

Mental Health Services Information Guide

Revised 08/03/2016



Primary Care/Mental Health Integration (PC/MHI):

- The in-between step for Primary Care and Mental Health Services.
- Provide education and support to Primary Care providers in their treatment of mental health symptoms.
- Brief medication management, psychotherapy, and care management to Veterans when primary care isn't enough.
- Services include open access to providers, such as walk-ins, warm handoffs, and self-referrals.
- Primary goals are to either: 1) successfully treat Veterans and return them to the care of their primary care providers, or 2) successfully transition Veterans to appropriate mental health services for continued, longer-term care.
- Of note, Veterans with severe mental illness will completely bypass PC/MHI services straight into mental health due to symptom severity.

General Outpatient Mental Health

- Provides assessments & management of care for patients with Schizophrenia, Schizoaffective disorder, Bipolar affective disorder, Depression, Anxiety, as well as mental health screenings for transplant candidates, and homeless program.
- Case management to assess patient needs, refers to treatment modalities within mental health specific to the patient's issues, and speaks with patients about achieving and maintaining overall wellness.
- Open access providing immediate care when needed and guaranteeing that patients are seen in a timely manner.
- Electroconvulsive therapy for severely depressed patients that have failed other forms of medication management.
- Nursing support such as blood pressure checks, flu shots, ppd placement, and reviewing reminders for complete care.
- Making referrals to various groups that are offered, neuropsychology testing, compensated work therapy, VA supported housing, cognitive behavioral therapy, and marital therapy.

VA



Veterans Health Administration
Ralph H. Johnson VA Medical Center

PRRC/VEC: Psycho-Social Rehabilitation and Recovery (PRRC)

VETERANS ENRICHMENT CENTER (VEC)

The VEC is a transitional learning center that teaches skills, offers supports, and promotes community opportunities essential for a Veteran to develop an active and meaningful life in their home community.

- Veterans living with a diagnosis of Schizophrenia, Schizo-affective Disorder, Bipolar, Major Depressive Disorder, and/or Severe PTSD.
- Daily functional life is seriously limited as results of the illness.

REQUIREMENTS FOR REFERRAL

- Veteran must have a diagnosis of a Severe Mental Illness noted above, and;
- Major functional impairment in daily life from the SMI that would equal a GAF score of <50
- Veteran is interested in participation as a student at the PRRC
- Veteran is independent, managing own transportation and self-care
- Participation is voluntary and flexible

Substance Abuse Treatment Center (SATC)

The Substance Abuse Treatment Clinic (SATC) is a multi-disciplinary treatment team. Our team of psychiatrists, psychologists, nurses, social workers, and a peer support specialist provide individual and group psychotherapy, medication management services (including outpatient detox), and aftercare offerings.

We are eager to work with Veterans on their personalized recovery goals of abstinence and harm reduction as well as self-sufficiency and improving overall quality of life.

Our Intensive Outpatient Program runs 5 days/week and involves attendance at daily group therapy sessions and regular meetings with case managers for individualized work.

The SATC also offers Opioid Replacement Therapy via the COAST team (Charleston Opioid Assessment and Substitution Therapy).

Health Care for Homeless Veterans (HCHV) Program

The mission of the HCHV program is to end homelessness among Veterans and Veterans with families through outreach efforts and Veteran and community partnerships.

- Veterans are engaged in treatment and rehabilitation programs.
- **HCHV Eligibility:** Homeless Male and Female Veterans with and without families that meet program criteria.
- The Homeless Program has a full continuum of care in offering housing case management services to Veterans and includes:
 - Grant and Per Diem/Contract transitional treatment beds
 - HUD-VASH permanent community placement, a joint partnership between the VA and HUD to provide eligible Veterans and Veterans with families HUD Housing Choice Vouchers and VA supportive treatment services.
- Services are individualized, person-centered, strength-based, and promote hope, responsibility, and respect.

SERVICES INCLUDE

- Case Management
- HCHV Outreach
- Health Care (HPACT)
- Residential Treatment for male and female Veterans and male or female Veterans with children
- Consultation
- HCHV Walk-In Clinic
- GPD Dental Program
- HUD-VASH-(VA Supported Permanent Community Housing): HCHV Telehealth Clinic
- National Call Center for Homeless Veteran
- Ineligible Veterans Services
- Peer Support
- SSVF Referrals
- Community Resource and Referral Center

Couples & Family Clinic

Respond to any Consult or direct referral with an initial (usually by phone) contact to confirm that each partner or family member signs on to evaluation and therapy. Appointments are typically scheduled with co-therapy teams within 2 weeks.

Evidence-based couple and family therapies that are sophisticated and focus feelings, thoughts, and behaviors in relationships (EFT, IBCT, CBCT for PTSD, BCT for Substance Use Disorders, PICT, etc.).

Typically 3 evaluation sessions (joint interview, individual relationship assessment interviews, and the feedback session leading to

patient-centered collaborative goal and objective setting.

Therapy sessions usually goes for 6 to 12 sessions, the couple or family drive both the number of sessions and frequency of sessions. We not only obtain a base-line questionnaire data assessment (large questionnaire packet) but also track outcome progress using a 2 page weekly questionnaire filled out at the beginning of each session.

About one-third to one-half of our couples and families are seen via CBOC or Home-based Telehealth. We see couples pre-marriage, during marriage, and post-marriage. We see families with young, teenage, or adult

children – also multigenerational families. We see all couples and families with major or minor co-morbidities (e.g., PTSD, mood and anxiety disorders, pain, substance use, medical problems unless the co-morbidity is severe (we then may refer for individual therapy with or without couples therapy).

Overall, our effectiveness or outcomes match the rate of the best studies out there --- i.e., about 50% of couples or families make statistically significant positive change AND clinically significant change (moving from the clinically distressed state to the non-distressed state).

3A Inpatient Recovery Unit

The 3A inpatient unit treats veterans with mental disorders that are severe enough to significantly impair functioning or make them an imminent danger to self or others. Average length of stay is 9-12 days.

Common disorders treated on the inpatient unit include depression, bipolar disorder, schizophrenia,

substance use disorders, anxiety disorders and dementia.

Patients are treated using a recovery model of care that ensures every patient has the opportunity to recover on some level.

Patients work with nursing, social work, MDs, pharmacy on treatment planning. Patients are offered

daily group programming.

There are 2 attending physicians on the unit (Dr. Christine Pelic and Dr. Paul Everman). There will be a 3rd attending soon with unit expansion.

All patients have discharge follow up in 7 days. High risk patients need follow up weekly for 4 weeks.

Compensated Work Therapy (CWT)

CWT provides vocational rehabilitation services to Veterans currently receiving mental health treatment. Referrals are made by consult from the mental health provider and include the following programs:

TRANSITIONAL WORK

- Veterans with diagnoses of PTSD, Major Depression, Bipolar Disorder, substance abuse, other anxiety disorder, or homelessness
- Veterans who are not ready to seek immediate competitive employment and have Identified specific goals for treatment that will provide them with the knowledge, skills, and abilities to be able to obtain competitive employment following successful completion of the program
- Veterans assigned participate in a temporary paid work experiences

SUPPORTED EMPLOYMENT

- Veterans referred with a primary diagnosis of psychosis, bipolar disorder, schizophrenia, or schizoaffective disorder
- VETERANS WHO BECAUSE OF THE SEVERITY OF THEIR MENTAL ILLNESS WOULD NOT BE ABLE TO FUNCTION INDEPENDENTLY IN EMPLOYMENT WITHOUT INTENSIVE ONGOING SUPPORT

COMMUNITY BASED EMPLOYMENT SERVICES

Veterans who are homeless or currently receiving mental health care that are ready for competitive employment and need short term assistance with job search in the community.



Homeless Patient Aligned Care (H-PACT)

HPACT is designed to ensure timely and effective treatment for homeless Veterans through two components: Mon-Fri walk-in hours and scheduled appointments.

Provides comprehensive health care and psychosocial services to promote, maintain, and restore health for the homeless Veteran. The aim is to provide preventative care as well as minimize the effects of illness and disability and to improve quality of life.

ELIGIBILITY CRITERIA

Homeless Veterans must be without a fixed, stable address of residence, or in a transitional housing situation, at the time of their initial visit. As homeless Veterans frequently cycle in and out of homelessness, a Veteran may continue to attend clinic once housed to maintain continuity of care. The Veteran may change to a traditional primary care provider per request and/or if deemed appropriate by the (HPACT) team.

REFERRAL PROCESS

Homeless Veterans may be referred through direct telephone contact to the HPACT, from outpatient clinics, homeless programs, ED, inpatient services, CBOC's in VAMC catchment area, or through self-referral. CPRS consult is available as well for non-urgent referrals (primarily from traditional PACT when Veteran seems appropriate for HPACT services).

EXIT CRITERIA

Transfer out of HPACT will occur if they are deceased, move out of the area, become stably housed for at least 1 year, have not been seen for >24 months or if the Veteran requests transfer.

The Philosophy is that the homeless Veteran should be afforded the same high level of primary care and preventative healthcare services available to non-homeless Veterans with the goal of achievement of optimum wellness.

HPACT, through comprehensive assessment, treatment, education, and referral will provide a venue of care that is accessible, timely, and customized to meet the unique needs of the homeless Veteran. The expected outcomes are decreased emergency room visits, decreased inpatient hospitalizations, improved quality of life, housing placement, and improved patient satisfaction.

HOURS OF OPERATION

HPACT is open 8:00 am to 4:30 pm, Monday through Friday, to see patients by scheduled and unscheduled appointments. Unscheduled patients are Triage'd.

H-PACT SCOPE OF SERVICES

- Evaluation and assessment of the patient
- Provision of medical and mental health care
- Inclusion of the patient in the planning of care
- Preventive health care and education
- Referral to specialty clinics
- Knowledge of available resources
- Plan for follow-up to hospitalizations when required
- Integration with Homeless programs (HCHV, GPD, HUD-VASH, VJO, HVSEP, SATC) to facilitate referrals to transitional housing, emergency shelters, substance abuse and mental health programs, employment assistance, and other community resources.
- Limited transportation assistance – 1 day bus pass and meal assistance (typically one each per Veteran)
- Immunizations, vital signs and screenings, orders for radiology, lab, prosthetics or other specialists as indicated, ordering of non-narcotic prescription medications.

Mental Health Intensive Case Management

MHICM (Mental Health Intensive Case Management) provides community-based services focusing on the treatment and rehabilitation of Veterans with SMI (Serious Mental Illness). Case managers visit Veterans in their homes, accompany them on appointments (if necessary), initiate and monitor any needed psychopharmacological medications, and teach relevant skills in their community locations.

The primary goals of the MHICM Program are to 1) improve participants' quality of life, 2) promote self-sufficiency and independent functioning, and 3) lessen relapses and psychiatric (re)hospitalizations.

Veterans are not discharged within a set time; instead, they are gradually reintegrated into the community as their psychiatric and psychological status improves. MHICM services expand upon those provided by other MHSL Programs community-based agencies. The MHICM care coordinator for the Veteran oversees and shepherds Veteran-centric therapeutic services.

The MHICM Program is specifically designed for Veterans who are diagnosed with severe and persistent mental illness and 1) who have been hospitalized for a minimum of 30 days or 2) have had three or more inpatient psychiatric admissions within the past year. Providers are encouraged to make referrals not only for Veterans with SMI alone but also for Veterans with SMI and a substance use disorder, impaired social and vocational functioning, and/or significant medical problems such as diabetes, HTN, chronic pain, etc.

A participating Veterans will expect to have a visit in his or her home with their MHICM Team Coordinator about once a week (more often if clinically indicated) to receive services such as a) medication management, b) assistance with money management, c) assurance of receiving needed medical care, d) facilitation of communication with family and significant others, e) assistance with obtaining additional VA or State benefits, f) accompaniment (with coaching) when having to deal with a stressful situation, g) shopping assistance, etc.

Post-Traumatic Stress Disorder Clinical Team (PCT)

The PCT provide intake assessments and evidence based treatment for PTSD symptoms to Veterans at the RHJ and via telehealth to our CBOCs and clinical partners.

The treatment consists of weekly appointments for 60–90 minutes, not typically longer than 3 to 6 months. Patients undergoing treatment are also given behavioral assignments to do as homework and often get provider phone calls in-between sessions for support.

The goal is to help people get over their PTSD symptoms by training them how not to avoid memories or normal non-dangerous situations that cause anxiety. Once people learn how not to avoid these situations and memories, they end up learning that the memories and situations cannot actually hurt them, the power and frequency of traumatic memories dissipate along with fear of public places.

Treatment sessions are chronologically staged (there is different content in Session 1 than in Session 2, which is different from Session 3, etc.). Providers track these stages and progress to plan for the next session.

Neuropsychology Clinic

Clinical neuropsychology is concerned with the behavioral expression of brain dysfunction. Neuropsychological evaluation may be requested when there are concerns about memory, attention, reasoning, or other areas of cognition. Difficulties in these areas can be caused by brain injury, neurological disease, psychiatric disorders, and other conditions. Referral for outpatient neuropsychological evaluation is by consult to Neuropsychology Clinic (under Mental Health consults). Evaluations may take

several hours over the course of one or two sessions. A separate, follow-up session to review the results and recommendations might also be scheduled.

Cognitive rehabilitation involves learning strategies to improve, or to work around, areas of memory and thinking that are causing difficulty. Neuropsychology Clinic offers cognitive rehabilitation for groups and individuals. Clinicians in MHC and throughout the medical center are encouraged to contact Neuropsychology Clinic staff for additional information, or to make a referral.

Veterans Justice Outreach (VJO) Program

The VJO program is a VA based program that works with local law enforcement and courts to get eligible Veterans the treatment that is clinically appropriate. The purpose of VJO is to avoid unnecessary criminalization of Veterans dealing with mental illness and extended incarceration of these Veterans. This program works to ensure that eligible Veterans who are in contact with the criminal justice system and are referred to VJO have access to mental health, substance use, and other VA services and benefits.

The process begins with identifying Veterans in the legal system, which can happen at multiple places, but include while they are in jail or if seen at the VA for services. The VJO goes into the county jails that VAMC Charleston covers to identify Veterans needing services. In turn, they work with the legal system to make them aware of VA options for treatment.

There is a VJO stationed in Charleston and Savannah. The program in Charleston started 5 years ago so it has more services, however the program in Savannah began in July of 2015 so the services offered are growing. In Charleston, there is a Veterans Legal Clinic which offers civil legal services to low-income Veterans through SC Legal Services. The services offered are for divorce, custody, visitation, guardianship/conservatorship, expungment/pardons, landlord/tenant, simple wills



and durable power of attorneys. This clinic is held the last Friday of each month at 1330 on a walk-in basis at the VA, typically in the Main Auditorium. There is also a Veterans Child Support clinic that offers a collaboration b/n Family Court, Child Support enforcement, the VA and two grant-funded attorneys through One80 Place for Veterans that have child support orders in the Tri-County area. This clinic meets at One80 Place on the last Tuesday of the month at 1300. Finally there is a VJO Walk-in Clinic that meets every Tuesday from 0900-1100 on the 5th Floor in MH. The sign-in sheet is kept on the PTSD side of the MH wing. Services in Savannah are currently being worked out.

If you would like to refer a Veteran to the VJO program, please feel free to give our contact information to your Veteran (Meredith Miller 843-297-0019 Meredith.miller2@va.gov for the Charleston and surrounding areas and Shanta Barron-Millan 843-300-7486 shanta.barron-millan@va.gov for the Savannah and surrounding areas).

STAND DOWN AGAINST HOMELESSNESS

The Ralph H. Johnson VA Medical Center in partnership with Goodwill Industries of Lower South Carolina holds an annual Stand Down Against Homelessness. The event offers medical and dental screenings and assistance, clothing, food, haircuts, and legal counseling for hundreds of homeless persons in the greater Charleston, Myrtle Beach and Savannah areas. Job assistance and opportunities to speak with local employers is also available for those seeking work. The Department of Veterans Affairs is the only federal agency that provides substantial hands-on assistance directly to homeless persons.

Military Sexual Trauma

The VA provides free MST-related treatment to Veterans who experienced sexual assault and/or sexual harassment while in the military. Veterans do not need to have a VA disability rating/service connection, and may be able to receive MST-related treatment even if they are not eligible for other VA health care services. Veterans, staff and others with questions about MST can call MST Coordinator Carol Denier, PhD at (843) 789-7721 or MST Counselor Carol Conway, LISW at (843) 789-6735.

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