

PSYCHOSOCIAL REHABILITATION AND RECOVERY SERVICES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy for the expectations, procedures, and reporting requirements for Psychosocial Rehabilitation and Recovery Services (PSR&RS) under VHA's Office of Mental Health and Suicide Prevention.

2. SUMMARY OF MAJOR CHANGES: This directive provides updates to the previous version of Directive 1163, and incorporates information about VHA Vocational Rehabilitation (VR) Service (formerly called Therapeutic and Supported Employment Services [TSES]), Psychosocial Rehabilitation and Recovery Centers (PRRCs), Peer Support, and Psychosocial Rehabilitation and Recovery Services Peer Support, previously found in VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program, dated July 1, 2011; VHA Handbook 1163.03, Psychosocial Recovery and Rehabilitation Centers (PRRC), dated July 1, 2011; and VHA Handbook 1163.05, Psychosocial Rehabilitation and Recovery Services Peer Support, dated July 1, 2011, respectively. Specific updates regarding each program include:

a. Updated references, terminology, and definitions to reflect current information for PSR&RS; the addition of the responsibility for the Serious Mental Illness (SMI) Re-Engage Program to the Local Recovery Coordinators' (LRC) duties.

b. Updated definitions and clinical and workload capture expectations for PRRCs; guidance for transforming existing Day Treatment, Day Hospital, or analogous programs to a PRRC. This programmatic information about PRRCs was formerly located in VHA Handbook 1163.03.

c. Regarding Peer Support (formerly located in VHA Handbook 1163.05), this directive now aligns with Public Law 110-387, Section 405, Veterans' Mental Health and Other Care Improvements Act of 2008, and the Executive Order 13625, dated August 31, 2012, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.

d. Additionally, this directive:

(1) Removes outdated references and inactive hyperlinks.

(2) Removed the word "consumer" to reflect more modern terminology regarding those receiving mental health services.

(3) Includes information about the new National Uniform Class Committee provider taxonomy for Peer Specialists and the Department of Veterans Affairs' Managerial Cost Accounting Office stop code compendium.

(4) Adds requirement for facilities to be compliant with Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) International standards for the provision of peer support services.

(5) Clarifies the requirement for a licensed independent practitioner to co-sign electronic medical record documentation entered by peer support staff.

(6) Includes guidance regarding the oversight of Without Compensation (WOC) peer support employees.

(7) Clarifies requirements for Peer Specialists for obtaining certification and maintaining competency on an annual basis.

(8) Clarifies Peer Specialists' supervisors' roles and responsibilities.

(9) Expands information about documentation and Peer Specialist ethical standards and clarifies risks for potential role confusion.

(10) Provides a decentralized communication plan using Peer Specialist and supervisor points of contact within each network.

(11) Replaces TSES Program office name with VHA Vocational Rehabilitation Service to provide a uniform name that encompasses the services offered.

e. Regarding VHA Vocational Rehabilitation Service (programmatic information formerly located in VHA Handbook 1163.02), this directive now aligns with Acting Deputy Under Secretary for Health for Operations and Management Memorandum, TSES Transformation Plan, dated May 17, 2016. Accordingly, this directive:

(1) Promotes recovery through community-based competitive employment as the primary goal of vocational rehabilitation participation.

(2) Includes the addition of new Compensated Work Therapy (CWT) vocational rehabilitation models, and the discontinuation of older prevocational models.

(3) Requires a dedicated VHA Vocational Rehabilitation Service Program Manager to oversee the administrative, clinical, business, regulatory, and financial operations of CWT.

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

4. RESPONSIBLE OFFICE: The Office of Mental Health and Suicide Prevention (10NC5) is responsible for the content of this directive. Questions may be referred to the National Mental Health Director for Psychosocial Rehabilitation and Recovery Services at VHA10NC5ACTION@va.gov.

5. RESCISSIONS: VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated July 1, 2011; VHA Handbook 1163.01, Psychosocial Rehabilitation and Recovery Services, dated July 1, 2011; VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program, dated July 1, 2011; VHA Handbook 1163.03, dated July 1, 2011; VHA Directive 1163.05, Psychosocial Rehabilitation and Recovery Services Peer Support, dated July 1, 2011; VHA Directive 2010-049, Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs, dated October 14, 2010; and VHA Directive 2007-005, Compensated Work Therapy Supported Employment Services Implementation Plan, dated January 18, 2007, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of August 2024. 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
Acting Deputy Under Secretary for
Health for Operations and Management

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, 2019.

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PSYCHOSOCIAL REHABILITATION AND RECOVERY SERVICES

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy regarding the programs organized under the Psychosocial Rehabilitation and Recovery Services (PSR&RS) section within the Office of Mental Health and Suicide Prevention (OMHSP). These services include but are not limited to Psychosocial Rehabilitation and Recovery Centers (PRRCs), Vocational Rehabilitation Programs, Local Recovery Coordinators (LRC), and Peer Support. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1718, 2031; 38 U.S.C. 7301(b); Title 38 Code of Federal Regulations (CFR) 17.38.

2. BACKGROUND

a. Psychosocial rehabilitation with a recovery orientation is a broad concept that guides all VHA mental health service delivery. The President's New Freedom Commission on Mental Health provided the foundation for recovery-oriented services in VHA by beginning its 2003 report with the following: "We envision a future when everyone with a mental illness will recover, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community" (<http://govinfo.library.unt.edu/mentalhealthcommission/index.htm>). This vision was reflected in a mental health strategic plan that ultimately developed into VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, which emphasized the transformation of mental health services to a Veteran-driven, recovery-oriented system of care that engages and inspires Veterans to achieve their highest possible level of health and well-being, consistent with recovery. In fulfillment of this vision, PSR&RS leads the transformation of mental health services to a recovery-oriented system of care that provides Veterans with personalized, proactive, patient-driven health care. The concepts of recovery and psychosocial rehabilitation inform the delivery of inpatient mental health care, intensive outpatient mental health care, and all other components of the continuum of care.

b. The mission of VHA PSR&RS is to help eligible Veterans with mental health problems recover, regardless of symptom severity, and to advocate for Veterans with serious mental illnesses to receive the services they deserve. PSR&RS includes high-quality, recovery-oriented care provided across the entire VHA mental health continuum. Specific PSR&RS programs incorporating this vision include Local Recovery Coordinators, Peer Support, PRRCs, Intensive Community Mental Health Recovery (ICMHR), Compensated Work Therapy (CWT), and skills training. These services are provided in partnership with Veterans and their families (as appropriate) and address the goals of recovery, rehabilitation, improved quality of life, and community integration in addition to supporting specific treatment of medical, mental health, and substance use disorders. PSR&RS services are coordinated, accessible, and readily available to Veterans with mental health conditions and especially to Veterans with serious mental illnesses.

c. All Veterans with mental health conditions can recover as “recovery” is defined in paragraph 3 of this directive, Definitions. That definition emphasizes the ability of the Veteran to improve their health and wellness, live self-directed lives, and strive to reach their full potential. Veterans with serious mental illness can define, pursue, and achieve personal goals that support their personal identity, result in improved health and well-being, and promote full participation in the communities of their choice.

d. Mental illness must not be a barrier to or a stigma against seeking mental health services or pursuing a meaningful and productive life. Veterans, family members, VA health care providers, and community partners must collaborate to prevent discrimination on the basis of mental illness. In addition, culture, ethnicity, religion, and individual differences (e.g., gender, gender identity, age, military era) can play an important role in the recovery process and must not be limiting factors in the provision of PSR&RS services. To ensure this is the case, PSR&RS provides timely access to holistic, state-of-the-art, evidence-based interventions as well as natural community-based supports, all of which are essential for living, working, learning, and participating fully in the community. In addition, PSR&RS collaborates with the Office of Academic Affiliations (OAA) to provide Psychosocial Rehabilitation Fellowships at several VA medical facilities and an Administrative Hub Site to manage the fellowships. These training opportunities prepare the next generation of mental health clinicians to provide evidence-based services to Veterans with serious mental illnesses (<https://www.va.gov/oaafellowships/psychosocial-rehab.asp?p=25>).

e. Veterans receiving PSR&RS services who have decision-making capacity as defined in VHA Handbook 1004.01, Consent to Clinical Treatments and Procedures, dated August 14, 2009, are empowered to direct their own treatment, including treatment components related to their mental illness, and they must have the opportunity to learn how to plan for periods of acute illness.

3. DEFINITIONS

a. **Certified Rehabilitation Counselor.** A health care provider credentialed by the Commission on Accreditation of Rehabilitation Counselors (CRCC) to practice rehabilitation counseling at the professional level.

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. Information and resources on Community inclusion can be found on the Temple Collaborative Web site located at <http://tucollaborative.org/>.

c. **Community Institutionalization.** Community institutionalization refers to linkages or PRRC-hosted 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. PRRCs are designed for transitional engagement and need to guard against fostering dependence on VA programs that ultimately undermine an individual's ability and motivation to independently engage in their communities. Examples of community institutionalization include program-based Tai Chi, Arts Workshop, newsletter, or bowling group, 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, church attendee, athlete, hobbyist, etc.) 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, CWT) or any leisure activities coordinated and organized on-site at VA medical facilities or at other treatment venues in the community. While these programs are important and valuable components of 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: Information and resources on Community Integration can be found on the Temple Collaborative Web site located at <http://tucollaborative.org/>.

e. **Compensated Work Therapy.** CWT is a recovery-oriented, vocational model in the continuum of the VHA's work restoration services authorized by 38 U.S.C. 1718.

NOTE: CWT is also referred to as "therapeutic work," 38 U.S.C. 1718(b)(2), and "work therapy," 38 U.S.C. 2031(a)(3).

f. **Dual Relationships.** Dual relationships are relationships in which VA staff concurrently participate in two or more role categories with a Veteran patient. Similarly, a dual relationship can occur between a VA health care provider and a Veteran peer support provider. 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 a Veteran peer support provider, the Veteran patient, or another health care provider, which may also have ethical implications.

g. **Licensed Independent Practitioners.** Licensed independent practitioners (LIPs) are clinical staff licensed by a state to provide a prescribed set of clinical services

independently as defined by local medical center bylaws and policies. Within VHA, LIPs are designated at the VA medical facility level by business rule councils. **NOTE:** See *VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.*

h. **Mental Health Guidance on Workload Capture.** Mental Health Guidance on Workload Capture refers to documents that contain information related to capturing workload in VHA Vocational Rehabilitation, the PRRC, and Peer Support. This guidance is located on the Mental Health Business Operations SharePoint site.

(1) **VHA Vocational Rehabilitation Workload Capture QuickGuide.** The VHA Vocational Rehabilitation Workload Capture QuickGuide provides the information needed to properly set up clinics and record and document vocational rehabilitation encounters. VA staff can find this document on the Business Operations SharePoint (https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2018%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}).

NOTE: *This is an internal VA Web site that is not available to the public.*

(2) **Peer Support Workload Capture Guide.** The Peer Support Workload Capture Guide provides the information needed to properly set up clinics, and record and document Peer Support encounters. The Peer Support Workload Capture Guide can be found on the Business Operations SharePoint

(https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}).

NOTE: *This is an internal VA Web site that is not available to the public.*

(3) **PRRC Workload QuickGuide.** The PRRC Workload QuickGuide provides the information needed to properly set up clinics, and record and document PRRC encounters, including PRRC Bridge Group encounters provided on inpatient mental health units. **NOTE:** See *paragraph 6.h.(12) for the description of the PRRC Bridge Group.* The PRRC QuickGuide documents can be found on the Business Operations SharePoint

(https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}).

NOTE: *This is an internal VA Web site that is not available to the public.*

i. **National Psychosis Registry.** The National Psychosis Registry (NPR) is an ongoing registry of all Veterans diagnosed with psychosis (defined by the Serious Mental Illness Treatment Resource and Evaluation Center [SMITREC] as including schizophrenia, schizoaffective disorder, bipolar disorders, and other non-organic psychoses) who have received VHA services (inpatient or outpatient) from 1988 to the present. SMITREC maintains the NPR. SMITREC distributes facility-specific data

regarding the number of Veterans seeking VHA services on the NPR on at least an annual basis. This information can be found at <http://vaww.smitrec.va.gov/>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

j. **Non-VA Community Peer Support.** Non-VA community peer support is support provided by a community mental health program or an individual contractor that offers peer support services. **NOTE:** *Contracting specifics are detailed below in paragraph 8.c.(3).*

k. **Peer.** In VHA, a peer is a Veteran who has had similar life experiences in terms of illnesses, life events, treatments for mental illness, substance use disorders, or other health conditions as the persons being served.

l. **Peer Specialist.** A Peer Specialist is a Veteran discharged under other than dishonorable conditions who is in recovery from a mental health or substance use disorder and who is certified to provide peer support services per Public Law 110-387. The Peer Specialist may be certified by either a VA-approved not-for-profit or state-approved certification training organization. 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 self-management practices.

m. **Peer Support Provider.** A peer support provider is a Peer Specialist, Peer Support Technician, or a Without Compensation (WOC) employee who has been certified to provide peer support services to Veteran patients. Peer Support Apprentices are also peer support providers, but they are in a training status and must obtain their peer support certification within a year from their VA appointment as a Peer Support Apprentice. **NOTE:** *Some applicants may have overcome past legal or employment problems as part of their recovery process. The judgment of the mental health staff serving as the selecting official or interview panel regarding the suitability of these Veterans, who could be excellent role models for other Veterans, should be considered in the selection of applicants.*

n. **Peer Support Apprentice.** A Peer Support Apprentice is a Veteran discharged under other than dishonorable conditions, who is in recovery from a mental health or substance use disorder and is not certified to provide peer support services.

o. **Peer Support.** Peer support is a system of giving and receiving help by a person who is actively engaged in personal recovery, founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. It is a process dedicated to promoting empowerment and self-determination in the service of others recovering from mental health conditions to identify and achieve specific life and recovery goals.

p. **Peer Support Technicians.** Peer Support Technicians is a term that was formerly a human resources (HR) job classification before legislation defined the qualifications for Peer Specialists. Peer Support Technicians were often non-Veterans,

may not have been certified, and may not have used mental health or substance use disorder treatment services themselves. The Peer Support Technician job series is no longer used to hire staff for peer support services since the development of the Peer Specialist classification in 2012. Previously hired Peer Support Technicians who do not meet the Peer Specialist qualification standards may maintain their Peer Support Technician positions to continue provision of peer support services after attaining the approved Peer Specialist certification training.

q. **Psychosocial Rehabilitation.** Psychosocial rehabilitation is the term used within VHA that is akin to psychiatric rehabilitation, which the Psychiatric Rehabilitation Association (PRA) defines as promoting “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” (<http://www.psychrehabassociation.org/about-pra>). Rehabilitation services must be collaborative, person-directed, individualized, evidence-based, and an essential element of any health care system.

r. **Recovery.** VHA adopts the definition of “recovery” from the Substance Abuse and Mental Health Services Administration (SAMHSA), which describes recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA has delineated four major dimensions 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 *Recovery and Recovery Support*, available at <https://www.samhsa.gov/recovery>.

s. **Recovery-Oriented Care.** Recovery-oriented care is the right care provided at the right time to meet the Veterans’ needs and to promote hope and encouragement to the Veteran. Recovery-oriented care is strengths-based, focuses on the Veteran’s self-chosen goals and preferences, and is founded in shared decision-making.

t. **Self-Help.** Self-help is a self-guided personal improvement effort, frequently aided by peer input, to improve on existing challenges in emotional, economic, intellectual, or other life domains. Self-help is most often associated with overcoming challenges in addiction and psychological conditions but may also include support for individuals managing chronic health conditions and physical rehabilitation experiences. Some examples of self-help organizations are Alcoholics Anonymous, Overeaters Anonymous, Depression and Bipolar Support Alliance, and Vet-to-Vet.

u. **Serious Mental Illness.** Serious mental illness (SMI) is a mental, behavioral, or emotional disorder (excluding cognitive and developmental disorders and disorders due to a general medical condition) that meets all of the following criteria:

(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; and

(3) The impact of these symptoms results in a functional impairment equivalent to a Global Assessment of Functioning (GAF) score of 50 or below. **NOTE:** *Functional status may be assessed using any valid and reliable measure that has norms for a Veteran population. A GAF score of 50 or below is to be used as a reference point to interpret the results of the measure of functional status that is used.*

v. **Vocational Rehabilitation.** Vocational rehabilitation is a service that enables persons with functional, psychological, developmental, cognitive and emotional impairments, or health disabilities to overcome barriers to accessing, maintaining, or returning to employment.

w. **Vocational Rehabilitation Counselor.** Vocational Rehabilitation Counselors (VRCs) are Professional Rehabilitation Counselors educated and trained at the graduate level specifically to serve individuals with disabilities. Full professional counseling knowledge is required, and VRCs are often nationally certified as Certified Rehabilitation Counselors (CRC) or State licensed as Licensed Professional Counselors. Rehabilitation counselors may be designated as an LIP when they hold State licensure, are included as an LIP in their VA medical facility bylaws, and function under a scope of practice that is within their licensure and within the GS-101 VRC job functions. VRCs work with an interdisciplinary team to provide and coordinate a wide range of rehabilitation counseling services to Veterans with disabilities, including assessment, counseling and case management services, development of rehabilitation plans, and assistance in attaining and maintaining employment.

x. **Vocational Rehabilitation Specialist.** Vocational Rehabilitation Specialists (VRSs) work with an interdisciplinary team to help eligible Veterans with disabilities attain and maintain competitive employment. VRSs develop rehabilitation plans, place Veterans into employment or work experiences, and provide follow-along support for job retention. VRSs possess a range of background training and experiences, and there are no mandatory educational requirements. VRSs apply counseling techniques and methodology in assisting Veterans with disabilities in attaining and maintaining competitive employment; however, full professional counseling knowledge is not required.

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

z. **Without Compensation Peer Support Employees.** Peer support services may be provided by Veterans who wish to work as peer specialists without being paid for their services. These individuals must go through the formal WOC registration and orientation process. WOCs do not receive payment or compensation for their services.

4. POLICY

It is VHA policy that all mental health services are recovery-oriented and that all eligible Veterans, wherever they obtain care, have access to needed mental health rehabilitation and recovery services. Further, it is VHA policy that all mental health providers must have a basic knowledge of mental health recovery principles and must incorporate those into their delivery of clinical services.

5. RESPONSIBILITIES

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

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

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

(2) Ensuring that each VISN Director has the resources required to support the execution of this directive in all of the VA medical facilities within that VISN.

(3) Confirming that each VISN has and utilizes on an ongoing basis a means for ensuring the terms of this directive are fulfilled in all the VA medical facilities of the VISN.

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 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 Section in OMHSP, is responsible for:

(1) Developing national policy and procedures for PSR&RS which are consistent with the evidence-based and promising practices literature; VHA's mission, goals, and objectives; VHA Handbook 1160.01; and other authorizing documents as they become available.

(2) Providing consultation and guidance to VISNs and their VA medical facilities in the development and operation of comprehensive PSR&RS clinical programs.

(3) Providing subject matter experts for ad hoc consultation and guidance in specific PSR&RS program areas.

(4) Continuing the ongoing transformation of VHA mental health services to a recovery-oriented system of care.

(5) Collaborating with OAA to maintain the Psychosocial Rehabilitation Fellowships (<https://www.va.gov/oa/fellowships/psychosocial-rehab.asp?p=25>) offered at several VA medical facilities and the Psychosocial Rehabilitation Fellowship Administrative Hub Site at the VISN 5 Mental Illness Research, Education, and Clinical Center (MIRECC).

(6) Establishing, maintaining, and communicating national policy regarding all PSR&RS programs.

e. **National Director, VHA Vocational Rehabilitation Services.** The National Director, VHA Vocational Rehabilitation Services, is responsible for:

(1) Developing national policy on matters relating to VHA vocational rehabilitation practices and services.

(2) Ensuring the availability of training for VHA vocational rehabilitation staff via virtual or face-to-face training on clinical and administrative practices. **NOTE:** See *paragraph 8, Training*.

(3) Ensuring the provision of consultation and assistance via national training calls, conferences, site visits, and individual consultation to VISN Chief Mental Health Officers, VA medical facilities, and VHA vocational rehabilitation staff and managers to guide vocational rehabilitation services and CWT implementation.

(4) Ensuring the marketing of CWT programs nationally to Federal and community employers via the internet site, videos, and presentations, with the aim of promoting Veteran employment.

(5) Developing responses to inquiries from internal and external stakeholders.

(6) Serving as the national discipline lead for VHA Rehabilitation Counseling and Vocational Rehabilitation.

(7) Reviewing and, if applicable, granting exceptions to the qualification requirements for the positions of VISN Supported Employment (SE) Mentor-Trainer and VA Medical Facility Vocational Rehabilitation Services Program Manager on a case-by-case basis.

f. **Director, Northeast Program Evaluation Center.** The Director, Northeast Program Evaluation Center (NEPEC) in OMHSP, is responsible for program monitoring and evaluation for PRRCs, ICMHR programs, and VHA Vocational Rehabilitation Services. **NOTE:** *All programs providing Psychosocial Rehabilitation and Recovery Services (PSR&RS) services are required to participate fully in all NEPEC evaluations following guidelines outlined by NEPEC.*

g. **Director, Serious Mental Illness Treatment Resource and Evaluation Center.** The Director, SMITREC in OMHSP, is responsible for program monitoring and evaluation for the SMI Re-Engage Program.

h. **Chief Academic Affiliations Officer, Office of Academic Affiliations.** The Chief Officer, Office of Academic Affiliations is responsible for collaborating with the National Mental Health Director, PSR&RS Section in OMHSP to maintain the Psychosocial Rehabilitation Fellowships offered at several VA medical facilities and the Psychosocial Rehabilitation Fellowship Administrative Hub Site at the VISN 5 MIRECC (<https://www.va.gov/oa/fellowships/psychosocial-rehab.asp?p=25>).

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

(1) Ensuring that PSR&RS 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 PSR&RS programs are operated in compliance with this directive and PSR&RS program guidance.

(3) Ensuring that PSR&RS services (e.g., PRRCs, peer support, vocational rehabilitation) are available to eligible Veterans living in areas distant from the parent VA medical facility. These services can be provided through Residential Rehabilitation Treatment Programs when this level of care is needed or in community-based programs by national or regional contracts, Veterans Care Agreements (VCAs), or local contracts, for eligible Veterans.

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

(1) Ensuring that PSR&RS policies and guidance are disseminated to, at minimum, the mental health leadership at the VA medical facilities in their network.

(2) Assisting the PSR&RS section in the collection of data from the field when requested.

(3) Consulting with OMHSP and PSR&RS leadership about the impact of anticipated changes in policy on field-based PSR&RS programs.

(4) Consulting with OMHSP prior to program changes that may affect Veteran access to PSR&RS services, in accordance with VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016. **NOTE:** *This directive and supporting documents may be found in the Program Restructuring folder on the Mental Health Business Operations SharePoint site at https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FProgram%20Restructuring&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}. This is an internal VA Web site that is not available to the public.*

(5) Establishing procedures to name VISN-level Points of Contact (POC) for the Local Recovery Coordinators (LRCs), Peer Specialists, Peer Specialist supervisors, and Compensated Work Therapy (CWT) Program Managers. The duties of the POCs are adjunctive to their current duties and do not require a promotion.

(6) Ensuring that a VISN SE Mentor-Trainer is designated to provide appropriate services as described below in paragraph 5.k.

(7) Ensuring that the POCs for the peer support program have at least 2 years of experience as a VHA Peer Specialist or Peer Specialist supervisor. The Peer Specialist POC candidates must have demonstrated at least fully satisfactory performance on the last two annual performance reviews, have leadership skills, and have intermediate to expert level skills in communication and group facilitation. The time commitment for this role is approximately four hours per month.

k. **Veterans Integrated Service Network Points of Contact.** Duties listed below are performed with the permission of the VISN Chief Mental Health Officer and the POC supervisors. The VISN POCs are responsible for:

(1) Maintaining the network email distribution lists of program staff and informing the appropriate VA Central Office (VACO) Director of changes in any field positions in their VISN, including vacancies, backfills, and new hires. They are also responsible for attending monthly conference calls with the VA Central Office Director of their specific program. They relay information on network needs and questions on policy or other matters to the VA medical facility Director while receiving information and announcements to pass along to program staff within their network.

(2) Maintaining contact with other program staff within the VISN, either through the network email distribution lists or a monthly call with network staff. The POC relays information from the VACO Director of the program to the field and responds within 24

hours to requests for delivering information or obtaining feedback from staff in the network in order to meet the requirements of the program.

(3) Sharing information with the VISN Chief Mental Health Officer under arrangements established by the VISN Chief Mental Health Officer.

(4) Assisting the VA medical facility Director of the program with special projects as requested.

(5) Welcoming new VA medical facility program staff in their VISN and assisting in informing new program staff of general orientation such as location of program information and resources, as needed (SharePoint link, national call information, etc.).

(6) Serving as POCs for a time period to which the VISN Chief Mental Health Officer, the POC, and the POC's supervisor mutually agree. The VISN Chief Mental Health Officer will recruit for replacements at the end of the agreed upon time period.

NOTE: *In some networks, when the identified POCs are unavailable (e.g. sickness, workload, vacation), this function may be performed temporarily by another person selected by the VISN Chief Mental Health Officer.*

I. Veterans Integrated Service Network Supported Employment Mentor-Trainer.

Each VISN Chief Mental Health Officer must designate a VA medical facility within their VISN to function as the VISN SE Mentor-Trainer site, and that VA medical facility must maintain a full-time VISN SE Mentor-Trainer. The SE Mentor-Trainer must have experience in the provision of Individual Placement and Support (IPS) and SE and be hired in a vocational rehabilitation occupational series (either GS-101 VRC or GS-1715 VRS). **NOTE:** *Exceptions to these qualifications must be reviewed and granted by VACO VHA Vocational Rehabilitation Service Office.* The VISN Mentor-Trainer is responsible for:

(1) Carrying an active CWT-SE caseload (see paragraph 5.q, VA Medical Facility Vocational Rehabilitation Program Staff, which defines vocational rehabilitation clinical responsibilities).

(2) Providing guidance and training on IPS SE to CWT-SE staff and CWT Managers at all VA medical facilities within their respective VISNs.

(3) Providing feedback to VACO VHA Vocational Rehabilitation Services staff on VISN and VA medical facility SE implementation, such as SE staffing and vacancies, access to services, implementation barriers, quality improvement data, and strong practices.

(4) Participating in national CWT-SE Mentor-Trainer calls and activities to ensure ongoing knowledge and skills are consistent with national expectations.

(5) Carrying out the roles and responsibilities of the VISN SE Mentor-Trainer as detailed on the VHA Vocational Rehabilitation Services SharePoint site

(<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). **NOTE:** This is an internal VA Web site that is not available to the general public.

m. **VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Providing and maintaining program oversight to ensure access, quality, and compliance with national VHA policy and procedures. The unique needs of special populations, including but not limited to Veterans with SMI, must be addressed.

(2) Providing safe, well-maintained, and appropriately furnished VA medical facilities that support and enhance the recovery efforts of all Veterans. **NOTE:** See the *Mental Health Facilities Design Guide* at <https://www.cfm.va.gov/til/dGuide/dgMH.pdf> and the *Mental Health Environment of Care Checklist* at <http://vaww.ncps.med.va.gov/guidelines/mheocc.html>. These are internal VA Web sites that are not available to the public.

(3) Ensuring that the VA medical facility's psychosocial rehabilitation and recovery resources are available to all eligible Veterans.

(4) Ensuring that staff in PSR&RS program have support and adequate resources (e.g., staffing, vehicles, information technology equipment) to fulfill their responsibilities.

(5) Consulting with OMHSP prior to program changes that may affect Veteran access to PSR&RS services, in accordance with VHA Directive 1043. This directive and supporting documents may be found in the Program Restructuring folder on the Mental Health Business Operations SharePoint site at https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FProgram%20Restructuring&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}. **NOTE:** This is an internal VA Web site that is not available to the public.

(6) Ensuring that Veterans have opportunities to provide input and the unique perspective of the Veteran into the operational plan and evaluation of the mental health continuum of care at the facility. **NOTE:** Veterans Mental Health Councils (VMHC) are one way to achieve this. VMHCs are described in paragraph 8 of VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, dated September 11, 2008. For more information, please see the *Veterans Mental Health Council Guide* (https://www.mentalhealth.va.gov/docs/vmhc_guide_2009.pdf). Other ways of seeking Veteran input include but are not limited to local townhalls, VA Mental Health Summits, program exit interviews, and inviting representative Veterans to serve on local VA medical facility boards, committees, and planning bodies.

(7) Ensuring that performance benchmarks, posted and updated annually on the VHA Vocational Rehabilitation Program Guide SharePoint site, are attained. (<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). **NOTE:** This is an internal VA Web site that is not available to the public.

(8) Ensuring that every VA medical facility and very large Community-Based Outpatient Clinic (CBOC) (i.e., those CBOCs serving 10,000 or more unique Veterans each year; see VHA Handbook 1160.01) hire multiple permanent Peer Specialists to provide peer support services in selected programs.

(9) Ensuring the completion of all data requests, reporting, monitoring, and Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation requirements by the applicable due dates and as prescribed by the needs of the specific program.

(10) Ensuring that any contracted PSR&RS services provided by a community organization offer safe, efficient, and effective services comparable to an on-station program and in compliance with the procedures in this directive.

n. **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) is responsible for:

(1) Providing and maintaining PSR&RS program oversight to ensure high-quality services and compliance with this directive and PSR&RS program guidance.

(2) Completing all mandated reporting, monitoring, evaluation, and accreditation requirements relevant to PSR&RS services.

(3) In conjunction with the PSR&RS section in OMHSP in VACO, establishing procedures for the ongoing monitoring and evaluation of the effectiveness of peer support services that includes input from Peer Specialists and their supervisors.

(4) Ensuring that the LRC's clinical workload constitutes no more than 25 percent of their time, with the remaining 75 percent of their time dedicated to ensuring that all mental health services demonstrate the principles of recovery through consultation and education.

(5) Completing all accreditation requirements and all reports and monitoring required by the PSR&RS programs offered at the VA medical facility. Requirements may vary by PSR&RS program.

(6) Ensuring that cooperative partnerships exist among Veterans, Veterans' families, VHA mental health providers, community providers, and other stakeholders to support a recovery-oriented continuum of care.

(7) Supporting and working collaboratively with the VA medical facility LRC in sustaining the transformation of services to a recovery model.

(8) Ensuring and supporting opportunities for ongoing Veteran input into local mental health programs and initiatives. Opportunities for Veteran input include but are not limited to VMHCs, local town halls, VA Mental Health Summits, program exit interviews, and invitations to representative Veterans to serve on local VA boards, committees, and

planning bodies. Efforts must be made to ensure that Veteran input is actively sought, valued, and incorporated into meaningful change as appropriate.

(9) Ensuring that PSR&RS services are available to all eligible Veterans with serious mental illnesses who require them as needed for rehabilitation and recovery.

(10) Overseeing the VHA Vocational Rehabilitation Service, including CWT programs, which is recommended to be organizationally aligned under Mental Health but may be aligned under the service line best able to meet the vocational rehabilitation needs of Veterans with a range of disabling conditions and employment barriers.

(11) Ensuring that VHA Vocational Rehabilitation Services are provided both to Veterans with mental health conditions and to Veterans without mental health conditions who have a physical disability that presents a barrier to employment.

(12) Ensuring that VA medical facility mental health providers are informed about vocational rehabilitation interventions for Veterans with occupational dysfunction, including the evidence-based practices of IPS SE.

o. **VA Medical Facility Chief Fiscal Officer.** The VA medical facility Chief Fiscal Officer is responsible for:

(1) Overseeing and monitoring all CWT Account activities, including those associated with VA-based nonprofit CWT corporations and Federal Health Care Centers.

(2) Conducting monthly reconciliations of the CWT Account and an annual account audit.

(3) Collaborating with the CWT Program Manager to ensure timely and accurate Veteran CWT-Transitional Work (CWT-TW) payrolls, bills of collection, CWT Account balances, deposits to CWT Account, and to ensure all expenditures utilize approved budgeting procedures, including internal controls and separation of duties.

p. **VA Medical Facility Local Recovery Coordinator.** The VA medical facility LRC is a cross-cutting leadership position. The VA medical facility LRC is responsible for:

(1) Sustaining the integration of recovery principles and recovery-oriented services into mental health provided at all points of service throughout the health care system.

(2) Promoting the use and availability of recovery-oriented PSR&RS services (including but not limited to peer support, Psychosocial Rehabilitation and Recovery Centers (PRRC), Intensive Community Mental Health Recovery (ICMHR), VHA Vocational Rehabilitation Services, and skills training).

(3) Providing training and consultation to top management and mental health staff and leadership at the VA medical facility to ensure that services are treating the whole person and that programs are collaborative and integrated. Training, education, and

consultation include ad hoc opportunities and may include formal trainings found in TMS. **NOTE:** See paragraph 9, Training.

(4) Discussing issues and sharing best practices to ensure consistency on the LRC SharePoint site

(<https://vaww.cmopnational.va.gov/CR/MentalHealth/Recovery%20Coordinators/Forms/AllItems.aspx>), through the LRC email discussion group, and on national LRC calls.

NOTE: This is an internal VA Web site that is not available to the public.

(5) Implementing a multi-year local plan to direct recovery transformation in collaboration with local mental health leadership. The LRC must review and update the plan, at minimum, every 3 years with mental health leadership to continually improve the local recovery transformation. While ultimately the plan must be tailored to the LRC's health care system, best practices are shared on the LRC SharePoint site (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Recovery%20Coordinators/Forms/AllItems.aspx>), through the LRC email distribution list, and on national LRC calls.

NOTE: This is an internal VA Web site that is not available to the public.

(6) Outreach to Veterans with SMI identified by the Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) as being lost to VA care for over 1 year, including facilitation of the Veteran's return to care pursuant to the Veteran request.

NOTE: See VHA Directive 1160, *Re-engaging Veterans with Serious Mental Illnesses in Treatment*, dated February 7, 2018. Engagement in these activities constitutes part of the 25 percent clinical time for the LRCs.

(7) Promoting the effective and appropriate use of peer support in PSR&RS programs through advocacy for peer services, consultation on the effective and appropriate use of peer support, and education about recovery practices and principles.

(8) Promoting activities and events to eliminate stigma associated with mental illness such as Mental Illness Awareness Week (MIAW), Mental Health Month, Disability Employment Awareness Month, National CWT Vocational Rehabilitation Recognition Week, and Recovery Month.

(9) Participating actively in all VA medical facility workgroups addressing inpatient mental health units, environment of care, and transformation to ensure recovery-oriented practices.

(10) Providing direct, recovery-oriented clinical services for no more than 25 percent of their tour of duty.

(11) 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. **NOTE:** If the Veteran does not have decision-making capacity as defined in VHA Handbook 1004.01, *Consent to Clinical Treatments and Procedures*, dated August 14, 2009, the treatment plan must be established with the Veteran's surrogate, as defined in VHA Handbook 1004.01.

(12) Participating in VHA national conference calls and training programs related to PSR&RS.

(13) Serving, if selected by VISN leadership, as the LRC who fulfills the role of VISN LRC POC in coordinating VISN-level recovery-oriented activities and training, communicating with VISN leadership, and collaborating with national PSR&RS leadership.

q. **VA Medical Facility Vocational Rehabilitation Services Program Manager.**

(1) The VA medical facility Vocational Rehabilitation Service Manager, also called the CWT Manager, must have a background in vocational rehabilitation, knowledge of various disabilities and resulting vocational implications, and knowledge of evidence-based vocational rehabilitation treatment models and employment services. VHA Vocational Rehabilitation managers must be recruited and hired in either the GS-101 VRC or GS-1715 VRS occupational series as education, knowledge, and experience, along with vocational rehabilitation job functions and responsibilities are only covered in these job series. VRCs and VRSs have specialized training and experience in psychosocial and disability-related issues that impact employment as well as with job development and placement practices for persons with disabilities and other employment barriers. **NOTE:** *Hiring staff can request exceptions to these qualifications. Exceptions to these qualifications must be reviewed and granted by VACO VHA Vocational Rehabilitation Service Office.*

(2) CWT administrative, financial, clinical, and supervisory operations are highly complex and require significant oversight. To ensure coverage of the full scope of responsibilities, the VHA Vocational Rehabilitation Program Manager is a 1.0 Full Time Equivalent Employee (FTEE) position and will not have responsibilities outside of the VHA Vocational Rehabilitation Services program. It is recommended that the manager have a CWT caseload or vocational rehabilitation or rehabilitation counseling clinical responsibilities in addition to management and supervisory responsibilities. This paragraph applies to the specific vocational rehabilitation clinical duties. The VA medical facility Vocational Rehabilitation Services Program Manager is responsible for:

(a) Serving as a focal point for organizing, implementing, and evaluating employment and vocational rehabilitation services in the VA medical facility.

(b) Ensuring the quality and success of VHA Vocational Rehabilitation services and outcomes, including:

1. Performing strategic planning for program growth and improvement in response to local Veterans' needs;

2. Utilizing VA and community resources, as needed, to meet national CWT outcome benchmarks, as described in paragraph 7.p.;

3. Developing a local quality improvement plan that is reviewed at a minimum quarterly and is used to guide quality improvement initiatives;

4. Identifying gaps in VHA Vocational Rehabilitation services and informing VA medical facility mental health leadership of resource needs to address gaps;

5. Ensuring each VHA Vocational Rehabilitation staff member completes initial and continued training as necessary;

6. Initiating weekly clinical case discussions with and providing guidance to VHA Vocational Rehabilitation staff members;

7. Conducting a clinical review of existing caseloads with VHA Vocational Rehabilitation staff members for services provided, treatment progression, and adherence to caseload sizes as part of ongoing supervision of VHA Vocational Rehabilitation staff members;

8. Coordinating other physical, mental health, or psychosocial services;

9. Adhering to Joint Commission, CARF, and other applicable standards;

10. Developing memoranda of agreement (MOA) with other VA medical facilities, other Federal agencies, and community-based programs for the provision of TW.

11. Monitoring adherence to CWT MOAs and Intra-Agency/Interagency Agreements (IAAs), including CWT TW placement requirements in paragraph 7.q. of this directive.

12. Terminating a TW MOA when requirements are not being met, thereby jeopardizing a safe and therapeutic TW placement site.

13. Following-up on national marketing leads provided by the VACO VHA Vocational Rehabilitation Services team.

14. Serving as the discipline lead for VA medical facility vocational rehabilitation staff (when an exception exists and the VHA Vocational Rehabilitation Manager is not a VRC or a VRS, then this responsibility is delegated to a lead VRC or VRS);

15. Fulfilling clinical, administrative, financial, and business responsibilities within the CWT program, including:

a. Supervising VHA Vocational Rehabilitation staff (including vocational rehabilitation staff assigned to each CWT program component, program coordinators for designated program components [e.g., TW Coordinator], the VISN SE Mentor Trainer if a SE Mentor Trainer site, and other support, peer, or clinical staff assigned to VHA Vocational Rehabilitation) and ensuring that staff has the necessary training and resources to provide vocational rehabilitation services in accordance with this directive and VHA Vocational Rehabilitation guidance. **NOTE:** *The VHA Vocational Rehabilitation Manager must have direct supervisory authority for CWT Program staff and may provide discipline-specific clinical supervision for vocational rehabilitation staff assigned throughout the VA medical facility.*

b. Fiscal oversight of the CWT account, in collaboration with Fiscal Service, to ensure accurate Veteran TW payrolls every two weeks, bills of collection, CWT account balances, appropriate account expenditures, and approved budgeting procedures.

c. Enrolling in the CWT Manager and VHA Vocational Rehabilitation email groups and attending scheduled VHA Vocational Rehabilitation training calls. **NOTE:** *It is strongly recommended that managers complete the CWT Management Curriculum. See paragraph 9, Training.*

r. **VA Medical Facility Vocational Rehabilitation Program Staff.**

(1) VA medical facility Vocational Rehabilitation Program Staff may include vocational rehabilitation counselors, vocational rehabilitation specialists, and other support, peer, or clinical staff assigned to VHA Vocational Rehabilitation who perform duties in support of VHA Vocational Rehabilitation under their discipline's scope of practice. VHA Vocational Rehabilitation Program Staff may also consist of vocational rehabilitation staff designated as program coordinators for individual program components (e.g., TW Coordinator), and vocational rehabilitation staff in the role of the VISN SE Mentor Trainer if the VA medical facility is a SE Mentor Trainer site. VHA Vocational Rehabilitation staff providing vocational rehabilitation services must have vocational rehabilitation education, knowledge, or experience. They must have a working knowledge of the physical, mental, social, and psychological aspects of disabilities and knowledge of vocational rehabilitation counseling.

(2) Vocational rehabilitation and rehabilitation counseling job duties and responsibilities are covered under occupational series GS-101 VRC and GS-1715 VRS. Positions involving vocational rehabilitation functions must be established, posted, and hired in either the GS-101 VRC or the GS-1715 VRS job series and must not be posted in non-vocational rehabilitation occupational series outside of the vocational rehabilitation series. **NOTE:** *Exceptions to these qualifications must be reviewed and granted by VACO VHA Vocational Rehabilitation Program Office.*

(3) The responsibilities of the VHA Vocational Rehabilitation Services staff include:

(a) **Service Provision.**

1. Vocational rehabilitation and rehabilitation counseling services must be provided in accordance with the practice standards and policies documented in this directive, paragraph 7. Staff members must attend monthly all staff trainings provided by the VACO VHA Vocational Rehabilitation Services Office and review the VHA Vocational Rehabilitation Program Guide SharePoint site to ensure ongoing knowledge and skills are concurrent with national expectations

(<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the general public.*

2. Vocational rehabilitation staff in all VHA Vocational Rehabilitation components are responsible for assisting Veterans to identify, obtain, and maintain employment commensurate with their vocational, social, psychological, and medical needs, based on

their strengths, abilities, and preferences. This includes the following responsibilities, of which the emphasis may vary based on the service component the VHA Vocational Rehabilitation staff is assigned to:

a. Assisting the Veteran prepare for employment:

(1) Analyzing pertinent findings from medical, psychological, or prior vocational services or work experience.

(2) Counseling regarding the techniques for obtaining and maintaining employment.

(3) Assisting Veterans in becoming knowledgeable regarding the impact of employment on disability and other benefits as well as providing information on the means to access such benefits.

(4) Eliciting job preference, salary expectations and needs, insurance needs, transportation needs, and hours and days available to work.

(5) Assisting Veterans in becoming knowledgeable about job duties, personnel benefits, rates of pay, employment policies and practices, and the job location prior to job acceptance.

b. Providing job development and placement:

(1) Contacting employers and appropriate Federal, State, and local employment agencies to develop or identify job opportunities for persons with disabilities.

(2) Providing on-site job analysis, consultation, and recommendations for work-site and job modification, when appropriate.

(3) Assisting employers to identify, modify, and eliminate architectural, procedural, instructional or communication, or attitudinal barriers to the employment and advancement of persons with disabilities.

(4) Educating employers about:

(a) Various disabilities and resulting vocational implications;

(b) Assistive devices;

(c) Job accommodations;

(d) Services provided by the Job Placement Program;

(e) Incentives to the employer; and

(f) Current disability-related legislation affecting the employer.

(5) Maintaining communication and coordination with other community agencies and resources.

(a) Maintaining an organized system of recording job openings.

(b) Providing follow-along support for job retention:

(c) Contact with the employed veteran and with the employer (with Veteran permission) within 2 days of initial employment report date.

(d) Being available for the Veteran and employer during or after the Veteran's working hours.

(e) A flexible work schedule should be made available to vocational rehabilitation staff to meet the Veteran's needs.

(f) The maintenance and documentation of contact as clinically indicated to assure adequate job adjustment and retention.

(6) Veterans participating in CWT services who have not been placed should have their plans reviewed at least every 30 days. Strategize with the Veteran, other appropriate professional staff, and the referral source to review the plan when the Veteran has not obtained or maintained a TW placement or employment or achieved their employment goals.

(b) Clinical Documentation.

1. Progress Notes. Progress notes must reflect the Veteran's experiences, perceptions, progress, and be individualized to the Veteran's needs and preferences. Progress must be documented timely in the electronic medical record for each encounter, per local policy. The initial assessment must be completed within 7 days of intake or a timeframe established by local policy. Assessments will include career development needs and goals.

2. Records of Veterans who have been placed in outside employment will contain the following information:

a. Place of employment,

b. Job title;

c. Rate of pay and fringe benefits;

d. Date on which employment began; and

e. Employment status 60 days following job start.

(c) The Employment Plan. The employment plan, as part of the interdisciplinary treatment plan, is developed in partnership with the Veteran, the Veteran's primary

treatment team, and the VHA Vocational Rehabilitation staff. The initial plan is completed within the timeframe established by local procedures and is updated whenever a significant change in treatment intervention or clinical status occurs. The plan must include the following elements:

1. The Veteran's vocational goals as stated in the Veteran's own words, including longer term career goals and training needs.

2. Strengths, needs, abilities, and preferences and any needs for accommodation as identified by the Veteran, the Veteran's primary treatment team, and the VHA Vocational Rehabilitation staff.

3. Integrated assessment with information contributed by all providers, the Veteran, and collateral contacts when available.

4. Measurable objective(s) to achieve the stated vocational goal.

5. Strategies for meeting each objective with target dates and individuals identified as responsible for participating in the achievement of the identified activity.

6. The anticipated length of time in which follow-up contact will be maintained, primarily based on the Veteran's identified and expressed needs.

(4) Completion of Northeast Program Evaluation Center (NEPEC) monitoring forms.

s. **Psychosocial Rehabilitation and Recovery Center Program Manager or Coordinator.** The Psychosocial Rehabilitation and Recovery Center (PRRC) Program Manager or Coordinator reports to the local VA medical facility Mental Health Leader or designee. The PRRC Program Manager or Coordinator must be 1.0 FTEE in PRRC (i.e., cannot share other roles). The PRRC Program Manager or Coordinator is responsible for:

(1) Overseeing day-to-day program operations (e.g., ensuring that all scheduled programming occurs and is high-quality, ensuring compliance with NEPEC program monitoring protocol, ensuring compliance with CARF accreditation requirements, and ensuring compliance with national guidance).

(2) Coordination of other physical, mental health, or psychosocial services.

(3) Ensuring that program staff adhere to this directive and PRRC procedures.

t. **Supervisors of Peer Support Providers.** Supervisors of Peer Specialists, Peer Support Apprentices, and Peer Support Technicians must be licensed independent providers (LIPs) or be other non-licensed providers who work under an LIP, which may include peer specialists themselves. Supervisors of peer support providers are responsible for:

(1) Using VACO Human Resources -developed position descriptions and complying with all HR policies for recruiting Peer Support Apprentices and Peer Specialists.

(2) Conducting interviews using the Structured Oral Interview provided by VA Central Office, Office of Mental Health and Suicide Prevention (OMHSP) and HR offices (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FSupervision&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}>), which ensures questions that address the peer aspect of the position are asked in a legal and tactful manner. **NOTE:** *Only supervisors in the peer specialist supervisory email distribution list have access to this folder. This is an internal VA Web site that is not available to the public.*

(3) Within 1 month of the Peer Support Apprentice's selection date, notifying the National Director of Peer Support Services, HR, and Employee Education Service to initiate the process for obtaining certification from a state-approved agency or the VA-approved not-for-profit training vendor.

(4) Ensuring that all documentation entered by Peer Specialists meets standards found in the local VA medical facility's established business rules and for co-signing Peer Support Technician/Peer Support Apprentice/Peer Specialist-entered notes in the electronic medical record. The documentation must be completed according to the most current documentation guidance provided by the national program office in the Peer Support Services Workload Capture Guide (https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7bAF9A7AEA-6621-497D-B567-BFE95B0FB762%7d). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(5) Providing face-to-face individual supervision for a minimum of 1 hour per week for each full-time peer support provider during the probationary period and thereafter until the peer support provider demonstrates the need for less frequent supervision based upon the peer support provider's experience and competencies. At a minimum, supervision must occur no less than once per month.

(6) Monitoring Peer Specialists' attendance at team meetings and communicating instructions on how to provide feedback to other team members during supervisory sessions to ensure that peer support providers function as full members of the clinical team and are fully integrated in all clinical and planning activities.

(7) Providing and supporting ongoing education and training. **NOTE:** *For more details on education and training, see paragraph 9, Training.*

(8) Developing and communicating performance standards for all peer support providers at the beginning of the rating period. Verifying that all peer support providers

meet required competencies and developing performance improvement plans to include relevant training when necessary. **NOTE:** For more details on competencies, see paragraph 8.c.(5)(f).

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

(10) Participating in monthly Peer Support VISN POC conference calls with other supervisors or peer support providers.

u. **Supervisors of Without Compensation Peer Support Employees.**

Supervisors of VHA-employed Without Compensation (WOC) Peer Specialists, Peer Support Apprentices, and Peer Support Technicians must be LIPs or be other non-licensed providers who work under an LIP (which may include peer specialists themselves). These supervisors are responsible for:

(1) Following all local policies and procedures pertaining to WOCs.

(2) Developing written position descriptions for WOCs using the Peer Specialist position descriptions as a model but modifying as necessary to fit the job as developed for a WOC.

(3) Establishing a tour of duty with the WOC that fits the needs of the Veterans in the programs served.

(4) Orienting the WOC to the assigned section of mental health services and to all relevant VHA policies as well as ensuring participation in the local VA medical facility's HR orientation.

(5) Ensuring local business rules governing the use of electronic medical records are in compliance with guidance provided in the Mental Health Peer Support Workload Capture Guide

([https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7bAF9A7AEA-6621-497D-B567-](https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7bAF9A7AEA-6621-497D-B567-BFE95B0FB762%7d)

[BFE95B0FB762%7d](https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7bAF9A7AEA-6621-497D-B567-BFE95B0FB762%7d)). **NOTE:** This is an internal VA Web site that is not available to the public.

(6) Ensuring WOCs are able to make entries in electronic medical records and that all documentation entered by WOCs meets standards and is completed according to the local VA medical facility's established rules. **NOTE:** All notes written by WOCs must be co-signed by the supervisor.

(7) Providing face-to-face supervision for a minimum of 1 hour per week for each full-time WOC peer support employee during the probationary period and thereafter until the WOC demonstrates the need for less frequent supervision based upon the WOC's

experience and competencies. At a minimum, supervision must occur no less than once per month.

(8) Providing and supporting ongoing education and training. WOC peer support employees must meet the same requirements that Peer Specialists have for training and continuing education (CE).

(9) Verifying that HR has ascertained that all Veterans appointed as WOC peer support employees have obtained their peer specialist certification from a state-approved agency or VA-approved not-for-profit training vendor before the commencement of their WOC appointment.

(10) Developing and communicating performance standards for WOCs at the beginning of their assignment. Verifying that they meet required competencies and develop appropriate performance improvement plans to include relevant training when necessary. **NOTE:** *For more details on competencies, see paragraph 8.c.(5)(f).*

v. **Peer Support Providers.** Peer Support providers (Peer Support Apprentices, Peer Specialists, Peer Specialist WOCs and Peer Support Technicians) are responsible for:

(1) Complying with all policies and procedures relevant to VA employees, including this directive.

(2) Providing recovery-oriented services by sharing their personal recovery stories and using psychosocial rehabilitation tools to support Veteran patients' goals. **NOTE:** *Psychosocial rehabilitation tools include Wellness Recovery Action Plans (WRAPs), Illness Management Recovery (IMR), Honest Open Proud (HOP), and Writing to Wellness. Peer support services do not duplicate mental health clinical treatments provided by other staff. Peer Support providers offer value-added services from individuals who have demonstrated skills acquired through their lived experiences to successfully manage recovery from mental health or substance use disorders.*

(3) Instilling hope by providing opportunities for Veteran patients to observe Peer Support providers who are further along in their recovery and participating in positive, productive roles of their choosing.

(4) Educating Veteran patients by role modeling successful management of illness symptoms and the ability to function independently within their environment.

(5) Teaching Veteran patients skills to advocate for themselves in and outside of the larger health care system, while also working to reduce stigma that can serve as a barrier to receiving necessary goods and services. Examples of advocacy skills are self-assertiveness and tactfulness.

(6) Being knowledgeable about 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 to VHA culture and policies.

(7) Demonstrating the required competencies to provide peer support services.

NOTE: *This applies to all peer support staff, including non-certified GS-5 Peer Support Apprentices.* The specific domains of competence that must be demonstrated are found on the VHA Peer Support Services SharePoint (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2fCR%2fMentalHealth%2fPeer%20Support%20Services%2fHuman%20Resources%2fCompetencies&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8>). **NOTE:** *This is an internal VA Web site not available to the public.*

(a) One domain of knowledge within these competencies is Whole Health Approach to Services, which may be confused with another VA initiative named Whole Health Coaching. Peer Specialists who provide services in mental health clinics must be aware of various overall issues that contribute to health and wellness including many of the same areas addressed in Whole Health Coaching. This holistic approach to peer support may include personal disclosures concerning successful resolutions of different physical symptoms as well as mental health concerns. The Whole Health Coaching initiative does not recommend that staff disclose details of their own recoveries and maintains that the technical training provided includes all the methods necessary to do effective coaching. Peer Specialists who work in Patient Aligned Care Teams (PACTs) are able to use their recovery stories when appropriate to positively impact a Veteran receiving care. While their input is based on holistic health principles and competencies, they may or may not incorporate the proprietary Whole Health Coaching model used in the VA's formal Whole Health Coaching initiative.

(8) Maintaining these competencies through ongoing CE and attaining of a minimum of 12 hours of competency-related training every year. 2 hours of CE must be in the domain of ethics. **NOTE:** *See details found in paragraph 9, Training.*

(9) Participating in monthly Peer Support network POC conference calls with other peer support providers or supervisors.

NOTE: *GS-9 employed and certified Peer Specialists, who have additional qualifications such as a minimum of a bachelor's degree and experience working in a mental health team format, may serve as a Mental Health Treatment Coordinator (MHTC) provided they have received specific guidance and training for the role. In fulfilling the role of MHTC, the Peer Specialist must receive consultation from an LIP when needed.*

6. PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTERS

a. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, called for a transformation of mental health care to a recovery-oriented model. A key component involved transforming all existing

day treatment centers (DTC), day hospitals, partial hospitals, or analogous programs to Psychosocial Rehabilitation and Recovery Centers (PRRCs) and establishing new PRRCs where they are needed. These older programs were outpatient stabilization programs for Veterans challenged with serious mental illness and significant functional impairment. The primary aim of these programs was to manage chronic symptoms and assist Veterans with avoiding re-hospitalization, and they had limited expectations for those in the program to recover or to be fully integrated into the community.

b. PRRCs are intensive outpatient specialty mental health transitional learning centers designed to support recovery and integration into meaningful self-determined community roles for Veterans challenged with serious mental illness and severe functional impairment. Programming is multimodal (e.g., curriculum-based classes, counseling, and in-vivo exercises) and is specifically designed to capitalize on each Veteran's skills, strengths, and talents. Additionally, programming focuses on building skills and accessing resources to define and realize one's 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.

c. VA medical facilities with 1,500 or more Veterans across all sites of care included in the National Psychosis Registry (NPR) annual reports must have a PRRC. Additionally, VA medical facilities are required to develop a PRRC in the event that the 1,500 NPR threshold is met at some point in the future.

d. VA medical facilities with 1000 to 1499 current (Fiscal Year 2006 and later) Veterans across all sites of care included on the NPR are strongly encouraged to have a PRRC.

e. VHA points of service that currently have DTCs, day hospitals, partial hospitals, or analogous programs must transform their existing programs into PRRCs.

f. **Characteristics of Psychosocial Rehabilitation and Recovery Centers.**

(1) PRRC services assist Veterans in decreasing their need for reliance on mental health services by establishing or re-establishing meaningful roles in the community.

(2) Participation in PRRCs is voluntary, and Veterans receiving PRRC services have the right to direct their own affairs, including those that are related to any mental health condition.

(3) PRRCs provide opportunities for Veterans to develop strategies for maintaining wellness and plan for life stressors as they arise. PRRCs must provide a therapeutic and supportive learning environment for Veterans and must be designed to maximize functioning in all domains of health and life.

(4) PRRC staff recognize family members and other natural supports as vital contributors to the Veteran's recovery. With the consent of the Veteran as set forth in VHA Directive 1004.1, Consent to Clinical Treatments and Procedures, dated August 14, 2009, and VHA Handbook 1160.01, family members and other natural supports are

involved in the Veteran's treatment planning and recovery in every situation where it is appropriate. Efforts to promote community inclusion emphasize independent, self-directed engagement in community activities and roles. Family members, friends, fellow Veterans, and other natural supports should be incorporated as much as possible in promoting community inclusion. PRRC staff also attend as much as possible to the role that environmental barriers such as prejudice, discrimination, poverty, and transportation play in the lives of the Veterans they support and work to address these barriers as much as possible.

(5) PRRC services are to be coordinated, accessible, and readily available as long as needed. Following the evaluation and treatment planning process, Veterans 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.

(6) 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.

(7) PRRC staff actively encourage and support program participants, regardless of symptom severity, to engage in community activities throughout their involvement in the rehabilitation process. Assistance in getting involved in community activities that is provided to Veterans seeks to increase empowerment, instill independence in the Veteran, and decrease reliance on the disability-related services.

(8) PRRC staff constantly strive to learn and offer innovative recovery-oriented practices and skills. They embrace attitudes that promote mental health recovery and community inclusion. Education of Veterans and staff via role models is expected.

(9) 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.

(10) PRRC programming must include PRRC staff educating Veterans on the importance and process of completing mental health advanced directives. **NOTE:** See the National Center for Ethics in Health Care Web site for additional information on this topic: <https://www.ethics.va.gov/activities/policy.asp>.

(11) 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.

(12) PRRC staff may utilize the established mail groups for networking and information sharing. The VHA PRRC mail group is available to all PRRC staff, PRRC leaders, and PRRC supervisors. Being in this mail group provides automatic access to

the PRRC SharePoint site. The VHA PRRC Leaders mail group is available to PRRC leaders and supervisors only.

g. **Mission.** The mission of PRRCs is to inspire and assist Veterans who experience serious mental illness to reclaim their lives by instilling hope and building on strengths. PRRCs assist in connecting Veterans to resources that lead to establishing or re-establishing a meaningful, self-determined community life. PRRC staff actively engage in expanding their knowledge, skills and attitudes that fully embrace the values outlined in this paragraph and incorporate the core principles of psychosocial rehabilitation and recovery in all areas of practice and program development. Psychoeducation, skills training, evidence-based treatments, peer support, and individualized community-based interventions are the foundation of PRRCs.

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

(1) PRRCs are outpatient transitional specialty mental health programs. The primary focus of PRRCs is to assist Veterans with fully integrating into the community. PRRCs do not provide ongoing general mental health care.

(2) PRRCs must provide a therapeutic and supportive learning environment for Veterans and must be designed to maximize functioning in all domains of health.

(3) **Focus on Psychosocial Rehabilitation and Recovery Goals.** PRRC 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. To address the many facets of psychosocial rehabilitation and to promote Veteran recovery, PRRC teams are encouraged to utilize a variety of professional disciplines (e.g., chaplains, kinesiotherapists, marriage and family therapists, mental health counselors, nurses, nutritionists, occupational therapists, peer specialists, pharmacists, psychiatrists, psychologists, recreation therapists, rehabilitation counselors, social workers, and vocational specialists) both as team members and as collateral partners. If not directly represented on the team or in regular team meetings, team members need to routinely collaborate with these professionals and with other related VHA programs such as Compensated Work Therapy/Supported Employment (CWT/SE), Health Care for Homeless Veterans (HCHV), Home Telehealth, Housing and Urban Development-VA Supportive Housing (HUD-VASH), Intensive Community Mental Health Recovery (ICMHR: MHICM, RANGE, and E-RANGE), Local Recovery Coordinators (LRCs), Veterans Justice Outreach, and Women's Health. In particular, strong partnerships between PRRC teams and ICMHR teams are important to the continuum of care provided to Veterans with serious mental illnesses. Consistent with VHA Handbook 1163.04, Intensive Community Mental Health Services, dated January 1, 2016, and in support of this partnership, a shared recovery plan must be in place for each Veteran simultaneously enrolled in a PRRC and ICMHR program.

(4) **Strength-based Recovery Plans with Focus on Community Inclusion and Integration.** The recovery plans for Veterans served by the PRRC should focus on

helping them 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 following 14 recovery domains are addressed in the recovery plan for each Veteran served in the PRRC to the extent that they are pertinent to the Veteran's goals. These 14 recovery domains include:

(a) Renewed sense of purpose: setting and achieving personal goals, having a sense of purpose, renewing commitment to pursue a meaningful life.

(b) Personal empowerment: developing and maintaining a sense of personal empowerment, decision-making, active citizenship, responsibility, internal locus of control, self-efficacy.

(c) Optimizing psychiatric symptom management: achieving and maintaining optimal psychiatric symptom management, feeling in control of one's illness.

(d) Interpersonal fulfillment: developing and maintaining satisfying personal relationships and friendships to include relationships and friendships outside a mental health system.

(e) Life satisfaction: achieving and maintaining a sense of well-being; improved quality of life or satisfaction.

(f) Optimism and hope: developing and maintaining a sense of optimism, renewing hope.

(g) Involvement in personally meaningful activities: involvement or participation in personal, meaningful activities as determined by the Veteran.

(h) Overcoming stigma: overcoming personal or externally induced stigma.

(i) Work: working for pay or volunteering at least part-time (enrolled in a full or part-time educational program directed toward a vocational goal).

(j) Community involvement and integration: participating in activities that are in the Veteran's community of choice (e.g., Veteran Service Organizations (VSO), local government, church, political groups, National Alliance on Mental Illness (NAMI), Mental Health America (MHA), youth activities, book clubs, school systems, sports and recreation leagues).

(k) Meeting basic needs: obtaining basic needs (food, shelter, finances).

(l) Optimizing physical health: physical health maintenance and promotion (medical problems, weight management, blood pressure, sleep hygiene).

(m) Spirituality: development and practice of a preferred spiritual life.

(n) Enjoyment and fun: involvement or participation in activities of personal choice that are healthy, pleasurable, enjoyable, and fun.

NOTE: This list was adapted from the 2008 PRRC Outcome Measures Workgroup Final Product. This document is available at the PRRC SharePoint site:

<https://vaww.cmopnational.va.gov/CR/MentalHealth/PRRC/Mental%20Health%20Services%20PRRC%20Guidance/PRRC%20Recovery%20Domains%20-%20PRRC%20Outcome%20Measures%20Workgroup%20Final%20Product%2011%2020%2008.fin.doc>. This is an internal VA Web site not available to the public.

(5) Efforts to promote community inclusion emphasize independent, self-directed engagement in community activities and roles. PRRC staff do not foster community institutionalization as defined in paragraph 3.c. of this directive. That is, staff 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 will be kept at a minimum and only be used when clinically indicated. The emphasis of staff-led community-based activities or interventions will 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.

(6) Hours of Operation and Weekend Programming. Hours of operation are typically Monday through Friday from 8:00 am to 4:30 pm. 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, churches, museums, preferred houses of worship) and relationships (e.g., family, friends, social groups). Evening and weekend program hours must be available on an as-needed basis to support Veterans' emerging skill development and integration in the community.

i. **Core Services.** A minimum array of services available to Veterans through a PRRC must include:

(1) Services that are individualized, person-centered, strengths-based, and promote hope, responsibility, and respect.

(2) Services that facilitate an enhanced quality of life based on individual Veteran viewpoints for each person receiving them.

(3) Services that are designed to address the unique needs of each Veteran consistent with the Veteran's cultural values and norms.

(4) Individual recovery planning and recovery coaching that occurs initially at least every 2 weeks to meet the clinical needs of the individual. As the Veteran makes progress toward their recovery goals, the interval may increase to no less often than once monthly, as clinically indicated.

(5) Individual psychotherapy (e.g., cognitive behavioral therapy [CBT], CBT for psychosis, CBT for insomnia, dialectical behavior therapy [DBT], motivational enhancement therapy, or supportive therapy) to assist with defining and realizing the Veteran's preferred life roles and goals.

(6) Social Skills Training classes.

(7) Psychoeducational classes.

(8) Illness Management and Recovery (IMR) classes. **NOTE:** Materials for these classes can be found in SAMHSA IMR Tool-Kit Material (<http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>). *This linked document is outside of VA control and may not conform with Section 508 of the Americans with Disabilities Act.*

(9) Wellness programming to promote an active and healthy lifestyle (e.g., nutrition, importance of regular meals, sleep hygiene, exercise, smoking cessation, healthy leisure activities, weight management, pain management, chronic disease management). **NOTE:** *Please refer to the SAMHSA Action Planning for Wellness and Recovery* (<https://vaww.cmopnational.va.gov/CR/MentalHealth/PRRC/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPRRC%2FSAMHSA%20Materials%20%28Public%20Domain%29&FolderCTID=0x01200068839DB73E2D0044A1CBF5335E384175&View={A6E73B3E-3C31-4CA4-8615-5752E22695FD}>) *for an action planning tool that is similar to the Wellness Recovery Action Plan (WRAP). Both resources are examples of acceptable Wellness programming. This linked document is outside of VA control and may not conform with Section 508 of the Americans with Disabilities Act.*

(10) Family psychoeducational and family educational programs.

(11) Peer Support Services (refer to paragraph 8 of this directive for specific information about the implementation of peer support in VHA).

(12) PRRC Bridge Groups, which are psychoeducational outreach groups that must be provided by PRRC staff on acute and non-acute inpatient mental health units. PRRC Bridge Groups may also occur in other mental health settings if indicated.

(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) All Veterans regardless of the type or severity of mental health challenges may attend PRRC Bridge Groups.

(c) Topics to be covered will 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, preferably through Peer Support Specialists as facilitators or co-facilitators.

(d) It is highly recommended that PRRCs coordinate the implementation of Bridge Groups with the acute and non-acute inpatient mental health units to minimize overlap with existing group programming in the milieu. The local PRRC program will facilitate any transition to the PRRC in coordination with the acute and non-acute inpatient mental health treatment teams and as desired by the Veteran.

(e) In order to maximize the probability that all Veterans on the acute and non-acute inpatient mental health units attend at least one PRRC Bridge Group during an inpatient mental health admission, PRRC Bridge Groups must be conducted at least once weekly on these units.

(13) Treatment of co-occurring substance use disorder.

j. **Programs and Services to Be Coordinated with PRRCs.** Other services that must be available to PRRC participants as clinically indicated and coordinated with the program include:

(1) MHTC and mental health diagnostic and treatment services (including psychopharmacologic therapy).

(2) Primary medical care.

(3) Case management services including Intensive Community Mental Health Recovery (ICMHR: MHICM, RANGE, and E-RANGE). For further information, see VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016.

(4) Health Care for Homeless Veterans (HCHV). For further information, see VHA Handbook 1162.09, Health Care for Homeless Veterans (HCHV) Program, dated May 2, 2014.

(5) Housing and Urban Development-VA Supportive Housing (HUD-VASH). For further information, see VHA Directive 1162.05(1), Housing and Urban Development Department of Veterans Affairs Supportive Housing Program, dated June 29, 2017.

(6) Home Telehealth. **NOTE:** Further information about this program found at Home Telehealth (<http://vaww.telehealth.va.gov/pgm/ht/index.asp>). This is an internal VA Web site that is not available to the public.

(7) Compensated Work Therapy (CWT) including Transitional Work (TW), Community-Based Employment Services, and SE as clinically indicated (see paragraph 7 of this directive for further information).

(8) Other evidence-based treatments as clinically indicated.

k. **Location.** Ideally, PRRCs are located in the community with readily-accessible public transportation. When PRRCs are on VA medical facility grounds, efforts should 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 Outpatient Mental Health Design Guide or equivalent guidance document and in the PRRC Implementation Checklist should be available to support PRRC program operations. **NOTE:** *The PRRC Implementation Checklist can be found on the PRRC SharePoint:*

<https://vaww.cmopnational.va.gov/CR/MentalHealth/PRRC/Getting%20A%20PRRC%20Started/SPGS%20PRRC%20SelfAssmnt%20Chklist%2011%2005%2008.doc>. *This is an internal VA Web site not available to the public.*

I. Staffing Guidelines/Recommended Panel Sizes.

(1) Interdisciplinary staffing for PRRCs includes: 1.0 Program Manager or Coordinator, 1.0 Masters prepared Social Worker, 1.0 Masters prepared Advanced Practice Nurse, 1.0 Occupational Therapist, 1.0 Psychologist, 1.0 to 2.0 Peer Support Specialists, and 1.0 Program Support Assistant.

(2) Actual staffing in each program is currently determined by the number of Veterans served, severity of impairment, and the services provided. A 1:6-10 staff to Veteran ratio is necessary to ensure that intensive specialty mental health services as defined in this directive can be delivered effectively. Future adjustments to the staff-to-Veteran ratio will be determined with input from an analysis of the Northeast Program Evaluation Center (NEPEC) PRRC program evaluation data.

m. **Supervision of Unlicensed Staff.** Supervision of unlicensed staff (e.g., peer support providers, mental health profession trainees, and other non-licensed providers) must be conducted to ensure the delivery of safe and effective clinical services. Licensed independent practitioners (LIPs) must readily be available to unlicensed staff in person or by phone. Additionally, supervision of peer support providers must comply with the guidelines detailed in paragraph 8 of this directive, Peer Support.

n. **Target Population and Admission Criteria.** PRRC Services are intended to provide necessary specialty mental health treatment and support for Veterans who meet all of the following criteria:

(1) Diagnosis of a Serious Mental Illness. The primary target population for PRRC services is Veterans with severe manifestations of psychosis, mood disorders, or PTSD whose functional status is severely impaired. To maintain an overall emphasis on services for Veterans with psychosis and bipolar disorder, PRRC coordinators must ensure that programs serve at least a 75 percent minimum proportion of Veterans meeting the diagnostic criteria established for the NPR. Once these targets have been reached, Veterans with other serious mental illness diagnoses and similar impairments in functional status may be enrolled in PRRC services. Other conditions such as Mild Traumatic Brain Injury (mTBI), substance use disorders, 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 Services staff working to assure coordination, non-duplication of services, and linking of all services to an overall recovery-oriented treatment plan.

(2) 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. In these cases, efforts need to be made 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.

o. Drug and Alcohol Screening.

(1) All individuals with a co-occurring alcohol or other substance use disorders are screened for current use prior to admission to the program. Substance use illness must never be an insurmountable barrier for treatment of Veterans with mental health conditions. Veterans cannot be denied admission to PRRCs based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number or recency of previous treatment episodes, the use of prescribed controlled substances, or legal history. The screening process must consider each of these special circumstances and determine whether the PRRC can meet the individual Veteran's needs appropriately while maintaining the program's safety, security, and integrity. However, individuals will be 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.

(2) PRRCs may not be able to provide the appropriate treatment objectives and therapies for many Veterans with active (untreated) substance use disorders. In these cases, efforts need to be made 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.

(3) To ensure a substance-free environment, Veterans enrolled in the PRRC 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.

p. **Admission to Psychosocial Rehabilitation and Recovery Center Services.**

PRRC teams provide an evaluation for service participation for Veterans who are referred to or who personally request PRRC Services. Referrals and PRRC Services team responses must be documented using the consult procedure in the electronic medical record. The process of evaluation for PRRC service participation must be guided by the following principles:

(1) Each referral needs to be 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.

(2) Veterans cannot be denied services solely due to the number of previous treatment episodes, legal history, homelessness, the diagnosis of a personality disorder or a substance abuse 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. Because PRRC services provide unique clinical services for Veterans with serious mental illness, PRRC teams need to make every possible effort to enroll referred Veterans who meet the definition of the target population and who desire PRRC services. While respecting the Veteran's right to refuse specific treatment options, PRRC teams need to exert additional efforts to reach out to those who initially are reluctant to enroll to ensure that they make an informed decision.

(3) Safety of PRRC team members and Veterans is a highly important consideration. Because PRRC services are often delivered in the community, PRRC team members work in settings that cannot be controlled in the same manner as the VA medical facility or clinic. Therefore, in addition to general considerations of safety while working in the community, PRRC team members must have access to cellular telephones. **NOTE:** *These cell phones are issued to PRRC staff by VA in accordance with local procedures and resources.*

(4) When a referred Veteran is not enrolled in PRRC, the PRRC team must partner with the MHTC or referring provider (if a MHTC has not yet been designated) to ensure that the mental health needs of the referred Veteran are met (e.g., suggesting alternative services).

q. **Initial Assessment and Recovery Plans.** An initial assessment and preliminary recovery plan must be completed with each Veteran admitted in the program for 10 participating days or longer. Completion of the initial assessment and preliminary recovery plan will formally establish admission to the PRRC. Full recovery plans must be entered into the electronic medical record within 20 participating days after admission to the PRRC and after completion of the initial assessment and preliminary recovery plan. The recovery plan is jointly completed by the Veteran and the clinical team. The recovery plan reflects an organized approach toward assisting Veterans with identifying specific, meaningful roles and goals. Additionally, 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.

r. **Clinical Documentation.** Clinical documentation reflects adequate supervision of services provided by unlicensed clinical staff. Appropriate documentation of program involvement and progress for each Veteran towards accomplishing their recovery plan occurs as detailed in the PRRC Workload QuickGuide 2017. This document can be found on the Business Operations SharePoint (https://vawww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}).

NOTE: This is an internal VA Web site that is not available to the public.

s. **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., general 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 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 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) Unimpeded by the abuse of substances.
- (5) Independently participating in necessary treatments.
- (6) Expressing a desire to receive less frequent clinical contacts or utilize a different treatment modality.

t. **Availability of Psychosocial Rehabilitation and Recovery Center Services Post-Discharge from the Psychosocial Rehabilitation and Recovery Center.**

Following successful discharge from the program, Veterans may be re-admitted to the

PRRC to participate in any element of the program on an as-needed basis in the future. The Veteran's current GAF score or equivalent cannot prevent re-admission to the PRRC, regardless of whether this score differs from the Veteran's score at initial admission. A new assessment and recovery plan must be completed when Veterans are re-admitted to the PRRC.

u. **Meals.** Including meals is not a requirement of PRRC programming. If meals are provided, there needs to be a clear, written psychosocial rehabilitation rationale in the participating Veteran's recovery plan, which includes an organized and clear path to ultimate independence in this area, by the PRRC staff member writing the recovery plan. Additionally, if meals are provided, staff must be mindful of the risk of fostering dependency that may develop over time.

v. **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. Clinical staff must be medically cleared and trained before transporting Veterans in Federal vehicles pursuant to VHA Directive 2008-020, Patient Transportation Program, dated April 16, 2008. 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.

w. **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 for a period of time 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.

x. **National Psychosocial Rehabilitation and Recovery Center Monitoring and Data Collection.**

(1) Program monitoring and outcome measures have been implemented. NEPEC, in collaboration with Psychosocial Rehabilitation and Recovery Services (PSR&RS), is responsible for developing and implementing program evaluation and outcome measures for PRRCs, analyzing the data it receives, and communicating the findings to the local facilities. PRRC staff are required to actively participate, including timely submission of all required information as requested.

(2) PRRC workload capture (e.g., clinic set up, stop codes, and Clinical Procedural Codes) is detailed in the PRRC Workload QuickGuide 2017. This document can be found on the Business Operations SharePoint: https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2F

[MH%5FCoding%2F2017%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View={AF9A7AEA-6621-497D-B567-BFE95B0FB762}](http://www.vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx)).

NOTE: This is an internal VA Web site that is not available to the public.

y. **Accreditation.** Endorsement from external accreditation agencies is an important aspect of ensuring ongoing, high quality programming. In connection with this, PRRCs must apply for Commission on Accreditation of Rehabilitation Facilities (CARF) International accreditation under the Psychosocial Rehabilitation field category and must meet the most recent version of the CARF International Behavioral Health Standards (Sections 1 and 2 as well as Section 3E, Community Integration Standards). The CARF standards are published at:

<http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx>. **NOTE:** This is an internal VA Web site that is not available to the public. PRRCs must also obtain and maintain the applicable Joint Commission Behavioral Health Standards detailed in the most recent version of the Joint Commission Accreditation Manual for Hospitals. These standards can be accessed via the TJC Manual via E-dition which can be found on this link: <http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx>.

NOTE: This is an internal VA Web site that is not available to the public. All PRRCs must have CARF International and Joint Commission accreditation within 1 year of PRRC formal designation and comply with the Office of Mental Health and Suicide Prevention (OMHSP) and CARF Accreditation Steering Committee schedule for applying for accreditation.

z. **Quality Improvement Initiative.** As required by CARF International, PRRCs will have organized, regular, and planned quality improvement initiatives to systematically improve their services. PRRCs are encouraged to utilize the NEPEC PRRC program monitoring and evaluation data for their PRRC program and input from Veterans served as part of this process.

aa. **Waiver Process.** A formal waiver process is available for some Day Hospital programs that are time-limited and closely associated with acute inpatient mental health when there is also a PRRC available. These time-limited programs that are closely associated with acute inpatient mental health programs are allowed when a PRRC is also available. VHA points of service with 10,000 or more unique Veterans annually are encouraged to have a PRRC. New Day Treatment Center, day hospital, partial hospital, or analogous programs may not be implemented without approval in advance from OMHSP. OMHSP does not support simple, socialization programs aimed at maintenance. Rather, all new programs must incorporate into their programming psychosocial rehabilitation principles and values that facilitate and support recovery and the acquisition of meaningful roles in the community.

7. VHA VOCATIONAL REHABILITATION SERVICE

a. **Background.** VHA Vocational Rehabilitation Service programs are recovery-oriented clinical vocational rehabilitation services and offer a continuum of vocational, educational, training and employment, and therapeutic work services, including skill development and assistance with obtaining and maintaining employment for Veterans

for whom the primary objective is competitive employment. The Veterans Omnibus Health Care Act of 1976 (Pub. L. 94-581) authorized a “therapeutic work” program and established in the Treasury of the United States a revolving fund known as the Department of Veterans Affairs Special Therapeutic and Rehabilitation Activities Fund (STRAF) for the purpose of furnishing Compensated Work Therapy (CWT) rehabilitative services. Subsequent legislation authorized the development of a Supported Employment (SE) program (Pub. L. 108-170, section 104) and the merging of the STRAF account (now called the CWT Account) with the Medical Services account (the Appropriations Act of 2005). VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, required that “each medical center must offer CWT with both TW and SE services for Veterans with occupational dysfunctions resulting from their mental health conditions, or who are unsuccessful at obtaining or maintaining stable employment patterns due to mental illnesses or physical impairments co-occurring with mental illnesses.”

b. In 2016, the Acting Deputy Under Secretary for Health for Operations and Management approved and released a VHA Vocational Rehabilitation Transformation Plan, prioritizing community-based competitive employment as the desired outcome of VHA Vocational Rehabilitation participation. The Transformation Plan recommended implementation of a new service, CWT-Community-Based Employment Services, expansion of strong practices (CWT-Supported Self-Employment (SSE) and CWT-Supported Education (SEd)), enhancement of CWT-TW to incorporate clinical and job retention services, and recommended discontinuation of older, prevocational models (i.e., Incentive Therapy [IT], Sheltered Workshop, Horticulture Therapy, and Therapeutic Print Plants) that result in lower rates of competitive employment than those endorsed through the Transformation Plan.

c. VHA Vocational Rehabilitation is an umbrella term that encompasses the clinical vocational rehabilitation services of CWT and vocational assistance. CWT is a VHA recovery-oriented, vocational service authorized by 38 U.S.C. 1718. CWT is an umbrella term encompassing several models of treatment.

d. **Mission.** The mission of VHA Vocational Rehabilitation is to promote recovery for Veterans living with mental illness or physical impairment, with barriers to employment, who want to secure and maintain meaningful community-based competitive employment that fosters self-esteem, dignity, respect, and independence through high-quality vocational rehabilitation services.

e. **Target Population.** VHA Vocational Rehabilitation is appropriate for all Veterans eligible for VA health care that are living with mental illness or physical impairment with barriers to employment and want to secure and maintain meaningful community-based competitive employment. VHA Vocational Rehabilitation is intended for Veterans with mental illness, substance use disorders, homelessness, criminal justice involvement, physical disabilities, and other disabilities that contribute to occupational dysfunction.

f. **Services Offered.**

(1) The major program components of CWT include: TW, SE, Community-Based Employment Services (CBES), SEd, and SSE services. **NOTE:** See *paragraph 7.q. for details*. Each VA medical facility must offer VHA Vocational Rehabilitation services consisting of CWT-TW and CWT-SE services to Veterans who experience occupational difficulties resulting from their mental health, medical disabilities, physical disabilities, or homelessness, or who are unsuccessful at obtaining or maintaining stable community competitive employment.

(2) VA medical facilities are also strongly encouraged to provide CWT-CBES.

(3) VHA Vocational Rehabilitation Services may also include Vocational Assistance, SEd, SSE, and training initiatives designed to improve job skills that lead to competitive employment.

(4) Each VISN must assign and maintain a VISN SE Mentor-Trainer to provide guidance and training to SE staff at all VA medical facilities within their respective VISNs and to provide feedback to VHA Vocational Rehabilitation and NEPEC staff.

g. **Program Organization and Management.**

(1) The VHA Vocational Rehabilitation Service Office in the Office of Mental Health and Suicide Prevention provides overall clinical and administrative oversight for Vocational Rehabilitation Services.

(2) At the VA medical facility level, it is recommended that Vocational Rehabilitation Services staff are aligned under the Mental Health service line, however, actual organizational alignment may vary according to Veteran need and resources at that VA medical facility. Vocational Rehabilitation Services will be aligned under the service line deemed best able to support vocational rehabilitation services to a range of Veteran populations at each VA medical facility.

(3) Vocational Rehabilitation Services are encouraged to be integrated within the Veteran's interdisciplinary treatment; however, some programs may align or dedicate non-vocational disciplines to the VHA Vocational Rehabilitation team to facilitate holistic service delivery and provide services within their disciplines' scope of practice.

(4) **Research.** The VHA Vocational Rehabilitation Services Program Manager at each VA medical facility is strongly encouraged to develop research appropriate to its service provision.

(5) **Affiliation and Clinical Training Programs.** The VHA Vocational Rehabilitation Services program at each VA medical facility is strongly encouraged to develop academic affiliation agreements with local universities and colleges for the training of Rehabilitation Counselors.

(6) VHA Vocational Rehabilitation coordinates and collaborates employment services with other VA, Federal, state, and local community partners.

h. **Recommended Caseload Sizes (Staff: Veteran Ratios)**. CWT-TW and CWT-SE services must be maintained at levels to meet Veteran need. CWT-SE staff must be solely dedicated to providing SE services in order to promote fidelity to the evidence-based practice of SE and to ensure high-needs Veterans have access to intensive vocational support.

(1) **CWT-TW: 1:30.**

(a) The recommended caseload size is 1:30 when the TW vocational staff provides only TW, which includes all the following services: vocational assessments and planning, regularly scheduled individual vocational guidance, discussion of worksite evaluation and planning, career development planning, work site observations, and job retention services. When the TW vocational staff provides other vocational services (e.g., CWT-CBES, Vocational Assistance) their caseload size will be prorated based on the time devoted to CWT-TW.

(2) **CWT-SE: 1:20-25.**

(a) The current Individual Placement and Support (IPS) Fidelity Scale recommendation is a caseload size of 1:20 (<https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf>). **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

(a) VHA Vocational Rehabilitation supports a full CWT-SE caseload size of 1:20 and should not extend above 1:25 in order to maintain fidelity to the model and to provide necessary service intensity.

(b) Individual caseload size may vary within this recommended range based on the phase of SE (job development, follow-along supports, etc.) that Veterans on the caseload are in.

(3) **CWT-CBES: 1:30.** Many staff providing CWT-CBES have additional responsibilities, such as provision of Vocational Assistance or CWT-TW. This will impact, and should be reflected in, their expected caseload size.

i. **Participation Criteria and Considerations.** Participation in the CWT Program must be available to any Veteran eligible for care, as clinically indicated. Information and participation criteria related to CWT must be made available by the CWT Manager to Veterans and staff at all VA medical facilities, as well as to VA providers furnishing services through telemental health programs and CBOCs and to non-VA providers (as requested). Considerations for participation include:

(1) There are no required pathways to participation in any VHA Vocational Rehabilitation program component such as duration of sobriety, routine vocational

testing, participation in another VHA Vocational Rehabilitation modality, or required time in a treatment program or clinical service prior to participation in VHA Vocational Rehabilitation.

(2) Participants in VHA Vocational Rehabilitation programs are not subject to the Means Test or co-payments for the services rendered in these programs.

(3) Per 38 U.S.C. 1718, program participants must not be held or considered as employees of the United States for any purpose. VA's Office of General Counsel has determined that VHA staff may not subject program participants to criminal background investigations, including fingerprint checks as a condition of acceptance for services, even with the Veteran's consent.

(4) VHA Vocational Rehabilitation program participants will participate in development of individualized employment plans that are based on the Veteran's goals, skills, and abilities. Services are outcome-oriented, resulting in meaningful community-based competitive employment.

j. Referrals to VHA Vocational Rehabilitation and Medical Clearance. Veterans may be referred to VHA Vocational Rehabilitation from other programs, both within and outside VHA. Referrals to all VHA Vocational Rehabilitation programs, except for Vocational Assistance, are required via an electronic consult or order in the electronic medical record and may be made to VHA Vocational Rehabilitation by any appropriately credentialed and privileged individuals who are permitted by law and the VA medical facility to practice independently as set forth in VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012. When a Veteran self-refers for vocational rehabilitation treatment, or is referred from outside VHA, VHA Vocational Rehabilitation staff work with the Veteran's Mental Health Treatment Coordinator or Primary Care Provider to generate a consult.

(1) The provider must indicate in the consult that the Veteran is medically cleared to participate in a VHA Vocational Rehabilitation program, identifying any restrictions or limitations that may impact a work placement or competitive employment while participating in VHA Vocational Rehabilitation. Medical clearance may be completed through review of medical records and information provided directly from the Veteran. An in-person physical exam is not required unless, after the provider's review of the Veteran's medical record or from intake and participation in VHA Vocational Rehabilitation, there are medical issues that need to be addressed for proper placement. If the consult is generated by a provider that does not have authority to provide medical clearance, then medical clearance must be provided via addendum to the consult by an appropriately credentialed provider.

(2) Immunizations, Tuberculin Skin Tests (i.e., TB tests), and urine drug screens are not requirements for admission to VHA Vocational Rehabilitation programs; however, these may be determined to be appropriate and necessary for specific work assignments. This would be locally determined based on the nature of the work setting and assignment, and not as an across-the-board requirement of participation.

(a) If any vaccination is needed, it must be provided by the Veteran's primary care team at no cost to the Veteran and documented by the team in the Veteran's electronic medical record.

(b) Urine drug screens, when utilized, are to inform treatment, and must not to be used for punitive or exclusionary purposes. When there is a clinical reason to do so (e.g., worksite safety concerns) a drug screen can be requested by CWT vocational staff or the CWT Manager; however, for the most part, natural consequences such as suspension from the worksite, loss of job, demotion, etc., for behaviors such as missing work, tardiness, etc., should be utilized. A drug screen order must be placed by someone with appropriate clinical credentials as defined by the local VA medical facility and coordinated with the Veteran's treatment team. Decisions made by the CWT Manager by utilizing drug screen results must be informed by discussions with the Veteran's treatment team. Veterans must be informed by the CWT Program staff of when and why this may occur and how results will be used as part of informed consent.

k. **Electronic Wait List Policy.** The Electronic Wait List (EWL) must be utilized for new patient requests that cannot be scheduled in the requested mental health clinic within 90 days as per VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016. In this directive, a "new patient appointment" refers to a patient who has not been seen in the corresponding stop code in the past 24 months. For example, if a Veteran is assessed as needing CWT-Transitional Work (CWT-TW) or CWT-SE, but a placement in CWT-TW or a slot on the CWT-SE caseload is not anticipated to be available within 90 days, the Veteran must be placed on the EWL. The Veteran can continue to receive Vocational Assistance services during this time; however, as Vocational Assistance is not the level of support that the Veteran was assessed as requiring, the Veteran would still be placed on the EWL.

I. Informed Consent and Orientation.

(1) Many Veterans are either eligible for or already receive Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or other forms of non-VA based entitlements. They may also have financial obligations such as child support and other forms of debt. Participation in VHA Vocational Rehabilitation programs may affect the receipt of non-VA entitlements or result in garnishing of payments or wages to meet court-ordered obligations. VHA Vocational Rehabilitation staff must inform Veterans of these possibilities and may need to assist the Veteran as part of a comprehensive psychosocial treatment plan in resolving these issues with the appropriate agency(ies).

(2) Additionally, Veterans participating in CWT-TW must provide informed consent regarding potential liability due to accident. CWT Managers and staff must use the following language when informing Veterans of their potential liability: "Accidents sometimes happen during CWT assignments. If you cause an injury or property damage during your assignment, you may be held liable." CWT managers and staff must discuss this specific language with the Veteran during the initial treatment planning meeting, and the discussion must be documented in the electronic medical record and part of Informed Consent documents.

m. VHA Vocational Rehabilitation Staff Use of Federal Vehicles to Transport Veterans. The provision of VHA Vocational Rehabilitation Services requires the use of Federal vehicles for the delivery of community-based services, including times when Veterans may ride with VA clinical staff in Federal vehicles. VHA Vocational Rehabilitation staff must be medically cleared and trained before transporting Veterans in Federal vehicles pursuant to VHA Directive 2008-020. Each use of Federal vehicles in the delivery of VHA Vocational Rehabilitation Services must be documented in the electronic medical record by the CWT vocational staff, with a clear linkage established between the need for Vocational Rehabilitation staff-provided transportation and specific items in the Veteran's employment plan. Part of that plan must include efforts to help the Veteran progress over time towards independence in transportation, when possible. Use of VHA Vocational Rehabilitation staff's personally owned vehicles for transporting Veterans is not permitted.

n. Injuries to Veterans While Assigned to VHA Vocational Rehabilitation Programs. In the event of injury or death occurring during treatment in CWT programs, such injury must be documented in the electronic patient incident reporting system.

(1) Participants in VA and community-based CWT-TW assignments are patients in a rehabilitation program and are not classified as Federal employees, per Title 38, Part II, Chapter 17, Subchapter II, Section 1718 (a). As such, they are not entitled to Federal Office of Worker's Compensation Program (OWCP) coverage. Claims involving such qualifying injuries or death may be processed through 38 U.S.C. 1151 procedures (providing benefits for persons disabled by treatment or vocational rehabilitation). The Veteran would submit an 1151 Claim with Veterans Benefits Administration (VBA) on a VA Form 21-526 and submit the form with evidence (<https://www.vba.va.gov/pubs/forms/VBA-21-526EZ-ARE.pdf>). To establish proximate cause of additional disability or death associated with the provision of training and rehabilitation services or a CWT program, the evidence must show:

(a) The Veteran was participating in an essential activity or function of the training, services, or CWT program;

(b) The training, services, or CWT was provided or authorized by VA; and

(c) The Veteran's participation in the essential activity or function proximately caused the disability or death.

(2) It is not necessary that the evidence demonstrate that VA approved the specific activity or function resulting in disability or death as long as the activity or function is generally accepted as being a necessary component of the training, services, or CWT program that VA provided or authorized. It is not the role of CWT staff to complete this form for on behalf of a CWT-TW Veteran. If an injury during CWT-TW occurs on VA grounds, Veterans do not report to Employee Health, but to the physician of record or an alternative provider. If an injury during CWT-TW occurs off VA grounds, Veterans must present to the closest VA medical facility for treatment. If the injury is urgent or life-threatening and the Veteran is off VA grounds, Veterans must be treated at the

nearest medical facility and then transported to a VA medical facility when stable. Under no circumstance may a participant return to the work assignment after an injury without medical clearance. A new medical clearance is required for each injury. Each VHA Vocational Rehabilitation Manager must develop its own medical emergency or injury plan for VHA Vocational Rehabilitation participants, containing the elements described in this VHA Vocational Rehabilitation directive, and communicate this plan throughout the medical center and with each non-VA medical facility TW partner.

(3) When VA medical facilities or other Federal facilities are not feasibly available, any costs incurred from emergency transportation or treatment at non-VA medical facilities while participating in CWT-TW program settings are the responsibility of the respective VA medical facility to the extent such costs are authorized or reimbursable in accordance with VHA Directive 1601, Non-VA Medical Care Program, dated January 23, 2013. Costs that are not authorized or reimbursed may be the responsibility of the Veteran.

(4) Participants in CWT-SE and CWT-CBES may be eligible for compensation through their employer's worker's compensation program and should consult with their employer upon hire.

o. **Accreditation.** All Vocational Rehabilitation programs must seek CARF accreditation as a means of attaining and demonstrating clinical excellence. VHA Vocational Rehabilitation Program Managers are responsible for ensuring that programs new to accreditation are included in their VA medical facility's next review cycle for facilities with existing CARF accreditation or within 1 year of operation for facilities new to CARF. Each program must be accredited under the Employment and Community Services Standards Manual, Employee Development Services standards for CWT-TW and the Community Employment Services standards for CWT-SE. Additional vocational service components are accredited under the standards most appropriate to the service as determined by the VHA Vocational Rehabilitation Manager. The CARF standards are published at the following VA intranet site: <http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx>. **NOTE:** This is an internal VA Web site that is not available to the public.

p. **Performance Outcome Management.**

(1) **Outcome benchmarks.** The National Director, VHA Vocational Rehabilitation Services, establishes outcome benchmarks and posts them on the VHA Vocational Rehabilitation Program Guide SharePoint site (<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx?PageView=Shared&InitialTabId=Ribbon.WebPartPage&VisibilityContext=WSSWebPartPage>). **NOTE:** This is an internal VA Web site that is not available to the public.

(2) **Workload Data Capture, Coding and Productivity.**

(a) Each year the VHA Vocational Rehabilitation Quick Guide worksheet is updated to include changes for DSS Stop codes, diagnosis codes, productivity measures, Work

Relative Value Units (wRVUs), and program changes. VHA Vocational Rehabilitation staff must refer to current year terminology and codes contained in the VHA Vocational Rehabilitation Workload Quick Guide located on the Business Operations SharePoint (https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FMH%5FBusiness%20Rules%2FMH%5FCoding%2F2018%20Quick%20Guides&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7bAF9A7AEA-6621-497D-B567-BFE95B0FB762%7d). **NOTE:** This is an internal VA Web site that is not available to the public.

(b) Effective vocational rehabilitation service delivery requires non-relative value unit (RVU) generating activities that are necessary and essential functions of the job and must be considered in evaluating individual employee productivity. In accordance with VHA Directive 1161, Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers, dated June 7, 2013, individual local productivity standards must be developed by the VHA Vocational Rehabilitation Manager that consider the nature of the program assignment and type of work (for example, job development with the patient not present, driving time for employer contacts, etc.).

(3) **Quality Improvement Plans.** Each VHA Vocational Rehabilitation Manager must develop a local quality improvement plan that is reviewed at a minimum quarterly and is used to guide quality improvement initiatives. Outcome benchmarks and Northeast Program Evaluation Center (NEPEC) program evaluation data can be used as part of this process.

q. **Compensated Work Therapy Program Elements.** The major program components of CWT include: TW, SE, CBES, SEd, SSE services, and SW in limited locations.

(1) **CWT-Transitional Work (CWT-TW).** TW is a component of CWT which provides participants with work restoration services in actual work settings. The goal of CWT-TW is to provide vocational supports and resources needed for a Veteran to successfully transition to competitive employment. Clinical services to support achieving this goal must be provided either directly or through referrals to VA or community services.

(a) Vocational Rehabilitation staff screen CWT-TW participants to assess Veteran interest areas, personality traits, life experiences, work environments, and work limitations and restrictions. The VHA Vocational Rehabilitation staff then match the Veteran to a work assignment for a period deemed clinically appropriate and meet individually with the Veteran at minimum every 2 weeks to provide vocational counseling and to track progress in each Veteran's medical records towards treatment goals. Work may be provided in the community or at the local VA medical facility. Work assignments should include a wide variety of settings and be individualized to each Veteran's skills, interests, and job goals.

(b) VHA Vocational Rehabilitation Program Managers must develop worksites in a variety of community settings in addition to those on VA medical facility grounds. Development of community CWT-TW placements must consider the interests, needs, skills, and desired career development of Veterans served. **NOTE:** *Community-based settings provide a more realistic work environment and are more likely to lead to competitive community-based employment.*

(c) Vocational Rehabilitation staff must develop and maintain a close and collaborative working relationship with the participating organization and CWT-TW worksite supervisors. Vocational Rehabilitation staff will:

1. Observe Veterans at the worksite at minimum every 2 weeks to provide regular support in addition to individual vocational counseling sessions.

2. Document the progress notes from these visits in the Veteran's medical record.

3. Develop training materials and provide training for all CWT-TW worksite supervisors on an annual recurring basis and prior to assuming the role of TW worksite supervisor. **NOTE:** *Sample training material is available on the program guide SharePoint site (<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). This is an internal VA Web site not available to the public. Programs are encouraged to use the samples to develop materials that fit their program needs.*

4. Develop a performance evaluation process for the CWT-TW worksite supervisor to provide systematic feedback on Veteran workplace performance, to be used to inform treatment planning and Veteran goal development. Feedback must be routinely documented in the electronic medical record by Vocational Rehabilitation staff. **NOTE:** *Sample performance evaluation tools are available on the program guide SharePoint site (<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). This is an internal VA Web site that is not available to the public. Programs are encouraged to use the samples to develop materials that fit their program needs.*

(d) Payment for work performed is based on an hourly wage.

1. Hourly wages must be reviewed annually by the VHA Vocational Rehabilitation Program Manager in relation to the prevailing wage rates for similar work in the community and the productivity of Veterans.

2. Base pay is determined by Federal minimum wage laws. In locations where the minimum wage exceeds Federal minimum wage, the higher of Federal, State or city minimum wage must be utilized as the base rate for determining hourly pay.

3. Pay periods must be weekly or every 2 weeks.

(e) CWT-TW staff provide job search support and community referrals for CWT-TW Veterans capable of independent job searches to assist the Veteran in getting a competitive job. Such services can include, but are not limited to, assistance with completion of job applications, job leads, support and use of a CWT computer lab where

job leads and applications can be completed, or through collaborations with non-VA community job placement services or non-CWT-TW vocational staff charged with assisting Veterans with community employment, where individual Veteran participation and progress is provided to CWT-TW staff on a recurring basis.

(f) VHA Vocational Rehabilitation Program Managers must ensure that VHA Vocational Rehabilitation staff:

1. Ensure that worksite supervision and training are provided to the participating TW Veteran by the TW worksite supervisor.

2. Consider job and worksite accommodations and ensure these accommodations are used, as they determine is necessary. They must also ensure the participating TW Veteran and the TW worksite supervisor consider these accommodations.

3. Assess and confirm the existence of a safe and healthy worksite at every CWT-TW site, either as an individual assessment or part of a job assessment. Specifically, safety training must be provided by the TW worksite supervisor to the TW Veteran at each placement site. Necessary safety apparatus must be provided in accordance with the CWT agreement between the CWT Program and the partnering agency, company, or organization.

4. Confirm physical accessibility of the worksite.

5. Review transportation accessibility, via public transportation or personally owned conveyance, in order to determine if the worksite is a good fit for TW Veterans.

6. Review the competitiveness of work tasks and demands in order to determine if the worksite is a good fit for TW Veterans.

7. Review the clinical appropriateness of work tasks.

8. Develop assignment descriptions which accurately describe job duties and expectations, skills, and parameters of the assigned jobs being offered at the placement site and provide Veterans with a copy of the written description prior to placement.

9. Ensure that Veterans placed within the VA medical facility do not have access to information protected by VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

10. Identify and consider workplace culture when determining if a worksite is an appropriate placement site.

11. Ensure that no TW labor is provided to personally benefit staff at the agency, business, or organization where the Veteran is placed. **NOTE:** *The labor provided must match the written assignment description of duties provided to the Veteran by the CWT program staff for which VA CWT bills the CWT partner, in accordance with the MOA, as described in the next paragraph.*

(g) CWT-Transitional Residence (CWT-TR) is a primary stakeholder and partner of CWT programs, promoting successful independent living and competitive employment for Veterans. As admission to the CWT-TR requires CWT enrollment, adequate and expeditious CWT-TW placements are to be available when possible for Veterans admitted to the CWT-Transitional Residence (CWT-TR) program to facilitate their goals of independent living and employment.

(h) Compensated Work Therapy Memorandum of Agreements. CWT-TW partnerships must be developed through a Memorandum of Agreement (MOA) with local business, city, county, State, or Federal government agency, including VA.

1. CWT agreements must delineate the conditions of the relationship between CWT and the participating organization or company and authorize the reimbursement of funds to the CWT account in return for the services provided by Veterans in CWT. These agreements are not subject to the provisions of Veterans Affairs Acquisition Regulation (VAAR; 48 CFR Chapter 8, Department of Veterans Affairs Acquisition Regulation System) or Federal Acquisition Regulation (FAR; 48 CFR, Federal Acquisition Regulation). The MOA, developed by VHA Vocational Rehabilitation staff or the VHA Vocational Rehabilitation Program Manager, is approved at the local level by the CWT program manager. MOAs must be reviewed annually by the CWT Manager.

2. National Memoranda of Understanding (MOUs) are valuable tools to support the work of CWT programs across the country.

a. Potential leads for such opportunities can be submitted to the VHA Vocational Rehabilitation National CWT Program Office (PSRHQ@va.gov).

b. National MOUs and partnerships can be viewed at the VHA Vocational Rehabilitation Program Guide SharePoint site (<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

3. MOA templates are provided on the VHA Vocational Rehabilitation Program Guide SharePoint site. VACO VHA Vocational Rehabilitation is available for consultation on MOA development and content (PSRHQ@med.va.gov).

(i) Liability.

1. MOA templates must include the following language, as reviewed and approved by the Office of General Council (OGC) and cannot be modified:

“The United States is only liable for the negligent acts and omissions of Federal employees. Because CWT patients are not Federal employees, the United States cannot be responsible for any damages caused by them during their CWT assignments.”

2. Because a participant in CWT-TW is not a government employee, the CWT participant may be personally liable for damages they cause during their CWT assignment. Veterans must be informed of their potential liability during the initial

treatment planning meeting and the discussion documented in the electronic medical record. CWT managers and staff must ensure that the following language is used when informing Veterans verbally and in writing of their potential liability:

“Accidents sometimes happen during CWT assignments. If you cause an injury or property damage during your assignment, you may be held liable.”

3. This language must be used in:

a. Orientation materials for CWT participants or those seeking CWT services;

b. Program handbooks for Veterans;

c. Local program policy documents; and

d. VA or other Federal agency CWT-TW site supervisor training materials.

(j) Transportation.

(a) Veteran participants in CWT-TW are neither VA employees nor VA volunteers and must not be allowed to drive on-the-road licensed government vehicles because they cannot receive coverage under the Federal Torts Claims Act, subjecting them to personal liability for injuries and damages incurred while driving a government vehicle. Veterans assigned to VHA Vocational Rehabilitation may, as part of their work assignment, operate VA-owned equipment on VA medical facility grounds based on assessment of risk by VHA Vocational Rehabilitation Program Manager with the written concurrence of the VA medical facility Director. A plan for driving off-road vehicles must be documented in the Veteran's medical record by Vocational Rehabilitation staff and shared with the treatment team where applicable. Veterans must be informed by CWT program staff of the potential for their personal liability for accidents or damages incurred through their operation of such equipment or off-road vehicles while in CWT-TW and obtain TW Veteran signed informed consent which is documented in the Veteran's medical record. CWT may not purchase insurance for liability of Veteran participants operating equipment at the VA medical facility or in Community CWT-TW assignments.

(b) Veterans must not be assigned to drive other Veterans to and from a job site in a personally owned conveyance unless they present appropriate and current insurance to their VHA Vocational Rehabilitation staff. Veterans who agree to drive other Veterans to and from a job site may do so in a personally owned conveyance upon presentation of appropriate and current liability insurance obtained with funds from a non-VA source.

(c) In the case of CWT-TW agreements with private businesses, the business may wish to have participants drive their company owned vehicles. In such cases, and when the Veteran agrees, the following precautions must be taken:

1. The Veteran's clinical treatment team must concur and document in the Veteran's medical record that such activities are in keeping with the Veteran's overall rehabilitation goals, and that there are no physical or psychological contraindications.

2. The CWT staff must ensure that the Veteran possesses a valid state driver's license and agrees to drive as part of the placement, or another placement must be offered.

3. The business (Partner) with which the CWT program has a MOA must demonstrate to the VHA Vocational Rehabilitation Program Manager that they maintain adequate insurance which would cover the Veteran in the case of accident, injury, or damage to the Partner's goods.

4. Vehicles owned by the business (Partner) must be safety inspected by the State per State requirements and must be equipped with first aid and safety equipment.

(2) CWT/Supported Employment (CWT-SE).

(a) CWT-SE follows the Individual Placement and Support (IPS) model of supported employment, a well-defined model demonstrated to substantially increase competitive employment for people who have severe disabilities and a demonstrated inability to gain or maintain competitive employment. "IPS Supported Employment Practice & Principles" may be viewed on the VHA Vocational Rehabilitation Program Guide SharePoint site

(https://vaww.portal.va.gov/sites/OMHS/TSES/Compensated_Work_Therapy/Forms/AllItems.aspx?RootFolder=%2Fsites%2FOMHS%2FTSES%2FCompensated%5FWork%5FTherapy%2FSupported%20Employment&FolderCTID=0x01200044F61130B396F546B732397F1BEB3005&View=%7B2EA5E62E%2D1168%2D4664%2D8C7D%2DC458906C6873%7D). **NOTE:** This is an internal VA Web site that is not available to the public. Fidelity of program implementation is positively associated with employment outcomes. VHA Vocational Rehabilitation Managers are required to ensure that CWT-SE services are provided with fidelity to the IPS Supported Employment (SE) model.

(b) CWT-SE is intended for Veterans with significant barriers to employment due to psychosis or other severe mental illnesses, Post-Traumatic Stress Disorder (PTSD), or physical disabilities such as Traumatic Brain Injury (TBI) and Spinal Cord Injury (SCI) who, because of the severity of their disabilities, would not be able to function independently in employment without intensive, ongoing support services. This includes ongoing vocational assessments, rapid/individualized job search, job development and placement, assertive engagement, and follow-along supports provided in the context of clinical treatment.

(c) The IPS model of SE is an evidence-based practice for individuals with serious mental illness (SMI); Veterans with psychosis were the primary target population for the initial roll-out of IPS SE in VHA. As research and pilot projects demonstrate the effectiveness of SE with additional populations of Veterans who have significant support needs, VHA Vocational Rehabilitation Managers must ensure that services for Veterans

with psychosis are maintained while promoting expansion to additional Veteran populations. As such, a CWT VRS or VRC must prioritize serving Veterans with SMI diagnoses by:

1. Integrating vocational services with Intensive Community Mental Health Recovery (ICMHR) or Psychosocial Recovery and Rehabilitation Center (PRRC) teams when offered at the same facility as CWT SE, and prioritizing these referrals or

2. Integrating with other treatment teams serving Veterans with SMI when ICMHR or PRRC teams are not available.

(d) Integration with other treatment teams serving Veterans with mental health or physical disabilities requiring intensive vocational support, (i.e., Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Posttraumatic Stress Disorder (PTSD), Behavioral Health Interdisciplinary Program (BHIP), etc.) is encouraged and will occur as locally identified based on service needs.

(e) It is recommended that a single SE FTEE integrate their vocational service delivery with no more than 2-3 treatment teams and maintain the recommended caseload size of 1:20-25.

(f) Each VA medical facility must maintain a minimum of 1.0 FTEE to provide SE services. Additional CWT SE FTEE are encouraged to be hired locally as needed to meet Veterans' need for intensive vocational support.

(g) CWT-SE assists Veterans to obtain meaningful, paid, competitive employment and provides necessary ongoing support while Veterans are still active in their treatment toward overall rehabilitation and recovery. Veterans with significant barriers to competitive work can engage in full- and part-time employment with appropriate supports and work place accommodations. This form of vocational rehabilitation should be considered by all providers early in treatment as an integral component of treatment for those Veterans interested in returning to work.

(h) During initial engagement, the Vocational Rehabilitation Counselor (VRC) or Vocational Rehabilitation Specialist (VRS) may engage the Veteran several times per week, developing a relationship and completing a Vocational Assessment Profile (VAP), documented in the Veteran's electronic medical record, which addresses interest areas, personality traits, life experiences, and work environments. The VAP will describe the Veteran's optimal employment situation, factoring in symptom management and clinical consensus. The VRC or VRS is encouraged to meet with the Veteran and clinicians weekly, or as needed. As job search begins, the VRC or VRS may continue to have several contacts per week, as needed, directly with the Veteran, engaging in community networking, job development and employer negotiations, and assisting Veterans with job interviews.

(i) When a Veteran becomes employed, job accommodations or job coaching may be needed, as determined by the Veterans and employer in consultation with the SE VRC or VRS. If job coaching is needed, the VRC or VRS will have frequent contact

(e.g., as much as daily, if necessary) as the Veteran learns the tasks of the job and acclimates to the work environment. If job coaching is not needed, follow along supports are provided based on the clinical indicators of the treatment plan and the negotiated plan developed with the Veteran and employer. Effective early interventions will be adjusted and refined to promote a gradual decrease in face-to-face contact based on the Veteran's need for support and the ability to engage natural supports to replace the VRC/VRS functions in the work environment. Follow-along supports may be provided as needed (weekly or as little as monthly), depending on the Veteran's need for support and stability. Follow-along support must be provided no less than once a month and consist of a face-to-face contact with the Veteran. VRC or VRS contact may increase to daily or several times per week if more intensive support is needed due to periods of job instability. Follow-along supports are time unlimited, provided as long as the Veteran has a clinical need (determined by the Veteran, CWT-SE VRC or VRS, and the clinical team), desires support, and is engaged in CWT-SE services. As Veterans develop natural supports and demonstrate job stability, follow-along supports may be transferred to other team members or natural supports and the Veteran discharged from CWT-SE. In preparation for this, the VRC or VRS must have face-to-face sessions with the Veteran to address benefits counseling, transfer of care, and follow-up plans.

(j) Veterans are not precluded from CWT-SE because of the lack of prior work history, level of disability, or vocational goal. The CWT-SE goal is competitive employment in integrated work settings, rather than prevocational, sheltered, or segregated work experiences. Job search starts as soon as possible after a Veteran expresses interest in work.

(k) Vocational rehabilitation is considered an integral component of treatment and rehabilitation for mental and physical disabilities. The VRC or VRS is not the primary clinician or a case manager; rather, the VRS or VRC is the key treatment team member focused on employment issues. The VRC or VRS helps Veterans find jobs appropriate for their interests and abilities as quickly as possible, identifies and addresses employment barriers and facilitates workplace accommodations, and provides ongoing community-based support as needed. The VRC/VRS interacts with businesses for competitive job development, job matching and employment services, and communicates with employers, the community, treatment staff, Veterans and their families. With the Veteran and Veteran's treatment team, the VRC or VRS develops an employment plan integrated with the overall Mental Health or clinical treatment plan the Veteran's electronic medical record. The majority of the VRC/VRS's time is spent in the community providing employment services. The VRC/VRS must have appropriate access to the necessary tools and equipment to work in the community such as government vehicles, cellular telephones, and laptops with Internet access.

(l) Vocational development is continuous and based in competitive work experiences rather than artificial or sheltered settings.

1. An integrated interdisciplinary team approach is used to promote the integration of vocational, clinical, and support services to achieve better employment outcomes.

2. Job choice, disclosure, and job supports are based on Veterans' preferences and choices.

3. Job supports continue for a time that fits the participating Veteran's needs, rather than terminating at a set point after becoming employed.

4. Services are provided in the community, rather than in clinical settings.

(c) CWT service delivery model for SE is implemented adhering to this VHA directive, VHA Vocational Rehabilitation Services Program operational guidance, and with fidelity to the principles and practices of IPS SE as described in the Evidence-based Supported Employment Fidelity Scale, adapted for VA (<https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf>). **NOTE:** *This linked document is outside of VHA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

(d) Representatives of the VACO VHA Vocational Rehabilitation Program Office may provide on-site fidelity consultation and technical assistance to a sample of the CWT-SE programs utilizing the SE Fidelity Scale Adapted for VA. Representatives will provide a written summary to the VHA Vocational Rehabilitation Manager as a quality improvement tool. VACO VHA Vocational Rehabilitation staff and the local VISN SE Mentor Trainer will work with CWT programs within their VISN to develop strategies to achieve better SE implementation.

(3) CWT-Community-Based Employment Services. Community-Based Employment Services (CBES) is a CWT service, available at some locations, for Veterans with mental health conditions or physical disabilities who have a history of sporadic employment, difficulty maintaining a job, or initiating and following through on their job search and who require a range of supports to obtain or maintain competitive work. Veterans in CWT-CBES desire to engage in a rapid job search for competitive employment and do not have a clinically indicated need for CWT-Transitional Work (CWT-TW) or CWT-SE. CWT-CBES provides a range of services leading to direct placement in competitive employment, where an employer hires the Veteran, and the Veteran receives continuing clinical support. Veterans with a psychosis diagnosis, SMI, or physical disabilities who have intensive employment support needs requiring IPS services should be referred to CWT-SE. When clinically appropriate, a Veteran in need of job placement and/or retention supports may be referred from TW to CBES. CWT-CBES is based on the Principles and Elements of IPS SE while providing a more flexible model of vocational service.

(a) Principles of CWT-CBES. The Principles of CWT-CBES are similar to those of CWT-SE.

1. Zero Exclusion. Veterans are not excluded from participation due to clinical symptoms, legal histories, or other job readiness criteria.

2. Integration of Vocational Supports within Clinical Treatment. The Veteran's providers integrate vocational services within clinical care to support the Veteran's employment goals and provide coordinated care.

3. Competitive Employment. The goal of CWT-CBES is to assist Veterans in obtaining competitive employment within their local communities.

4. Rapid Job Search. Veterans begin their job searches quickly by making contact with employers and exploring job opportunities within 30 days of entry into CWT-CBES.

5. Systematic Job Development. VRSs develop relationships directly with employers based on the Veteran's interests and make systematic contact to assist Veterans in securing employment.

6. Follow-along Supports. Supports to assist Veterans in maintaining their employment after securing a job are provided based on the Veteran's need for ongoing support.

7. Preferences. Vocational services and employment opportunities are based on the Veteran's strengths, skills, and interests. Vocational supports are Veteran-driven.

8. Benefits Counseling. The impact of returning to work on the Veteran's VA, Social Security Administration (SSA) and housing benefits are discussed so Veterans may make informed choices regarding their employment goals. VRSs connect Veterans with appropriate sources for benefits counseling to help Veterans understand the impact of employment on benefits.

(b) Elements of CWT-CBES. Veterans may receive some or all of the vocational supports described in CWT-CBES. Vocational supports will be provided at varying intensities of service to meet the Veteran's support needs.

1. Referral. Referral to CWT-CBES will be made for Veterans who are eligible for CWT, who have a history of sporadic employment, or who have difficulty maintaining a job or who are unable to obtain competitive work independently.

2. Assessment. Veterans will be provided a "Veteran-centered assessment", conducted by the VRC or VRS, such as a Vocational Assessment Profile (VAP), which will provide information on Veteran's interests, strengths and skills; assist in job development activities; provide direction on what vocational supports are needed and how they will be provided. Veterans will be encouraged by the VRC or VRS to involve significant people in their lives in the assessment process, such as family and friends. Issues of disclosure and benefits counseling will be discussed. The VRC/VRS and Veterans will utilize a VAP process and will begin the job search process within 30 days of referral. Assessment is ongoing and will be modified by the VRC or VRS based on new information such as work experiences and changes in interest areas. A vocational plan describing the Veteran's employment goals will be developed with input from the Veteran, significant people in the Veteran's life and relevant clinical providers and documented in the Veteran's electronic medical record.

3. Integration. VRC and VRSs will coordinate vocational supports within clinical treatment to provide an integrated approach to service delivery. The CWT VRC/VRS and clinical providers will meet to discuss the Veterans' employment and clinical needs. The VRC/VRS and clinical providers will "additionally sign" the Veteran's electronic medical record notes and meet as often as necessary to share clinically relevant information and ensure coordinated care.

4. Job Search. Veterans will begin their job search rapidly and will make contact with employers to explore job opportunities within 30 days of referral to CWT-CBES. Veterans needing more support may have the VRC or VRS approach employers on the Veteran's behalf to inquire about job opportunities or to explore the job market. The VRC or VRS will seek individualized, competitive employment opportunities based on the Veteran's strengths, skills and interest areas. In some circumstances, the VRC or VRS may utilize techniques such as job carving to assist a Veteran in securing a competitive job.

5. Job Placement. The VRC or VRSs will assist Veterans to match the Veteran's skills and interests with a competitive job that meets the Veteran's and employer's needs. If needed, the VRC or VRS may provide a number of onsite vocational supports to the Veteran and the employer such as assistance with job accommodations, assistive technology, co-worker education, worksite orientation, and job coaching.

6. Follow-Along Support.

a. Once a Veteran is placed on a job, ongoing follow-along support may be needed to assist the Veteran in maintaining employment. This support may occur on or off the job site and may or may not involve the Veteran's employer, depending on the Veteran's preferences and needs. Proactive follow-along support is critical to assisting Veterans who have difficulty maintaining their employment. Follow-along support must be provided no less than once a month and involve a face-to-face contact with the Veteran.

b. Ideally, follow-along support should be provided for as long as there is a clinical need to assist the Veteran to maintain employment. For some Veterans this may be a relatively short period of time before they are stable in their employment, and for others, it may be ongoing for several months.

7. Developing Natural Supports. As Veterans become stable in their employment, they will be ready for discharge from CWT-CBES. It is important to develop natural supports as much as possible throughout the entire job search and placement process so when the Veteran is discharged, there is a support network in place that may provide ongoing support to the Veteran. A natural support network may include co-workers, providers, family, and friends. When the Veteran is stable in their employment, the Veteran and the Veteran's clinical providers must have a discussion and develop discharge plans. Discharge plans are documented in the Veteran's electronic medical record.

8. Jobs as Transitions. The concept of “Jobs as Transition” is a critical component of ongoing support. VHA Vocational Rehabilitation Services consider all employment to be a success. Veterans may lose their jobs from time to time for a variety of reasons including issues related to the cyclical nature of mental illness. If a Veteran loses their employment, regardless of the reason, CWT-CBES staff continue to assist that Veteran to seek new competitive employment opportunities. Additionally, Veterans who are successful may desire increased hours or promotional opportunities. CWT-CBES staff will continue to assist Veterans to develop their careers by providing support to obtain better employment opportunities.

9. Assertive Engagement. Assertive engagement and outreach techniques are used to accommodate Veterans who may have some reluctance to engage in the job search process. Ideally, the VRC or VRS should actively engage and meet Veterans in a variety of community-based settings. The VRC or VRS will need to utilize multiple strategies to assertively engage Veterans including having phone calls, scheduling regular meetings with Veterans in settings of their choosing, exploring jobs in the community, going with Veterans to job interviews, etc. Multiple outreach techniques are needed to engage Veterans who miss appointments.

10. Community-based Service Delivery. To fully implement CWT-CBES, VRC/VRSs should ideally spend approximately 65 percent of their time in the community in activities such as engaging Veterans in job exploration, job developing, networking, etc. It is expected that the VRC/VRS will maximize time spent in the community especially in engaging Veterans actively in their job search and in direct job development with employers.

(4) **CWT- Supported Education (CWT-SEd).** CWT programs include a focus on assisting the Veteran with identifying career development needs through inclusion in assessments and care planning, referrals for necessary training, and support with successful completion of training as appropriate.

(a) CWT-SEd provides individualized support to Veterans with mental health or physical impairments with career development services, which may consist of individualized supports for Veterans engaged in education and training programs and linkages with educational facilities that will facilitate Veterans’ successfully achieving their training and employment goals. Individualized support may include services such as:

1. Educational and vocational assessment;
2. Cognitive rehabilitation;
3. Assistance with connecting with college or university disability services;
4. Assistance in utilizing other VA educational benefits as well as State vocational programs;

5. Assistance with identifying and acquiring needed academic accommodations;
and

6. Assistance with developing organizational and other skills necessary for academic success.

(b) VRCs and VRSs assist Veterans in exploring potential funding mechanisms to assist Veterans enrolled in a CWT service for whom training is required to achieve longer term career goals. Use of the CWT account to provide short term specialized skills training directly related to Veterans' employment goals is authorized through this directive. Before initiating specialized skills training through CWT, Veterans with service-connected disabilities must be referred first by CWT staff or other treatment team member to the Veterans Benefits Administration (VBA) and Vocational Rehabilitation and Employment Service (VR&E) to determine whether they meet the criteria for entitlement to benefits under 38 U.S.C. 17, Chapter 31, Training and Rehabilitation for Veterans with Service Connected Disabilities. Veterans enrolled in CWT seeking career development with short term training needs who are not entitled to Chapter 31 or eligible for other community non-VA payment of such training may have such costs covered by the CWT account, if the CWT account has capacity. Such training must be part of a vocational plan of care, and the training must have a direct correlation to achievement of a career goal.

(5) CWT-Supported-Self-Employment (CWT-SSE). The goals of CWT-SSE are to assist Veterans participating in CWT to achieve successful self-employment consistent with their career goals by providing them with the specific knowledge and skills necessary for self-employment, peer support from those who have achieved self-employment success, and connections with funding sources which can assist with the enterprise. CWT-SSE staff provides guidance on business practices, training, networking opportunities, and linkages with community financial institutions that will assist Veterans with disabilities in achieving the benefits from self-employment. The provision of CWT-SSE has a strong relationship to IPS SE principles. CWT-SSE requires intensive integration of clinical supports between the CWT Vocational Rehabilitation staff and the clinical team providing services to the Veteran. CWT staff must also ensure that Veteran preferences dictate the type of business development that CWT-SSE supports and that this support is provided on an ongoing basis for as long as it is needed by the Veteran. Self-employment can offer many benefits to Veterans, including the ability to perform preferred work activities in work settings of the Veterans' choice, flexible work hours and schedules, self-management, a wide array of disability accommodations when needed, and the potential to generate substantial income. Any Veteran served in CWT who indicates a desire for self-employment will be offered CWT-SSE by the CWT staff if the service is available in the CWT program.

(6) VHA Vocational Rehabilitation-Vocational Assistance. Vocational Assistance is a VHA Vocational Rehabilitation service provided on an individual or group basis that is designed to assist Veterans who are capable of independent job searches to return to competitive employment. A formal consult for Vocational Assistance is not required, and Veterans may self-refer by directly contacting the CWT program; however, the

resulting encounter must be captured with appropriate coding by Compensated Work Therapy (CWT) staff. It is appropriate to refer Veterans who need more intensive job development or employment support services than Vocational Assistance offers to CWT programs such as CBES, TW, or SE.

(a) Vocational Assistance services consist of vocational assessment, vocational counseling, and community resource utilization for job placement services provided by CWT staff.

(b) Vocational Assistance may include the following supports and services:

1. Vocational assessment:

a. Assessment of the vocational rehabilitation needs of eligible Veterans.

b. Translation of military skills to civilian occupations.

c. Interest or aptitude testing as needed for career development or SEd purposes.

2. Vocational counseling:

a. Resume and job seeking skills assistance.

b. Groups: Job Club, Job Seeking Skills, Maintaining Employment/Celebrating Successes.

c. Counseling to develop skills to obtain or maintain employment.

3. Referrals for community resource utilization:

a. Referral and support to access Department of Labor services, Disabled Veterans' Outreach Programs (DVOPs), Local Veterans' Employment Representatives (LVERs), and community employment services.

b. Assistance with navigating access to community services and education including higher education coordinators, Veterans Service Organizations (VSO), benefits counseling, etc.

c. Referral to appropriate agency for assistance with benefits counseling.

d. Referral to VBA for Vocational Rehabilitation & Employment (VR&E) services.

e. Referral to State vocational rehabilitation services.

r. **Discontinuation of Pre-Vocational VHA Vocational Rehabilitation.** In October 2013, an interdisciplinary work group comprised of VA Central Office, VISN, and field-based members advised in the creation of a Transformation Plan. The plan prioritized community-based competitive employment as the primary goal of VHA Vocational Rehabilitation Service.

(1) As part of VHA's transformation of VHA Vocational Rehabilitation Service and with the issuance of this directive, the following prevocational programs are required to be discontinued. Additionally, VHA contracts with nonprofit CWT entities for prevocational services will no longer be authorized. New prevocational services may not be implemented.

- (a) Incentive Therapy (IT);
- (b) Sheltered Workshops;
- (c) Therapeutic Printing Plant (TPP); and
- (d) Horticulture Therapy (operated as a therapeutic work program).

(2) Discontinuation must occur within 2 years of this directive.

(3) Discontinuation is VA medical facility-wide, regardless of local organizational alignment.

(4) Discontinued program's staffing resources must be redirected within VHA Vocational Rehabilitation Service to support Veterans in obtaining community employment.

(5) VA medical facilities must operate the programs within the current VA policies and procedures for VHA Vocational Rehabilitation Service while still in operation.

(6) This mandate to discontinue pre-vocational services does not preclude VA medical facilities from developing CWT TW placements in Medical Media or use of CWT-TW placements for landscaping or gardening purposes, or other such placement opportunities related to the discontinued services. Such therapeutic work must be in the form of CWT-TW under an MOA between the department responsible for operational oversight and the CWT Program, and not aligned under CWT.

s. **Financial Aspects.**

(1) **Income to Participants.** Payments to participants in CWT-TW are not considered income for VA compensation, pension, Means testing, SSDI (RS 01402.485 VA IT and CWT Programs (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0301402485>), or Internal Revenue Service (IRS) purposes (IRS issued Rev. Rul. 2007-69). Earnings from CWT-SE and CWT-CBES are not considered income for VA compensation or pension but are taxable based on applicable IRS regulations and are considered income for Social Security benefits purposes. VA benefits protection is only for CWT participants in vocational rehabilitation treatment as authorized by 38 U.S.C. 1718.

(a) **VBA Benefits and CWT Earnings.** Participation in CWT cannot be used to reduce, deny, or discontinue VA compensation or pension. Pursuant to 38 U.S.C. 1718(g)(2)(B), a Veteran's participation in or receipt of a distribution as a result of participation in an activity carried out under 38 U.S.C. 1718 may not be considered as a

basis for denial or discontinuance of a rating of total disability for the purposes of compensation or pension based on the Veteran's inability to secure or follow a substantially gainful occupation as a result of disability. Pursuant to Title 38 Code of Federal Regulations (CFR) 3.343(c)(1), neither participation in, nor the receipt of remuneration as a result of participation in, a therapeutic or rehabilitation activity under 38 U.S.C. 1718 shall be considered evidence of employability, and pursuant to 38 CFR 3.342(b)(4)(ii)-(4), the following shall not be considered as evidence of employability: (ii) Participation in, or the receipt of a distribution of funds as a result of participation in, a therapeutic or rehabilitation activity under 38 U.S.C. 1718. For the purposes of 38 U.S.C. Chapter 15, Pension For Non-Service-Connected Disability, a distribution of funds and a payment made to a Veteran under a program of rehabilitative services authorized by 38 U.S.C. 1718, are considered to be a donation from a public or private relief or welfare organization and are not included in determining annual income.

(b) Means Testing and CWT Earnings. Donations from public or private relief, welfare or charitable organizations, are not included on VA Form 10-10EZ in determining eligibility and copays. CWT-TW are considered to be a donation from a public or private relief or welfare organization.

(c) Social Security and CWT Earnings.

1. CWT-TW. The income Veterans receive while participating in CWT-TW is not wages for Social Security coverage purposes. The IRS considers TW income non-taxable medical services; therefore, the VA does not withhold Federal Insurance Contribution Act (FICA) tax nor does it issue a Form 1099. **NOTE:** See <https://secure.ssa.gov/apps10/poms.nsf/lnx/0301402485>.

2. CWT-SE and CWT-CBES. Participants in CWT-SE and CWT-CBES work for local community employers and receive pay directly from the employer. The income the Veteran receives from the employer while participating in CWT-SE and CWT-CBES is wages for Social Security purposes. The Veteran will receive a Form W-2 (Wage and Tax Statement) from the employer. For information on how to treat this income for substantial gainful activity purposes, see policy and procedure on military service in DI 10505.023 (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505023>), and see policy and procedure on special employment situations in DI 10505.025 (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505025>).

(d) Fair Labor Standards Act, Title 29 CFR. Part 525, of the Fair Standards Act, wage guidelines are followed in paying participants in all vocational rehabilitation settings. This requires that wage rates paid to workers with disabilities are commensurate with those paid to experienced workers who do not have disabilities that impair their performance. Commensurate wage rates need to be analyzed by the VHA Vocational Rehabilitation Service Manager in the context of the industry and in the vicinity for essentially the same type, quality, and quantity of work.

(2) **CWT Account 5287.07.** CWT Account 5287.07 (Medical Care Costs Fund-MCCF Account) is a dedicated account comprised of funds collected from participating

companies and governmental organizations for the value of work performed by Veterans participating in CWT activities. Funds generated by the labor of Veterans participating in CWT services must be deposited in the CWT Account. There are no exceptions. These funds can be utilized only for supporting the operation of CWT Programs. The CWT program manager is responsible for the use of these funds, subject to any fiscal and acquisition regulations that may apply.

(a) Fiscal oversight of the CWT account. Local VHA Finance Service staff monitors this account, performing monthly reconciliations and annual audits. In coordination with Fiscal Service and Allocation Resource Center (ARC), VHA Vocational Rehabilitation Managers receive monthly reports from VHA Fiscal Service on CWT deposits and account balances. VHA Vocational Rehabilitation Managers monitor the expenditures and revenues, in collaboration with fiscal staff, monthly and annually to ensure timely and accurate accounting of Veteran CWT-TW payrolls, bills of collection, CWT account balances, appropriate account expenditures, and approved budgeting procedures.

(b) Budgeting, Costing, and Internal Controls. Each VHA Vocational Rehabilitation Program Manager is responsible for developing an annual operating budget, in accordance with current fiscal guidance, in coordination with their VA medical facility Finance Service. The VHA Vocational Rehabilitation Program Manager and Finance Service Manager must discuss the budget on a recurring basis, recommended no less than quarterly.

1. In the absence of yearly carryover funds in the CWT Account, CWT programs may receive a 2-month advance in October to cover Veteran payroll and program needs at the beginning of the FY. These advance funds are withdrawn from the CWT Account in Quarter 4 of each FY by VHA Office of Finance.

2. VHA Vocational Rehabilitation Program Managers must coordinate the withdrawal of the advance funding with their VA medical facility Finance Service Manager. At that time, the VA medical facility and CWT Program managers will review remaining funding to see if surplus CWT funding can be returned to the VA medical facility or if additional funding is needed by the Vocational Rehabilitation Program. CWT Account funds must not be utilized for non-CWT purposes or returned to the VA medical facility prior to this review in Quarter 4. The VHA Vocational Rehabilitation Manager and the VA medical facility Finance Service Manager must ensure that there is sufficient funding available to meet program requirements when the advance and any surplus funding are withdrawn.

(3) **Procurement.** CWT programs may have one or more purchase cardholders, depending upon the program's local leadership. Cardholders purchase supplies using a Government credit card. Cardholders and approving officials must comply with all Acquisition and Material Management's (A&MM) and Finance policies and procedures for use of purchase cards (see <https://www.va.gov/finance/policy/pubs/volumeXVI.asp>), procurement of paid services, or purchase of goods and supplies for the operation of the CWT programs. Separation of duties and internal controls must be defined locally, and regular review of the CWT account will be conducted by Finance Service.

(a) VHA Vocational Rehabilitation Program Managers authorize expenses using the CWT Account for basic operational expenses for CWT programs including, but not limited to:

1. Veteran payments (payroll) in CWT-TW.

2. Purchase of supplies, equipment, tools, transportation services, career development support for participating Veterans, accommodations, information technology including Internet access, marketing materials, and office equipment necessary to provide therapeutic rehabilitation services in the CWT programs. Purchase of OI&T and non-networked computers must follow VA Directive 6008, Acquisition and Management of VA Information Technology Resources, dated November 2, 2017. Purchases must also be allowed in accordance with VA Financial Policy Volume II Chapter 04, Awards, Ceremonies, Food or Refreshments, Gifts or Mementos, dated August 31, 2017.

3. CWT Program staff travel, per diem expenses, and educational expenses for purposes directly related to CWT program operations and vocational rehabilitation service delivery. Use of CWT Account funds for travel, per diem expenses, and educational expenses for staff members of collaborating treatment teams is not an approved use of CWT Account funds; use of CWT Account funds for purposes not directly related to CWT operations and vocational rehabilitation is not an approved use of CWT Account funds.

4. Contracted services, authorized by 38 U.S.C. 1718, such as job development, placement, support; contract procurement services; CWT-TW payroll services; and other contracted vendor services for CWT as posted to VHA Vocational Rehabilitation Service Program Guide SharePoint Site (<https://vaww.portal.va.gov/sites/OMHS/TSES/default.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(4) VA Central Office VHA Vocational Rehabilitation Service withdraws funds from CWT VA medical facilities Programs' CWT Account at the rate of 1 percent of the previous year's reimbursements. These funds are used by VA Central Office VHA Vocational Rehabilitation Service for national program enrichment purposes such as conferences, training and education, national marketing, start-up funds, and other expenses to support national CWT operations.

(5) CWT is a VHA clinical program; and, as such, a VA medical facility cannot charge the CWT program for rent, utility costs, and similar expenses related to program operations, and funds for those purposes cannot be withdrawn from the CWT account by a VA medical facility.

(6) **Payment of Veterans and Billings to Principals.** CWT-TW participant timesheets are verified for accuracy by the participating worksite supervisor and the Veteran and are submitted to CWT by the worksite supervisor.

(a) Separation of duties and internal controls are necessary in the preparation and certification of timesheets, development of payroll, and Bills of Collection. A check and balance system must be developed and utilized for CWT payrolls and billings involving staff responsible for constructing payroll and billings and additional staff responsible for auditing the accuracy of payrolls and billings. Staff (such as a program clerk) must develop payroll based upon timesheets submitted by the TW worksite as signed by the site supervisor and Veteran. Additional staff (such as the CWT Program Manager or other delegated individual) audits payroll before submitting to Fiscal. Staff (such as a program clerk) must develop the bills based upon hours worked and the reimbursement rate noted in the agreement. The CWT Program Manager or other delegated individual audits, approves, and submits the billing. The CWT Program Manager must ensure all bills are reimbursed within the reimbursement timeframe specified in the MOA and posted to the CWT Account in the next monthly deposit. A representative sample, as determined by the VHA Vocational Rehabilitation Program Manager based on program size, timesheets, payroll, and Bills of Collection are audited by the VHA Vocational Service Manager (or other delegated individual) each pay period to ensure accuracy.

(b) Adherence to Finance policies is mandated for all staff developing and approving Bills of Collection. Staff preparing the Bills of Collection must indicate the correct Revenue Source Code, which is entered into IFCAP by Finance Service when the Bill of Collection is processed. Separation of duties and internal controls need to be defined locally and regularly reviewed by Finance Service for the processing of time card certification, Bills of Collection, reconciliation of payments, and posting of receivables to CWT account. Local designated Finance Service staff monitor the CWT account, performing monthly reconciliations and annual audits. The CWT Program Manager is responsible for ensuring that an Intra-Agency Agreement (IAA) (VA Form 2269; <https://vaww.fsccollaboration.fsc.va.gov/IGOVFASPAC/Shared Documents/Agreement Forms/VA2269.pdf>) is submitted to their local VA Finance Service every fiscal year for each VA department or service with whom they enter into an agreement to provide TW labor. **NOTE:** *This is an internal VA Web site that is not available to the public.* The CWT Program Manager is also responsible for ensuring that a United States Government Interagency Agreement (IAA) (Form 7600 A (https://vaww.fsccollaboration.fsc.va.gov/IGOVFASPAC/Shared Documents/Agreement Forms/Form_7600A_Nov_2016.pdf) & B (https://vaww.fsccollaboration.fsc.va.gov/IGOVFASPAC/Shared Documents/Agreement Forms/Form_7600B_Nov_2016.pdf) is submitted to their local VA Fiscal Service each fiscal year for each Federal partner with whom they enter into an agreement to provide TW labor. **NOTE:** *These are internal VA Web sites that are not accessible to the public.* The CWT Program Manager or other delegated individual will complete sections of the IAA as the Servicing Organization/Servicing Agency and ensure each respective partner completes the sections of the IAA as the Requesting Organization/Requesting Agency. The CWT Manager must ensure each IAA is submitted to Fiscal Service before the start of each fiscal year and when each agreement is altered or terminated.

(c) Pursuant to guidance from VA Office of General Counsel and the VHA Office of Finance, billing submitted by a CWT program for labor provided by Veterans in CWT-TW to VA medical facilities, other governmental agencies, and private businesses, will

charge an overhead to cover the full cost of the product or service being provided, and must include indirect costs reflective of program operational needs and reserves for payment of earnings to Veterans, including those incurred for common objectives which cannot be directly charged to a single cost objective.

t. **VA-Based Nonprofit Compensated Work Therapy Corporations.** Several CWT programs were implemented and established non-profit status prior to legislation officially authorizing VA to establish CWT programs. Section 105 of the Veterans Omnibus Health Care Act of 1976, Pub. L. 94-581, codified and subsequently modified as 38 U.S.C. Section 618(b), provided legal authority for the establishment of both CWT Programs within VA and the retention of the existing non-profit corporations previously associated with VA while prohibiting additional programs to establish non-profit status. At the time of publication of this directive, two of the VA nonprofit CWT programs remain in operation. This paragraph of the directive pertains only to those CWT programs in existence when Pub. L. 94-581 became effective (October 21, 1976) as having non-profit status.

(1) Terms and conditions of an agreement to be entered between VA and each nonprofit CWT entity will be set out in a contract by the CWT Program Manager which must be reviewed and approved by VHA officials with programmatic responsibility for the CWT Program and by the General Counsel. These nonprofit corporations do not include community nonprofit corporations; i.e., Veterans of Foreign Wars, American Legion, Goodwill Industries, etc. All such contracts must provide that:

(a) Bidding practices must be based upon practices and guidelines recommended by the Commission on Accreditation of Rehabilitation Facilities (CARF).

(b) All Veteran participants will be paid at rates not less than the wage rates specified in the Fair Labor Standards Act, 29 CFR Part 525, relating to employment of handicapped persons.

(c) A statement of the services to be performed by the nonprofit entity must be included.

(d) The contract must state terms and conditions under which the nonprofit entity can retain funds for overhead and operating expenses, including designation of what items constitute such expenses, and a limitation on accumulation of such funds earned from projects where Veteran participants are involved.

(e) A provision for assessing liability must be included about loss of, or damage to, goods and materials which comprise or are used in connection with CWT, and for assessing liability for damage.

(2) The nonprofit may not accrue any funds generated by VA patients working as part of the CWT Program in a nonprofit corporation. Funds generated by the labor of Veterans participating in CWT services must be deposited in the CWT Account. There are no exceptions. In each contract, nonprofit corporations may retain certain funds for

expenditures which are subject to prior VA approval and accounted for at the end of the contract, or at the end of the fiscal year if the has been in force for all of the fiscal year.

(3) No VA employee can serve in any capacity for any nonprofit entity with which VA contracts in connection with the CWT Program. VA employees may not serve as officers or members of boards of directors of nonprofit CWT entities with which the VA has contracts.

(4) VA employees may function only as vocational rehabilitation providers in regard to patients participating in CWT projects. **NOTE:** *The contract will describe how VA personnel are to be involved.*

8. PEER SUPPORT

a. Background.

(1) Peer support services are an integral part of VHA health care. Peer support is a recovery-oriented service and is considered a promising best practice within the recovery literature and by the Centers for Medicare & Medicaid Services.

(2) 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 a White House Executive Order 13625, directing the Department of Veterans Affairs to hire and train these new staff by the end of calendar year 2013. Peer Specialist services support Veteran patients pursuing rehabilitation from various mental health conditions, substance use disorders, and other chronic physical health conditions. Peer services are Veteran-centric and whole health, recovery-oriented services that focus on individual strengths to maximize Veteran patients' recovery. This rehabilitative approach recognizes that persons with mental illnesses and substance use disorders, 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 cooperation with Peer Specialists.

(3) Peer support services must be available for all Veteran patients for whom this service is clinically indicated, especially for those with serious mental illnesses, and those services must be included in the Veteran patient's treatment plan. All facilities and networks must maintain their initial allocation of Peer Specialist positions so that the requirement of a peer support workforce strength of at least 800 positions set forth in the Executive Order 13625 of August 31, 2012, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families is maintained. **NOTE:** *Networks and facilities were assigned a total number of peers based on the proportion of Veterans projected to receive mental health services at each facility in Fiscal Year 2013. These network requirements are available from the Director of Peer Support Services.*

b. Mission, Vision, and Goal.

(1) **Mission.** Peer support services in the Veterans Health Administration are specifically designed to offer hope for Veteran recovery, and peers serve as role models for that recovery, health, and wellness. Peer Specialists help Veteran patients 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 setting.

(2) **Vision.** All Veteran patients pursuing recovery from mental illnesses including those with serious mental illnesses or substance use disorders in VHA will have access to peer support services.

(3) **Goal.** To provide peer support services to all eligible Veteran patients, delivered by Veterans recovering from the same or similar types of health conditions as the individuals being served.

c. Program Elements.

(1) Methods of Delivering Peer Support Services:

(a) All facilities must design peer support services for the treatment of Veteran patients who receive services in VHA. Each VA medical facility must assess the needs of the Veterans and the availability of high-quality resources to provide peer support. The following methods of delivering peer support services are typical of those in use in VHA at the time of this writing:

1. Peer Specialists.

2. Without Compensation (WOC) Peer Support Employees.

3. Referrals to Non-VA community peer support programs as described below:

a. Vet-to-Vet is a specific form of non-VA self-help peer support services, founded by Vietnam Veteran Moe Armstrong, in which Veterans are trained in Vet-to-Vet procedures and facilitate formal structured group meetings involving educational activities based on a standard Vet-to-Vet curriculum.

(1) Vet-to-Vet facilitators are Veterans in recovery who most often offer their services without compensation; in some instances, however, they may be paid. Paid Vet-to-Vet providers usually receive an hourly stipend from a not-for-profit service organization for providing limited services in VHA mental health programs.

(2) Vet-to-Vet facilitators may be given training and supervision by professional VHA staff when offered in a VHA mental health program setting. If such supervision and training are provided, the VA medical facility must enter into a Memorandum of Understanding (MOU) that delineates the specific relationship between the facility and the Vet-to-Vet program. The MOU must specifically delineate the training and supervision to be provided to Vet-to-Vet facilitators. If the VA medical facility chooses not to enter into a MOU with Vet-to-Vet, then the relationship between the VA medical

facility and the Vet-to-Vet program would be the same as with any other self-help support group.

b. Partnerships with community providers to facilitate outreach and collaborative planning for peer support services when indicated, is desired, and oftentimes required by legislative mandates or executive orders. These partnerships have the goal of increasing access to mental health services through accelerated referrals to VA services.

(b) All methods of service delivery must adhere to the established supervisory and documentation requirements written in this directive.

(2) **Settings.** Peer support services may be provided in a variety of physical and mental health treatment programs under the supervision of licensed independent practitioners (LIPs). Many VHA mental health programs are currently utilizing peer support services. These include but are not limited to: substance use treatment services, inpatient mental health, outpatient mental health, Intensive Community Mental Health Recovery programs, Psychosocial Recovery and Rehabilitation Centers, Residential Rehabilitation Treatment Programs, Therapeutic and Supported Employment Services programs, and Veterans Integration to Academic Leadership. Innovative applications may also include emergency room services, outreach efforts, telemental health, and enhancement services to spinal cord injury-disability, poly-trauma, Health Promotion Disease Prevention, and mental health/primary care collaborative initiatives.

(3) **Contracts.** Peer support services may be provided on a national or regional contract basis by community providers for medical centers and Community-Based Outpatient Clinics (CBOCs) where peer support services are desired in programs that do not currently have staff to provide them. When services are not available through the national or regional contract, a Veterans Care Agreement (VCA) may be utilized. The last option is a local contract prepared by a warranted VA contract officer. Such contracts are initiated by the programs desiring them and carried out under the VA medical facility's contracting and procurement departments. Contract language must specify, in detail, that services meet the same professional quality standards of care as provided by VHA peer support providers.

(4) **Documentation of Need.** The need for peer support services must be documented in the Veteran's plan of care. Documentation must specify how services will be delivered, in what context, for what duration, and the goals of the intervention must be specified. Peer support services do not occur in isolation but are a component of the overall services offered by the program in which they exist. As such, they are adjunctive services that enhance the delivery of services provided.

(5) **Hiring and Managing Peer Support Providers.**

(a) Qualifications.

1. VHA peer support providers must be Veterans who have been living at least 1 year in successful recovery from a mental health or substance use disorder. Successful recovery is exemplified by one who manages symptoms of illness and pursues healthy lifestyle, lives independently; has been employed or volunteers significant time approximating at least a part-time employment schedule; has meaningful relationships with family or friends; has involvement in his/her community through attendance at social functions like clubs, hobby groups, church, civic organizations, or Veteran organizations in which the individual participates by providing a service to others.

2. The position of Peer Support Apprentice has been established at the GS-5 grade level for those Veterans who have not yet acquired their Peer Specialist certification or who do not otherwise qualify at the GS-6 Peer Specialist grade. Once hired, Peer Support Apprentices must demonstrate competencies by obtaining their peer specialist certification from a state-approved agency or a VA-approved not-for-profit training vendor.

3. The GS 6-9 Peer Specialist positions require that Veterans be certified by a state-approved agency or a VA-approved not-for-profit training vendor before hiring. In all cases, where the individual is appointed in grades GS 6-8, the ultimate outcome must be that the individual will sufficiently develop their skills and abilities to be promoted to and perform at the GS-9 target grade in accordance with the applicable requirements and procedures.

(b) Position Description and Duties.

1. Peer support providers must have position descriptions based on those developed by the VA Office of Human Resources Management, Compensation and Classification Service. The position descriptions must meet the legislative mandates written in Pub. L. 110-387. Minor divergence from these position descriptions is allowed for unique duties specific to the program's needs. However, every effort should be made to stay within the parameters of the position descriptions already developed.

NOTE: *The official position descriptions for GS-5 Peer Support Apprentices and GS-6, 7, 8, 9 Peer Specialists along with other guidance for hiring can be found on the VHA Peer Support Services SharePoint*

([https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/For ms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Serv ices%2FHuman%20Resources&FolderCTID=0x0120007ED8487946EC4541ABCE372 1142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}](https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/For%20ms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FHuman%20Resources&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0})). This is an internal VA Web site that is not available to the public.

2. Office of Mental Health and Suicide Prevention (OMHSP) no longer supports hiring of Peer Support Technicians and requires facilities to use the new classification for Peer Specialists.

(c) Recruitment.

1. A VHA peer support provider can be a Peer Specialist, Peer Support Apprentice, or a WOC employee who provides peer support services to Veteran patients. Veterans who meet the statutory requirements to be GS-102 Peer Specialists or Peer Support Apprentices are the only eligible candidates to be recruited for these paid positions.

2. 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 substance use disorder. However, the legislation did not change the prohibitions on asking candidates to share their diagnosis or all treatment regimens concerning their care. VHA OMHSP and Human Resources (HR) have developed a Structured Oral Interview (SOI) to be utilized for all peer support positions. This "Department of Veterans Affairs SOI for PSA" document incorporates all the legal and HR requirements that pertain to this position. This document contains approved interview questions to be used. Use of this instrument is voluntary. Local program managers may conduct interviews using other questions or adding questions to the existing SOI, as long as every candidate applying for the specific position is asked the same questions. The SOI can be found in the Supervision folder on the VHA Peer Support Services SharePoint (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx>). **NOTE:** This is an internal VA Web site that is not available to the public. Hiring managers should work with the local facility's HR office to determine the best recruitment strategy.

(d) Appointments and Promotions.

1. Veterans who are not certified to provide peer support services, but who meet the basic requirements for the Peer Specialist occupation may be considered for a GS-5 Peer Support Apprentice position. Peer Support Apprentice positions are time-limited appointments filled through any hiring authority for which a Veteran candidate is eligible. VHA will provide training for Peer Support Apprentices within the first year of their employment through a contract with a VA-approved not-for-profit organization to provide these services. Peer Support Apprentice is a term position which does not have promotion potential. However, after certification, time in grade, and meeting specialized experience requirements, the Peer Support Apprentice should be provided an opportunity to apply for a permanent GS 6-9 Peer Specialist position. Peer Support Apprentices who fail to become certified prior to completion of their term appointment may have their employment terminated or another term appointment established by HR.

2. Hiring managers and supervisors should consult with their local VA medical facility's HR office regarding the use and benefits of various hiring authorities and appointments as well as strategies and requirements for transitioning Peer Support Apprentices to Peer Specialists and GS-6, 7, and 8 Peer Specialists to higher grades until the staff reaches the target GS-9 full performance level.

3. It is important that VA medical facilities retain all peer support positions to ensure that the peer support provider staffing requirements of VHA Handbook 1160.01,

Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, and the Executive Order 13625 of August 31, 2012, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families are maintained.

(e) Supervision. Supervision is required for all peer support providers. Specific responsibilities for supervisors are outlined in paragraphs 5.r. and 5.s. However, supervision must be consistent with the following guidelines:

1. Clinical supervision should be provided by an LIP. In the rare situation where a peer support provider's specific worksite does not have an LIP available for clinical supervision, a non-LIP may provide the supervision for the peer support provider's work at that site as long as an LIP is designated as supervisor for the non-LIP by the program supervisor.

2. Peer Support Apprentices and GS-6 Peer Specialists must have face-to-face individual supervision at least once per week. The frequency of supervision for GS 7-9 Peer Specialists must be weekly during the probationary period. Thereafter, supervision may be less frequent if the Peer Specialist demonstrates sufficient experience and competence. At a minimum, ongoing individual supervision must occur no less than once per month.

3. Peer support providers must be able to reach their supervisor or designee by telephone or in-person at all times during their tour of duty.

4. Additional forms of supervision, such as group supervision for training purposes, are encouraged.

5. Supervisors must follow the most current documentation guidance provided in paragraph 8.c.6. and by the national program office, which can be found on the VHA Peer Support Services SharePoint (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FGuidance%2FDocumentation&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}&InitialTabId=Ribbon%2EDocument&VisibilityContext=WSSTabPersistence.>) **NOTE:** *This is an internal VA Web site that is not available to the public.*

(f) Work Performance Standards and Competencies. VHA peer support providers must adhere to the same regulations as all other VHA employees in regard to performance standards, ethics, and competencies.

1. All peer support providers must demonstrate the required competencies found on the VHA Peer Support Services SharePoint (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.* Sustained competency must be demonstrated annually.

2. Supervisors must develop performance plans with Peer Support Apprentices and Peer Specialists for meeting the elements included in their performance appraisals.

3. Supervisors will conduct semi-annual performance evaluations. WOCs must have position descriptions, and their supervisors must document assessment of their competencies prior to appointment as a WOC and annually thereafter in the WOC HR file for the employee. The documentation will be held by HR. VA medical facilities utilizing WOCs to provide peer support services must follow the same guidelines for these staff as for Peer Support Apprentices and Peer Specialists in regard to training, certification, and supervision.

(g) Reasonable Accommodations. Until peer support providers voluntarily reveal a medical or mental health condition and request accommodation, it is not appropriate to raise the issue in relation to job performance. When supervisors have a concern about the Peer Support Apprentice or Peer Specialist's performance that may be related to a health issue, the supervisors must contact their local VA medical facility's HR office for specific guidance and document this concern in the personnel file for the employee.

(h) WOC Peer Support Employees.

1. All volunteer peer support providers must be appointed with a WOC Employee status.

2. Veterans who have their peer specialist certification and wish to volunteer as a peer support provider at the facility must be appointed with a WOC status. Qualifications, including approved peer support certification training, continuing education (CE), and responsibilities of WOC peer support employees are identical to those described in paragraph 5.u., above. 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 electronic medical record.

3. 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.

(6) Documentation Requirements.

(a) Peer support providers are full members of the mental health treatment team, and they are expected to document the patient care services they deliver in the electronic medical record.

(b) In VHA, peer support providers 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 the Department of Veterans Affairs, or a state mental health department/certification/licensing authority (National

Uniform Claim Committee). Current guidance for accomplishing documentation can be found on the VHA Peer Support Services SharePoint (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FGuidance&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(c) All Veteran patient care documentation entered by GS-5 Peer Support Apprentices, GS-6 Peer Specialists in their first year of VA employment, and WOC peer support employees must be co-signed by a LIP. The co-signature requirement for GS-7, GS-8, and GS-9 Peer Specialists is dependent upon the supervisor's determination that this is necessary based upon the Peer Specialist's experience and competence.

(d) The peer support provider's role in the development and documenting of formal treatment and recovery planning is to assist the Veteran patient to identify goals and the means to achieve them. Local VA medical facilities must follow guidance in this document and the Workload Capture Guidelines found on the VHA Peer Support Services SharePoint site (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx>) to accurately capture peer support providers' documentation and their role in treatment planning and ensure that adequate training about documentation has been provided. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(e) The Managerial Cost Accounting Office has established a secondary stop code (183) for Peer Specialists. There is also a CHAR 4 code, "peer" that is to be attached to the primary stop code when the secondary 183 code cannot be used. The procedural code for all peer support service encounters is H0038. Further guidance is available in the documentation folder on the VHA Peer Support Services SharePoint site (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FGuidance%2FDocumentation&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(f) WOC peer support employees are required to document the patient care services they deliver in Veteran patients' electronic medical records.

(g) Local VA medical facilities are strongly encouraged to institute peer reviews of peer support documentation, which should be conducted by their supervisors on at least a quarterly basis. The VHA Peer Support Services SharePoint site contains examples of documentation quality review forms (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(7) Ethics.

(a) Peer support providers must adhere to the United States Government's Executive Branch Code of Ethics and the Principles of Ethical Conduct for Government Officers and Employees (see <https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Guidance/Ethics/US%20Government%20Code%20of%20Ethics.pdf> and <http://vaww.ethics.va.gov/>). **NOTE:** *These are internal VA Web sites that are not available to the public*) and must complete the Talent Management System's mandatory ethics training. They must also adhere to their own professional code of ethics, which may be the code of ethics of their peer specialist certification training agency. For more information, see paragraph 8, Training.

(b) All rules of employee-patient relationships concerning ethical issues found in the mandatory training cited in (a) above such as, but not limited to, buying or selling goods or services and loaning or borrowing money must be followed. Peer support providers do not handle Veteran patient funds or enter into any conservator or payee relationships.

(c) Peer support providers and supervisors must review and discuss relevant codes of ethics and ethical decision-making frameworks within 30 days of the peer provider's starting date and quarterly thereafter to ensure the peer provider has met all ethics training requirements. An ethical decision making tool for peer support providers can be found on the VHA Peer Support Services SharePoint site (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.* When higher level consultation is needed, be sure to follow local VA medical facility procedures for consulting with the local Integrated Ethics Committee (see <https://vaww.ethics.va.gov/activities/consult.asp>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(8) Dual Relationships.

(a) Dual relationships, as defined in paragraph 3.f., must be avoided between peer support providers and Veteran patients as well as between peer support providers and other staff. Both peer support staff and clinical providers need to keep the focus of their discussions with one another on topics related to the roles and responsibilities of the peer support staff and their work performance. Both parties must avoid discussions that the peer provider could perceive as a clinical intervention targeting their own wellness. Peer support providers should discuss any conflicts they experience about their roles with their supervisor or other colleagues with their supervisor. Clinical providers should address their own concerns or those expressed to them by a peer support provider with their own supervisors. Peer support providers also have access to a Veterans Integrated Service Network Peer Support Point of Contact and monthly network conference calls for anonymous consultations. Current practice should adhere to guidance in the following sections (b)-(e).

(b) Peer support providers should not be assigned to work in the same program where they are currently receiving services. Dual relationships can compromise professional judgment for both peer support providers and other health care providers, causing undue harm to the Veteran patients whom they serve. Placing VA health care providers into such relationships could result in violations of their professional codes of conduct and disciplinary actions that could affect their licenses or certifications. Should 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 should ideally be explored (e.g., another VA facility or non-VA care). If the peer support provider requests to receive services in the program in which he/she works, then the manager of the program must seek consultation from the local VA medical facility's Integrated Ethics Committee to determine how to proceed.

(c) Peer support providers must not be supervised by an LIP who provided them with clinical services within the past 3 years. If the peer support provider and other staff members in the program in which the peer support provider is working had a clinical relationship in the past and are now co-workers, the clinical staff and peer support provider need to discuss this situation with their respective supervisors and communicate boundaries that uphold the confidentiality and integrity of both the peer support provider and the clinical staff members. This would mean, at a minimum, that the clinicians would not share with other staff any information about the peer support provider that was obtained during therapeutic sessions. In addition, the peer support provider must not communicate any opinions of clinicians' therapeutic efficacy or affability based upon their previous clinical relationship to Veteran patients receiving services. Every effort should be made to ensure that there has been adequate exploration of any potential harm that may occur to the peer specialist, who is a Veteran, before entering into such a supervisory relationship. The LIP must address such potential challenges with caution. The respective supervisors should document in a memorandum this discussion with their supervisees and should provide a copy of the memorandum to their respective supervisees.

(d) Being on the same treatment team as peer support providers can also cause some indirect dual relationship issues for health care providers who may not have treated the peer support providers directly but were on a team where a colleague spoke about the peer support provider in clinical consultations. That prior knowledge may also affect the relationships between the peer support provider and other members of that same team or within the mental health program in general. Such indirect information obtained in this manner must be treated as confidential.

(e) Peer support providers must not deliver services to individuals with whom they have a personal relationship outside of the treatment environment.

1. If the peer support provider currently has or formerly had a non-sexual friendship with a Veteran patient entering the program in which the peer support provider is now working, the peer support provider must notify the supervisor. The peer support provider must inform the Veteran patient of the concerns about their dual

relationship and, if possible, the Veteran should be reassigned to another peer support provider if they wish to continue to be in a friendship.

2. Under no circumstances is it permissible for a peer support provider to engage in sexual relationships with Veteran patients for whom the peer support provider is providing services. If the peer support provider currently has or formerly had a sexual relationship with a Veteran patient entering the program, the peer provider must inform the supervisor so that another peer provider can be assigned. Similarly, if a peer support provider begins to develop romantic feelings toward a Veteran for whom he/she is providing provided peer services, the peer support provider must inform the supervisor immediately. The supervisor must discuss the peer support provider's ethical standards and advise the peer support provider that their Code of Ethics about sexual relationships must be followed so that there are no potential risks of harm to the Veteran involved. Violations of this standard will result in the supervisor following local procedures for notifying the appropriate peer specialist certification organization. Veterans receiving services who have had such a prior relationship with a current peer specialist should have other avenues explored with them for alternative peer support services from other peer specialists at the local VA medical facility, use of telemental health tools to connect with peer specialists at other locations, or referral to community peer support services. The supervisor and peer support provider will make as many feasible options available to the Veteran as possible.

(9) **Program Evaluation.** Mental Health leadership, supervisors of Peer Specialists, and the Peer Specialists themselves in programs which utilize peer support providers are required to participate fully in national monitoring and program evaluation activities. The results of national monitoring and program evaluation will be disseminated to the field on an annual basis by OMHSP.

(10) **Accreditation.** Programs that offer Peer Support services accredited by The Joint Commission or Commission on Accreditation of Rehabilitation Facilities (CARF) International must ensure that its peer support provider selection, scope of practice, competencies, and Human Resources (HR) data stand up to the same rigors of measurement placed on all staff within the mental health programs.

9. TRAINING

a. Peer Support Providers.

(1) Peer support providers must complete all mandatory training required for all VA employees.

(2) Continuing education (CE) is mandatory. All VHA peer support providers, including WOCs, must complete 12 hours of training annually on topics related to the provision of peer support services. Competencies addressed in CE should be related to the competency list found on the Peer Support Share Point site (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Serv>)

[ices%2FTraining%2FCompetencies&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}](#)). **NOTE:** This is an internal VA Web site that is not available to the public. Due to their unique role, VHA peer support providers 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 2 hours of CE annually should be on topics related to ethical considerations in peer support services. Such training can be attained through OMHSP- and Employee Education System-sponsored webinars related to peer support ethics. Mandatory annual ethics training in the Talent Management System (course number VA 3812493), while required for all VA employees, does not meet the additional 2 hours of ethics training required above. Additional training materials can be acquired through Substance Abuse and Mental Health Services Administration (SAMHSA) and other local and national peer support associations.

(3) VHA CE hour requirements may be met by several methods such as attending VA medical facility grand round presentations, regional or national webinars, workshops, college courses, and conferences. It is the responsibility of peer support providers to maintain a record of all CE attended each year and to provide a copy of that record to their supervisors annually. TMS provides a mechanism for recording both VA and external learning experiences. A copy of this form in TMS may be used to document the learning activities, or individual certificates of completion of courses may also be submitted. If a peer support provider has been certified by a not-for-profit organization or state-approved process that requires recertification, the peer support provider must attain the necessary annual CE hours required by that State to become recertified.

b. **VHA Vocational Rehabilitation Managers.** It is strongly recommended that VHA Vocational Rehabilitation Managers complete the Compensated Work Therapy (CWT) Management Curriculum.

c. **All Mental Health Staff.**

(1) **Mental Health Recovery: An Introduction (TMS VA 29476).** Recommended for non-clinical staff working in Mental Health and Psychosocial Rehabilitation and Recovery Services (PSR&RS) programs or those new to the concept of mental health recovery.

(2) **Mental Health Recovery: How to Transform Principles Into Practice (TMS VA 33942).** Recommended to clinical staff working in Mental Health and PSR&RS programs or those who want a deeper dive into recovery-oriented practices.

10. RECORDS MANAGEMENT

All records in any medium (paper, electronic, electronic systems) created in response to this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. If you have any question regarding any aspect of records

management you should contact your facility Records Manager or your Records Liaison.

11. REFERENCES

- a. Pub. L. 94-581.
- b. Pub. L. 108-170, Section 104.
- c. Pub. L. 110-387.
- d. 38 U.S.C. 17, Chapter 31.
- e. 38 U.S.C. 1151.
- f. 38 U.S.C. 1718.
- g. 38 U.S.C. 2031.
- h. 38 U.S.C. 7301(b).
- i. 29 CFR 525.
- j. 38 CFR 17.38.
- k. 48 CFR 8.
- l. Federal Acquisition Regulation FAR; 48 CFR, Federal Acquisition Regulation Executive Order 13625 of August 31, 2012, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.
- m. VA Directive 6008, Acquisition and Management of VA Information Technology Resources, dated November 2, 2017.
- n. VA Financial Policy Volume II Chapter 04, Awards, Ceremonies, Food or Refreshments, Gifts or Mementos, dated August 31, 2017.
- o. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- p. VHA Directive 1160, Re-Engaging Veterans with Targeted Serious Mental Illnesses in Treatment, dated February 7, 2018.
- q. VHA Directive 1161, Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers, dated June 7, 2013.
- r. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016.

- s. VHA Directive 1700, Veterans Choice Program, dated October 25, 2016.
- t. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.
- u. VHA Directive 2008-020, Patient Transportation Program, dated April 16, 2008.
- v. VHA Handbook 1004.01, Consent to Clinical Treatments and Procedures, dated August 14, 2009.
- w. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.
- x. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.
- y. VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019.
- z. Business Operations SharePoint (https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx). **NOTE:** This is an internal VA Web site that is not available to the public.
- aa. Commission on Accreditation of Rehabilitation Facilities (CARF) (<http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx>).
- bb. DI 10505.023 Military Service (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505023>).
- cc. DI 10505.025 Special Employment Situations (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505025>).
- dd. Guidance on Workload Capture: Peer Support Services (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2fCR%2fMentalHealth%2fPeer%20Support%20Services%2fGuidance%2fDocumentation&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8>). **NOTE:** This is an internal VA Web site that is not available to the public.
- ee. Home Telehealth (<http://vaww.telehealth.va.gov/pgm/ht/index.asp>). **NOTE:** This is an internal VA Web site that is not available to the public.
- ff. Integrated Ethics Committee (<https://vaww.ethics.va.gov/activities/consult.asp>). **NOTE:** This is an internal VA Web site that is not available to the public).
- gg. Intra-Agency Agreement (IAA) Cross-Servicing Support Agreement (VA Form 2269; <https://vaww.fsccollaboration.fsc.va.gov/IGOVFASPAC/SharedDocuments/AgreementForms/VA2269.pdf>). **NOTE:** This is an internal VA Web site that is not available to the public.

hh. Joint Commission Accreditation Manual for Hospitals
<https://www.jointcommission.org/accreditation/hospitals.aspx>.

ii. LRC SharePoint
(<https://vaww.cmopnational.va.gov/CR/MentalHealth/Recovery%20Coordinators/Forms/AllItems.aspx>). **NOTE:** This is an internal VA Web site that is not available to the public.

jj. Mental Health Environment of Care Checklist
(<http://vaww.ncps.med.va.gov/guidelines/mheocc.html>). **NOTE:** This is an internal VA Web site that is not available to the public.

kk. Mental Health Facilities Design Guide
(<https://www.cfm.va.gov/til/dGuide/dgMH.pdf>).

ll. Mental Health Services Business Operations SharePoint
(https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx). **NOTE:** This is an internal VA Web site that is not available to the public.

mm. National Center for Ethics in Health Care Home (<http://vaww.ethics.va.gov>).
NOTE: This is an internal VA Web site that is not available to the public.

nn. National Center for Ethics in Health Care Web site
(www.ethics.va.gov/activities/policy.asp).

oo. Office of Academic Affiliations, Interprofessional Fellowship in Psychosocial Rehabilitation and Recovery Oriented Services
(<https://www.va.gov/oaafellowships/psychosocial-rehab.asp?p=25>).

pp. Office of Finance, Volume XVI – Charge Card Programs
(<https://www.va.gov/finance/policy/pubs/volumeXVI.asp>).

qq. Peer Specialist Toolkit.
(<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FSupervision&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}>). **NOTE:** Only supervisors in the peer specialist supervisory email distribution list have access to this folder. This is an internal VA Web site that is not available to the public.

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(<http://govinfo.library.unt.edu/mentalhealthcommission/index.htm>).

ss. Principles of Ethical Conduct for Government Officers and Employees
(<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Guidance/Ethics/US%20Government%20Code%20of%20Ethics.pdf> and

<http://vaww.ethics.va.gov/>). **NOTE:** These are internal VA Web sites that are not available to the public.

tt. PRRC Recovery Domains

(<https://vaww.cmopnational.va.gov/CR/MentalHealth/PRRC/Mental%20Health%20Services%20PRRC%20Guidance/PRRC%20Recovery%20Domains%20-%20PRRC%20Outcome%20Measures%20Workgroup%20Final%20Product%2011%2020%2008.fin.doc>). **NOTE:** This is an internal VA Web site that is not available to the public.

uu. PRRC Self-Assessment Checklist

(<https://vaww.cmopnational.va.gov/CR/MentalHealth/PRRC/Getting%20A%20PRRC%200Started/SPGS%20PRRC%20SelfAssmnt%20Chklist%2011%2005%2008.doc>). **NOTE:** This is an internal VA Web site that is not available to the public.

vv. Psychiatric Rehabilitation Association

(<http://www.psychrehabassociation.org/about-pra>).

ww. RS 01402.485 Department of Veterans Affairs (VA) Incentive Therapy (IT) and Compensated Work Therapy (CWT) Programs

(<https://secure.ssa.gov/apps10/poms.nsf/lnx/0301402485>).

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yy. Salzer, M. S., Baron, R. C., Menkir, S. M. A., & Breen, L. (2014). Community integration practice: Promoting life in the community like everyone else. In P. Nemeč & K. F. Norman (Eds.), *Best practices in psychiatric rehabilitation*. Columbia, MD: Psychiatric Rehabilitation Association.

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ccc. Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) at <http://vaww.smitrec.va.gov/>. **NOTE:** This is an internal VA Web site that is not available to the public.

ddd. Supported Employment Fidelity Scale (<https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf>). **NOTE:** This linked document is outside of VHA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

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jjj. VHA Peer Support Services Peer Specialist Toolkit: Position Descriptions (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FHuman%20Resources%2FPosition%20Descriptions&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}>). **NOTE:** This is an internal VA Web site that is not available to the public.

kkk. VHA Peer Support Services Peer Specialist Toolkit: Training (<https://vaww.cmopnational.va.gov/CR/MentalHealth/Peer%20Support%20Services/Forms/AllItems.aspx?RootFolder=%2FCR%2FMentalHealth%2FPeer%20Support%20Services%2FTraining&FolderCTID=0x0120007ED8487946EC4541ABCE3721142E15E8&View={008B4700-3813-41FD-B0B1-0C15380837B0}>). **NOTE:** This information is found on an internal VA Web site not available to the public.

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(https://vaww.portal.va.gov/sites/OMHS/TSES/Compensated_Work_Therapy/Forms/AllItems.aspx?RootFolder=%2Fsites%2FOMHS%2FTSES%2FCompensated%5FWork%5FTherapy%2FSupported%20Employment&FolderCTID=0x01200044F61130B396F546B732397F1BEB3005&View=%7B2EA5E62E%2D1168%2D4664%2D8C7D%2DC458906C6873%7D). **NOTE:** *This is an internal VA Web site that is not available to the public.*