SERVICES FOR VETERANS EXPERIENCING EARLY PSYCHOSIS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes VHA policy for the expectations, procedures and reporting requirements for services provided to Veterans in an early stage of a psychotic disorder under VHA's Office of Mental Health and Suicide Prevention (OMHSP).

2. SUMMARY OF CONTENT: This new directive:

a. Implements Early Psychosis Intervention Coordination (EPIC), a national Department of Veterans Affairs (VA) initiative to assure high-quality services for Veterans with early psychosis consistent with the practices and principles of Coordinated Specialty Care (CSC).

b. Defines the roles of the VA medical facility points of contact and associated treatment teams (see paragraph 5).

c. Describes efforts to support implementation through education, case identification and evaluation by VHA OMHSP.

3. RELATED ISSUES: VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019; VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019; VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008; and VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016.

4. RESPONSIBLE OFFICE: The Office of Mental Health and Suicide Prevention (OMHSP) (10NC5) is responsible for the content of this directive. Questions about the contents of this directive may be directed to VHA10NC5Action@va.gov. Questions about analytical support for this initiative may be directed to VHASMITREC@va.gov.

5. RESCISSIONS: None.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of October 2025. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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

/s/ Renee Oshinski
Assistant Under Secretary for Health
for Operations

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 October 8, 2020.

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1. PURPOSE

The purpose of this Veterans Health Administration (VHA) directive is to establish policy for services to be provided to Veterans in an early stage of a psychotic disorder. This directive implements the VHA Early Psychosis Intervention Coordination (EPIC) program to identify individuals with early psychosis and provide them with guideline-concordant services designed to lessen the severity of emerging psychotic disorders. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 2031(a), 7301(b).

2. BACKGROUND

a. 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-20's for males and mid to late 20's for females, in close proximity to common ages of military service. Therefore, many individuals who eventually develop these conditions may experience first psychotic symptoms during military service and may ultimately separate from service due to these symptoms. Other individuals who are eligible for Department of Veterans Affairs (VA) health care may develop these conditions after separation from the military.

b. The period surrounding 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; one longitudinal study of individuals with schizophrenia spectrum disorders showed an over 80 times elevated risk of suicide in the first 2 years after first symptoms relative to the general population.

c. Effective biopsychosocial interventions for early psychosis are available at VHA and have been shown to improve clinical and functional outcomes. The most effective health care programs for early psychosis offer multiple services concurrently including medications, cognitive therapies, patient and family education, case management and vocational services (supported employment and education). The benefits of these interventions are most evident in individuals who receive treatment early after the first emergence of their psychotic symptoms.

d. Active 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.

e. 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. By developing a national initiative to help active Service members with early psychosis transition to VHA health care and provide early interventions to Veterans who experience a new onset of psychosis, VHA has the potential to reduce the morbidity and mortality due to these conditions.

f. This directive must be implemented in all VA medical facilities that have, as of the date of issuance, both an existing Intensive Community Mental Health Recovery (ICMHR) and Psychosocial Rehabilitation and Recovery Center (PRRC) program. Other sites are strongly encouraged to implement this initiative.

3. DEFINITIONS

a. **Coordinated Specialty Care.** Coordinated specialty care (CSC) is, according to the National Institute of Mental Health (NIMH), 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, vocational rehabilitation, individual resiliency training and family education and support. ***NOTE:*** *First episode psychosis is the period from the first appearance of primary psychotic symptoms until significant symptomatic remission is achieved. A first episode psychosis is one in which no other period of psychotic symptoms appeared in one's past and resolved. (See https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml).*

b. **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 resolved, the term "early psychosis" is used in this directive to allow for more uniformity in defining the target population.*

c. **Early Psychosis Intervention Coordination.** EPIC is the national VA initiative to assure high-quality services for Veterans with early psychosis.

4. POLICY

It is VHA policy to provide 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.

5. RESPONSIBILITIES

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

b. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

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

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

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

c. **Executive Director, Office of Mental Health and Suicide Prevention.** The Executive Director, Office of Mental Health and Suicide Prevention (OMHSP), is responsible for:

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

(2) Supporting the efforts of the Psychosocial Rehabilitation and Recovery Services (PSR&RS) section in OMHSP by ensuring sufficient resources are available both within OMHSP and in the field to support the execution of this directive.

(3) Supporting the evaluation of PSR&RS programs through collaboration with the OMHSP evaluation centers.

d. **National Mental Health Director, Psychosocial Rehabilitation and Recovery Services, Office of Mental Health and Suicide Prevention.** The National Mental Health Director, PSR&RS, with the assistance of the National Director for Intensive Case Management Services is responsible for:

(1) Developing and maintaining VHA policy to guide the delivery of mental health services to Veterans with early psychosis through EPIC, integrating inpatient and outpatient services.

(2) Developing and providing education on early psychosis and CSC to mental health and primary care service providers in the VA health care system, to include Readjustment Counseling Service.

(3) Collaborating with appropriate staff in the Department of Defense (DoD) to facilitate development of VA medical facility-level plans for service delivery that provide a seamless transition between DoD and VHA care.

(4) Collaborating with DoD at the national level to address the needs of active Service members and Veterans who experience early episode psychosis.

(5) Developing collaborations with other national entities responsible for delivery of clinical services for Veterans with early psychosis.

(6) Recommending changes to the field to address early episode psychosis based on the findings of program evaluation and operational experience in the project.

e. **Director, Serious Mental Illness Treatment Resource and Evaluation Center.** The Director, Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) or designee is responsible for:

(1) Providing a dashboard to support VA medical facilities in identifying Veterans who likely are experiencing early psychosis for the purposes of targeting clinical efforts and assessing the degree to which this group of Veterans is served.

(2) Evaluating using administrative data the degree to which Veterans experiencing early psychosis are receiving adequate services, including identifying unmet needs and assessing the effectiveness of VHA services in providing care to persons with early psychosis.

(3) Collaborating with other staff in OMHSP to develop metrics regarding service provision for this population.

(4) Producing an annual report based on available clinical and administrative data to OMHSP, evaluating the state of service delivery to Veterans in VHA and identifying opportunities for improvements in these services.

f. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that EPIC services are accessible to all eligible Veterans and their families by providing the services at their VA medical facilities or through contracts with community organizations, as appropriate and if available.

(2) Ensuring that EPIC services are operated in compliance with relevant law, regulation, VHA policy and procedures.

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

(1) Ensuring that this directive is disseminated to, at minimum, the mental health leadership at the VA medical facilities in their network.

(2) Assisting SMITREC in the collection of clinical data from VA medical facilities when requested. (See paragraph 5.e.(4) for more information on clinical data and reporting.)

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

(1) Ensuring adequate staff are available to provide the services required by this directive.

(2) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

i. **VA Medical Facility Mental Health Leader.** The VA medical facility Mental Health Leader is responsible for:

(1) Establishing EPIC at each VA medical facility to provide outreach services to Veterans who experience early psychosis and provide services sufficient to meet their needs.

(2) Supporting the quality of mental health services for early psychosis as consistent with CSC and as monitored by SMITREC in OMHSP. (See paragraph 5.e. for more information on SMITREC monitoring and evaluation.)

(3) Providing and maintaining EPIC program oversight to ensure quality services and compliance with all VHA policy, including this directive; VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008; VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019; VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019; VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016; and procedures.

(4) Completing all mandated reporting, monitoring, evaluation and accreditation requirements relevant to EPIC services as outlined in this directive.

(5) Identifying a VA medical facility EPIC Point of Contact (POC). The EPIC POC must be a licensed independent provider who is actively engaged in clinical service delivery to Veterans with serious mental illness (SMI). EPIC POCs may be chosen from those working in programs such as PRRC, ICMHR, VHA Vocational Rehabilitation Service, inpatient mental health, or the Local Recovery Coordinator (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. ***NOTE:*** *Where possible, assigning specifically designated employees (with corresponding allocation of effort) for this EPIC clinical care team - particularly for the EPIC POC - is recommended. The appropriate amount of FTEE dedicated to the duties for the EPIC POC will vary based on the size of the VA medical facility but generally would be expected to be a minimum of 0.20 FTEE. Membership of other clinicians on the EPIC clinical care team may be through dedicated FTEE 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).*

j. **VA Medical Facility Early Psychosis Intervention Coordination Point of Contact.** The VA medical facility EPIC POC is responsible for coordinating the following outreach and clinical services to Veterans with early psychosis through the following activities:

(1) Developing, in consultation with the Facility Mental Health Leader, an ad hoc 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. ***NOTE:*** *The EPIC clinical care team is expected to be composed of clinicians whose duties already are 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 will have a clinical home in an existing clinical program, with EPIC efforts focused on assuring access to additional clinical services included in CSC.*

(2) Developing and updating annually a VA medical facility-level plan for delivery of services to Veterans with early psychosis that is consistent with the practices and principles of CSC. The plan must include evidence-based therapeutic treatments, both pharmacologic and non-pharmacologic. The latter must include supported employment and educational services, cognitive therapy, individual resiliency training, family support, and other therapies as needed by the individual. Provision of substance use disorder services is also essential. ***NOTE:*** *For more information, please see https://navigateconsultants.org/manuals/.* It must also include psychoeducation about mental illness for the Veteran and their family. This plan must utilize existing clinical resources such as the LRC or those individuals working in programs like PRRC, ICMHR, VHA Vocational Rehabilitation Service, mental health crisis services and inpatient mental health.

(3) Creating an electronic referral system to the EPIC (i.e., electronic health record consult template) for facilitating identification of patients.

(4) Utilizing analytics, including dashboards identifying Veterans with a high likelihood of early psychosis, provided by SMITREC of OMHSP to help identify Veterans experiencing early psychosis. When an appropriate Veteran is identified, the POC will facilitate delivery of CSC to that Veteran.

(5) Facilitating and promoting educational efforts of PSR&RS to staff at the VA medical facility on early psychosis and CSC.

(6) Working with DoD to develop VA medical facility-level referral relationships of active Service members with early psychosis to facilitate the transition between DoD and VHA health care.

k. **VA Medical Facility Early Psychosis Intervention Coordination Clinical Care Team.** The VA medical facility EPIC clinical care team is responsible for:

(1) Working together with the EPIC POC to assure timely referral to indicated clinical services for each Veteran experiencing early psychosis. This team must meet at least monthly to coordinate and facilitate care for Veterans with early psychosis.

(2) Developing a plan with the EPIC POC for VA medical facility delivery of Coordinated Specialty Care to Veterans experiencing early psychosis. The plan will

involve the Veteran and, as warranted and desired by the Veteran, the Veteran's family members. The plan must also include coordination with primary care services.

(3) Delivering the following types of clinical services: outreach and engagement, pharmacotherapy consistent with early psychosis evidence-based guidelines, case management, mental health crisis services, vocational services (e.g., Supported Employment and Supported Education), family involvement and education and inpatient mental health services. These services utilize existing resources to provide a framework for collaboration for Veterans with early psychosis. ***NOTE:*** *For more information, please see: http://navigateconsultants.org/manuals/.*

6. TRAINING

There are no formal training requirements associated with this directive. As noted in paragraph 5.d.(2), educational opportunities on treatment of early psychosis will be offered by the National Mental Health Director, PSR&RS with the assistance of the National Director for Intensive Case Management Services regularly.

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

8. REFERENCES

a. 38 U.S.C. § 2031.

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

c. VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019.

d. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

e. VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016.

f. Kane, J.M., Robinson, D.G., Schooler, N.R., et al. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry, 173*, 362-72.

g. Melle, I., Johannesen, J.O., Haahr, U.H., et al. (2017). Causes and predictors of premature death in first-episode schizophrenia spectrum disorders. *World Psychiatry*, *16*, 217-218.

h. Navigate Manuals. Available at: https://navigateconsultants.org/manuals/.

i. What is Coordinated Specialty Care (CSC)? Available at: https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml/.