support staff must demonstrate the required peer support staff competencies. Sustained competency must be demonstrated annually through participation in a minimum of 12 hours of CE directly relevant to the work of peer specialists. **NOTE:** *Competencies can be found in the Human Resources section of the [VHA Peer Support Services SharePoint](#). This is an internal VA website that is not available to the public.*

b. Supervisors must develop performance plans with all peer support staff and conduct semi-annual performance evaluations.

c. WOC peer support employees must have position descriptions, and their supervisors must document assessment of their competencies prior to appointment as a WOC peer support employee and annually thereafter in the WOC HR file for the employee. The documentation is held by HR. VA medical facilities utilizing WOC peer support employees to provide peer support services must follow the same guidelines for the WOC peer support employees as for paid peer support staff regarding training, peer specialist certification, and supervision requirements.

## 7. PEER SUPPORT STAFF CERTIFICATION AND CONTINUING EDUCATION REQUIREMENTS

a. Peer support staff must complete all mandatory training required for all VA employees.

b. Peer support staff must complete all program-specific trainings that are required for the program setting where they are assigned to work.

c. All WOC peer support employees and paid certified peer support staff are required to maintain a full, current, and unrestricted VHA-approved peer specialist certification throughout the duration of their employment in the peer specialist profession in VHA. For state-certified peer specialists, this means that they must also

comply with their state's requirements to keep their full, current, and unrestricted state-issued peer specialist certification current over time. Failure to maintain the peer specialist certification will result in immediate removal from patient care activities as a peer specialist and possible termination of their employment. The list of VHA-approved peer specialist certifications and requirements for maintaining those certifications can be found in the VHA-Approved Peer Specialist Certifications Guide that is located in the Human Resources section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

d. Peer support staff who obtained a state-issued peer specialist certification that has state-specific CE requirements or requires renewal for the certification must attain the necessary CE required by that state and meet the state's other requirements to become recertified and maintain their peer specialist certification over time. This is in addition to meeting VHA's annual CE requirements for peer support staff.

e. Annual CE is mandatory for all peer support staff, including WOC peer support employees. VHA requires a minimum of 12 hours of CE directly related to the work of peer specialists every year, where 1 hour of CE must be in the domain of ethics relevant to the work of peer specialists and 1 hour of CE must be on the topic of providing peer support services to Veterans who have experienced military sexual trauma. Congressionally mandated trainings for peer support staff can be found in TMS within the curriculum VHA-269. Details about mandated training topics can be found in the Training section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

f. Due to their unique role, VHA peer support staff will likely encounter challenging situations where questions about confidentiality or boundaries may arise. To continue to provide guidance about how to manage these situations, at least 1 hour of the 12 hours of annual CE must be on topics directly related to ethical considerations in the delivery of peer support services. Examples of resources for ethics trainings for peer support staff include: OMH-sponsored webinars for peer support staff; VHA national conferences for peer support staff and peer support supervisors; in-service trainings for peer support staff developed at the local VA medical facilities; and ethics trainings provided by local, state, and national organizations that provide trainings for peer support staff.

## 8. DOCUMENTATION REQUIREMENTS

a. Peer support staff are full members of the treatment team, and they are required to document the patient care services they deliver in an approved record.

b. In VHA, peer support staff have a provider classification called a "person class," which is defined as individuals certified to perform peer support services through a training process defined by a government agency such as VA, or a state mental health department/certification/licensing authority. Current guidance for accomplishing documentation can be found in the Mental Health Coding Guide on the [Mental Health Business Operations SharePoint](#). Examples of content for peer support staff's individual

and group progress notes can be found in the Documentation section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *These are internal VA websites that are not available to the public.*

c. All Veteran patient care documentation entered by GS-5 peer support apprentices and GS-6 peer specialists in their first year of VHA employment must be co-signed by a LIP or an appropriately credentialed health care professional (ex. supervisory peer specialist, physician assistant, rehabilitation counselor). Supervisory peer specialists can serve as the documentation co-signer for peer support staff they supervise. It is a local VA medical facility decision as to which health care professionals can serve as co-signers for documentation where co-signature is required. Documentation co-signature is required for peer support staff members hired into the peer specialist occupation in VHA at the GS-7/8/9 levels during their first year of entry into the occupation. Otherwise, the co-signature requirement for peer support technicians and GS-7/8/9 peer specialists is a local VA medical facility decision which may be removed dependent upon the supervisor's determination of the peer support technician's or GS-7/8/9 peer specialist's experience and competence.

d. WOC peer support employees are required to document the peer support services they deliver in Veterans' EHRs. All Veteran patient care documentation entered by WOC peer support employees must be co-signed by a LIP or an appropriately credentialed health care professional (e.g., supervisory peer specialist, physician assistant, rehabilitation counselor).

e. Peer support staff's role in the development and documentation of formal treatment and recovery planning is to assist Veterans to identify goals and the means to achieve them. A peer support staff member does not serve as the lead in developing and writing a Veteran's treatment plan in the EHR. The peer support staff member must add the peer support service goal(s) to the Veteran's existing treatment plan in the EHR.

f. Local VA medical facilities must follow guidance in this directive and the Mental Health Coding Guide regarding how to set up the peer support staff's clinic with the appropriate stop codes. The Managerial Cost Accounting Office established a secondary stop code (183) for peer support staff to use for their documentation. There is also a CHAR 4 code, "PEER," that must be attached to the clinic coding when the secondary 183 code cannot be used. The most current documentation guidance is provided in the Mental Health Coding Guide available on [Mental Health Business Operations SharePoint](#) (MH Coding Guidelines > Crosscutting Codes > Peer Support Services). **NOTE:** *This is an internal VA website that is not available to the public.*

g. All peer support services must be documented in the Veteran's EHR and the Current Procedural Terminology (CPT) procedure code H0038 must be used for all peer support service encounters. Further guidance is available in the in the Mental Health Coding Guide available on the [Mental Health Business Operations SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

h. Local VA medical facilities are strongly encouraged to institute peer reviews of peer support staff documentation on at least a quarterly basis. The Documentation section on the [VHA Peer Support Services SharePoint](#) contains examples of documentation quality review forms. **NOTE:** *This is an internal VA website that is not available to the public.*

## 9. ETHICS

a. All peer support staff must adhere to the United States Government's Executive Branch Code of Ethics and the Principles of Ethical Conduct for Government Officers and Employees as per requirements in 5 C.F.R. § 2635.101(b). They must also adhere to the guidance in the VHA Code of Integrity as per requirements in VHA Directive 1030(2), VHA Integrity and Compliance Program, dated December 29, 2020. These documents can be found in the Ethics folder which is located in the Training section on the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.*

b. Peer support staff must complete the mandatory annual ethics training that is required for all VA employees. This training does not meet the VHA annual requirement for 1 hour of CE on ethics directly related to the work of peer specialists. The ethics CE hour for peer support staff must be acquired through other available ethics trainings offered within VHA for peer support staff or non-VHA training organizations that provide ethics trainings relevant to the work of peer specialists.

c. All peer support staff must also adhere to their own professional code of ethics, which may be the code of ethics of their peer specialist certification body.

d. All rules of VA employee-VA patient relationships concerning ethical issues found in the mandatory ethics training such as, but not limited to, buying or selling goods, or services and loaning or borrowing money must be followed. Peer support staff do not handle Veteran funds or enter into any conservator, power of attorney, or fiduciary relationships with Veterans. Peer support staff and Veterans with whom they have a professional relationship do not exchange gifts or money for goods or services.

e. Peer support staff and supervisors must review and discuss relevant codes of ethics and ethical decision-making frameworks within 30 days of the peer support staff member's starting date and at least once a year thereafter to ensure the peer support staff member has met all annual ethics training requirements. An ethical decision-making tool for peer support staff can be found in the Ethics folder that is located in the Training section of the [VHA Peer Support Services SharePoint](#). **NOTE:** *This is an internal VA website that is not available to the public.* When higher level consultation is needed, local VA medical facility procedures must be followed for consulting with the VA medical facility Health Care Ethics Consultation Service.

f. Dual relationships must be avoided between peer support staff and Veterans, as well as between peer support staff and other staff. Both peer support staff and clinical health care professionals must keep the focus of their discussions with one another on

topics related to services for Veterans and peer support staff's roles, responsibilities, and work performance. Both parties must avoid discussions that the peer support staff member could perceive as a clinical intervention targeting their own wellness. Peer support staff must discuss with their supervisor any conflicts that they experience about their roles or with other colleagues. Clinical health care professionals must address their own concerns or those expressed to them by a peer support staff member with their own supervisors. Peer support staff and peer support supervisors also have access to a VISN Peer Specialist POC and a VISN Peer Support Supervisor POC as well as monthly VISN conference calls for peer support staff and peer support supervisors for consultations when needed.

g. Peer support staff must not be assigned to work in the same program where they are currently receiving services. Also, peer support staff must not be assigned to work in the same program where they received intensive health care services within the past 3 years. Dual relationships can compromise professional judgment for both peer support staff and other health care professionals, causing undue harm to the Veterans whom they serve. Placing VA health care professionals into such relationships could result in violations of their professional codes of conduct and disciplinary actions that could affect their licenses or certifications. If any of the staff working in a program need health care services that are provided by that particular program, every possible alternative for treatment outside of that program must be explored (e.g., another VA medical facility or non-VA care). If a peer support staff member requests to receive services in the program in which they work, the manager of the program must seek consultation from the local VA medical facility's Health Care Ethics Consultation Service to determine how to proceed and consider requesting to have the peer support staff member reassigned to work in a different program where they do not receive services.

h. Peer support staff must not be supervised by LIPs or other appropriately credentialed health care professionals (e.g., supervisory peer specialist, physician assistant, rehabilitation counselor) who provided them with health care services within the past 3 years. After the 3-year period, every effort must be made to ensure that any potential harm that may occur to the peer support staff member has been adequately explored before entering into a supervisory relationship with a health care professional who previously provided them with health care services. The peer support staff member's supervisor must address such potential challenges with caution with their own supervisor. The respective supervisors for the peer support staff member and peer support supervisor must document in a memorandum this discussion with their supervisees and provide a copy of the memorandum to their respective supervisees.

i. Being on the same treatment team as peer support staff can also cause indirect dual relationship issues for health care professionals who may not have treated the peer support staff member directly but were on a team where a colleague spoke about the peer support staff member in clinical consultations. That prior knowledge may also affect the relationships between the peer support staff member and other staff of that same team or within the program in general where the peer support staff member is working. Indirect information obtained in this manner must be treated as confidential.

j. If the peer support staff member and other health care professionals in the program in which the peer support staff member is working had a clinical relationship in the past and are now co-workers, the peer support staff member and other health care professionals involved must discuss this situation with their respective supervisors and communicate boundaries that uphold the confidentiality and integrity of both the peer support staff member and the other health care professional(s) involved. At a minimum, the health care professionals do not share with other staff any information about the peer support staff member that was obtained during therapeutic sessions. In addition, the peer support staff member must not communicate any opinions of the health care professionals' therapeutic efficacy or affability based upon the peer support staff member's experiences receiving health care services.

k. Under no circumstances is it permissible for a peer support staff member to provide peer support services for Veterans with whom they have a current or prior personal relationship (e.g., family member, friend, romantic relationship) If the peer support staff member currently has or formerly had a personal relationship with a Veteran referred to work with them, the peer support staff member must inform the supervisor that they currently have or had a personal relationship with the Veteran so that another peer support staff member can be assigned to work with the Veteran. If the peer support staff member already met with the Veteran, the peer support staff member must inform the Veteran of the concerns about their dual relationship and that the Veteran will need to be referred to work with a different peer support staff member. Alternative avenues for the Veteran to obtain peer support services must be explored, such as receiving peer support services from other peer support staff at the VA medical facility, using telehealth services to connect with peer support staff at other VA medical facilities, or receiving a referral to community peer support services. The supervisor and peer support staff member must make as many feasible options available to the Veteran as possible.

## **10. WITHOUT COMPENSATION PEER SUPPORT EMPLOYEES**

a. Veterans who have their VHA-approved peer specialist certification and wish to volunteer as a peer support service provider must be appointed with a WOC status. Qualifications, including VHA-approved peer specialist certification, CE, and responsibilities of WOC peer support employees are identical to those described for paid peer support staff. This includes being knowledgeable about VHA policies and procedures that apply to all VHA employees, including confidentiality and its limitations, appropriate boundaries, and ethical practices so that they can effectively perform their duties and document their work with Veteran patients in the EHR.

b. Non-certified Veterans or non-Veterans who wish to volunteer to provide services to Veterans that may be similar to peer support services may volunteer under a different job title (e.g., System Navigator, Recovery Coach). This directive does not address other volunteer titles or activities.

c. Refer to Appendix A, paragraph 5.b., Supervisor Roles and Responsibilities, above for the list of responsibilities required for supervisors of paid peer support staff and WOC peer support employees.