

**PROGRAMS FOR VETERANS WITH POST-TRAUMATIC STRESS
DISORDER (PTSD)**

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook establishes procedures for a continuum of programs for treatment of eligible Veterans with post-traumatic stress disorder (PTSD) within the Office of Mental Health Services (OMHS).
- 2. MAJOR CHANGES.** This is a new Handbook dealing with VHA's treatment of eligible Veterans with PTSD.
- 3. RELATED DIRECTIVE.** VHA Directive 1160 (to be published).
- 4. RESPONSIBLE OFFICE.** The Office of Mental Health Services (116), and the Office of Patient Care Services (11) is responsible for the contents of this Handbook. Questions may be addressed to 202-461-7364.
- 5. RECISSIONS.** VHA Manual M-2, Part X, Paragraphs 2.09, 3.03g., 3.04b, and 3.10, are rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled to be recertified on or before the last working day of March 2015.

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PROGRAMS FOR VETERANS WITH POST-TRAUMATIC STRESS DISORDER (PTSD)

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for a continuum of post-traumatic stress disorder (PTSD) care of all eligible Veterans.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) operates an internationally recognized network of more than 230 specialized programs for the treatment of PTSD. Through its medical facilities and clinics and more than 90 specialized mental health programs for Veterans returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), these programs provide a continuum of care from outpatient PTSD Clinical Teams (PCTs) through specialized inpatient units, brief-treatment units, and residential rehabilitation programs around the country.

b. Every VA medical center has PTSD specialty capability as do an increasing number of community-based outpatient clinics (CBOCs). There are increasing numbers of PTSD programs or tracks within PTSD programs to meet special needs of Veterans such as those with co-occurring PTSD and substance use disorders (SUDs), or those who are survivors of military sexual trauma (MST). Mental health programs, especially those for OEF and OIF Veterans, have ties to the National, regional, and local rehabilitation programs for Polytrauma and traumatic brain injury (TBI).

c. Since 2005, Services for Returning Veterans-Mental Health (SeRV-MH) teams, also known as Mental Health OEF and OIF teams, have been established across VA system in virtually every state. The efforts of these programs at early identification and management of stress-related disorders may decrease the long-term disease burden of returning troops. Outreach is the purview of Re-adjustment Counseling Service Veteran Centers, but the SeRV-MH programs are available to support Veteran centers in that role as needed. SeRV-MH teams include a focus on providing mental health services in primary care post-deployment health clinics and Polytrauma-TBI programs (“in reach”).

d. The Office of Mental Health Services (OMHS) PTSD Programs are primarily oriented toward clinical care delivery, although there is a significant component dedicated to promoting research and education on PTSD, in particular through VA's National Center for PTSD (NCPTSD). In 2004, a new Mental Illness Research, Education and Clinical Center (MIRECC) was established at VA Medical Center in Durham, North Carolina, to focus on issues of post-deployment health for returning OEF and OIF Veterans. It collaborates with the NCPTSD and the nine other MIRECCs, as well as with the Department of Defense (DOD), the VA Office of Research and Development (ORD), and Employee Education Service (EES). In 2005, Congress mandated that three centers of excellence in mental health care, with particular emphasis on PTSD, be recognized in VA medical facilities at Waco, Texas, Canandaigua, New York, and San Diego, California.

3. DEFINITION OF PTSD

PTSD is an anxiety disorder. PTSD is defined as: "...the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; or other threat to one's physical integrity; or witnessing an event that involves death, injury or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (see subpar. 19a). Characteristic symptoms include re-experiencing the trauma, avoidance of stimuli associated with the trauma, numbing of responsiveness, and persistent symptoms of increased arousal.

a. The diagnosis of PTSD must be consistent with the criteria of the psychiatric diagnosis system approved by VA, found in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV).

b. The onset of manifestations of PTSD is variable. PTSD is categorized as acute, chronic, or delayed onset. The manifestation of delayed on-set PTSD does not appear for at least 6 months, or may not appear for decades after the traumatic event. Having PTSD surface for the first time near the end of life can be particularly unexpected and distressing for the Veteran and family. Severe PTSD is identified by the frequency and intensity of symptoms and the degree to which these symptoms impair patient functioning.

c. The effects of war zone trauma have been demonstrated to be long lasting and severe. Thus for these Veterans, the most common stressor for PTSD is war zone stress, including both combat and dealing with mass casualty situations (see subpar. 19e). Also included may be other non-war zone military experiences, such as the crash of a military aircraft or sexual assault.

4. CLINICAL COMPLEXITY OF VA PATIENTS (COMORBIDITIES)

Complex PTSD is characterized by the presence of one or more co-occurring mental disorders. Veterans who are treated for PTSD in VA may have significant complicating features, including:

a. Comorbid anxiety disorders, such as panic disorder and general anxiety disorder.

b. Comorbid depressive disorders. *NOTE: These disorders are found in the 16 to 20 percent range even in non-treatment-seeking Vietnam Veteran populations.*

c. SUD, with a prevalence reported from 58 percent to 80 percent in Veteran treatment populations.

d. General medical disorders. Because of the aging of the Veteran population and of the implication of PTSD in the development or exacerbation of certain internal medical disorders, assessment and treatment of patients with PTSD must include a particular focus on the presence and management of physical disorders (see subpar. 19g).

5. SCOPE

This Handbook defines requirements for PTSD services that must be provided as clinically needed at VA medical facilities and CBOCs (see VHA Handbook 1160.01). *NOTE: It is not the purpose of this Handbook to describe all outpatient mental health programming that could be appropriate and effective.*

6. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

Each VISN Director is responsible for:

a. Ensuring that PTSD treatment services are accessible to all eligible Veterans. The entire continuum of clinical services may not be present in a single facility, but must be available to all patients treated within a VISN. *NOTE: Some components of the continuum may be provided in coordination with neighboring VISNs.*

b. Ensuring that programs are operated in compliance with relevant law, regulation, policy and procedures.

7. RESPONSIBILITIES OF THE FACILITY DIRECTOR

Each Facility Director is responsible for:

a. Providing and maintaining program oversight of the PTSD treatment program to ensure access, quality services, and compliance with VHA policy and procedures. This includes ensuring mental health staff receive training and consultation in evidence-based psychotherapies for PTSD.

b. Providing safe, well-maintained, and appropriately-furnished facilities that support and enhance the recovery efforts of all Veterans being treated for PTSD.

c. Ensuring the timely completion of all mandated reporting, monitoring, and accreditation requirements of the PTSD treatment program.

8. PRINCIPLES OF TREATMENT AND REHABILITATION OF VETERANS WITH PTSD

a. It is widely acknowledged that optimal treatment of PTSD requires specialized knowledge and skill. Accordingly, PTSD treatment, particularly for Veterans suffering from acute, severe, or complex PTSD, is optimally delivered by specialized teams whose work is primarily focused on treating Veterans with PTSD. Specialized PTSD treatment staff must be trained in evidence-based psychotherapy for PTSD and best practices in pharmacotherapy of PTSD. Depending on severity of PTSD and availability of clinical resources, PTSD treatment can also be provided in general mental health or primary care settings.

b. Evidence-based psychotherapies, including exposure-based psychotherapies such as Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) are effective for PTSD and are highly recommended in VA and DOD Clinical Practice Guidelines for PTSD (see http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp.) VA is disseminating CPT and PE Nationally throughout VA health care system through extensive training and ongoing consultation of VA mental health providers. VA is also assisting DOD in their dissemination of these psychotherapies. Although there is a less robust evidence-base for pharmacotherapy of PTSD, data indicates that medications, such as selective serotonin reuptake inhibitors (SSRIs), can be effective for some symptoms (see subpar. 19g).

c. Positive treatment outcomes for PTSD have been documented for VA's inpatient and outpatient PTSD programs and Veteran centers; documented in VA's on-going PTSD program evaluation documents (see subpar. 19h). Improvements are noted in PTSD symptoms, as well as in significant quality of life parameters such as employment, family, and legal status. However, the nature of treatment appears to require a specific expertise.

d. VHA OMHS (116), and VA's Northeast Program Evaluation Center (NEPEC), in conjunction with facilities and the VISNs, have developed a standard National outcome monitoring system including Global Assessment of Functioning (GAF) and performance measures for specialized PTSD programs; these include both population outcome measures and program outcome measures. *NOTE: Such measures assist in evaluating the effectiveness of treatment.*

9. PTSD CONTINUUM OF CARE

Provision of a PTSD continuum of care implies matching the unique needs of a patient with the level of care required at the time, as well as the potential to move the patient to a higher or lesser intensity level as needed. *NOTE: VHA Handbook 1160.01 defines the requirements for services that must be provided when clinically indicated at VA medical facilities and CBOCs.* Services provided need to be based on the individual patient's clinical needs; not all patients require the entire continuum of services. Patients must be able to move among the components of the continuum as is clinically appropriate, with minimal disruption in treatment, and in a manner which facilitates positive treatment outcomes.

a. **Components of a Continuum.** The following components in this continuum need to be readily accessible to all eligible Veterans:

- (1) Early identification and intervention;
- (2) Assessment, triage, and referral;
- (3) Acute stabilization and intervention, including hospitalization, as necessary;

(4) Treatment and rehabilitation; short-term or long-term (greater than 30 days) on an outpatient or residential basis for those patients in need of such a setting; and

(5) Other outpatient care, encompassing continuing care, monitoring, and relapse prevention for those with SUD comorbidity.

b. **Integrated Services Within a Continuum.** Although this Handbook focuses specifically on PTSD, it does so within a comprehensive and integrated health care system. Depending on a patient's clinical needs, the following services may be part of a comprehensive individualized treatment plan:

(1) Medical services;

(2) Mental health services for PTSD and non-PTSD comorbid diagnoses;

(3) Education and counseling for eligible family members consistent with VA's legal authorities;

(4) Screening for domestic violence with counseling, as needed;

(5) Educational, vocational, and employment services, including Compensated Work Therapy (CWT);

(6) Social and independent living skills;

(7) Relapse prevention skills training for patients with SUD comorbidity; and

(8) Housing assistance encompassing Health Care for Homeless Veterans (HCHV), placement assistance, and domiciliary services. *NOTE: Statutory and regulatory eligibility and enrollment criteria are different amongst various programs within VHA. Employees are encouraged to become familiar with the criteria for various programs and consult with appropriate program offices as needed.*

c. **Patient Perspective Services Within the Continuum.** From the perspective of a patient suffering from PTSD, VA health care includes a range of services designed to meet their clinical needs.

(1) A Veteran coming to VA for the first time is screened for the presence of symptoms of PTSD, depression, and alcohol abuse. Follow-up screening varies with the target disorder. For PTSD, the screen is repeated every year for the first 5 years the Veteran is in VA care and every 5 years thereafter, unless there is a clinical need to screen earlier. Screens for depression and alcohol abuse are repeated annually.

(2) Should the Veteran screen positive for any of these conditions, the Veteran is further evaluated either by the primary care provider or by referral to a mental health clinician. Veterans who screen positive for PTSD or depression are assessed for suicide risk. If the clinical evaluation confirms the presence of a mental health problem, the Veteran is treated. Treatment depends on the nature of the condition and its severity.

(3) Based on the patients' needs, they may receive acute outpatient or inpatient services and, if appropriate, longer rehabilitative residential or outpatient care. The goal of treatment is always to assist the patient in achieving the fullest possible degree of satisfaction and social and occupational functioning of which they are capable, provided in the least restrictive setting.

(4) A spectrum of treatment options must be preserved for Veterans with PTSD. Outpatient settings should maximize accessibility, expertise, and clinical efficacy. Staff should have the capacity to address the severity, chronicity, complexity, and comorbidities associated with PTSD. There are patients for whom treatment in an intensive inpatient or residential setting is a medical necessity. There are times when a patient whose primary problem is PTSD may also require other psychiatric services in addition to those found in specialized PTSD settings. Examples include:

(a) Emergencies, such as suicidal behavior, which may require care in a general psychiatric unit; or

(b) Specialized SUD treatment needed before PTSD care is initiated, or during the course of treatment.

10. SPECIALIZED MENTAL HEALTH PTSD SERVICES

The great majority of returnees do not suffer long-term consequences of their war zone experience, although many will have some short-term reactions. Of those who do develop mental or emotional problems, PTSD is not the only problem to be addressed. Major depression, and substance abuse are two problems that can be anticipated and these disorders carry with them significant risk for dangerous behaviors, such as suicide or family violence. Specialized PTSD services are designated inpatient, residential, and outpatient programs specifically designed to meet the needs of Veterans with PTSD, particularly those with new onset, severe, or complex, (e.g., dual diagnosis PTSD). These programs provide a continuum of care from intensive inpatient and residential services to outpatient care that increasingly is penetrating into non-mental health venues, such as primary care at CBOCs, to enhance accessibility to specialized services and reduce stigma. Veterans of all service eras are served by these programs

a. Requirements for VISNs, VA Medical Facilities, and CBOCs

(1) Every VISN is required to have specified inpatient or residential PTSD programs in sufficient locations and numbers to meet the needs of Veterans in their catchment area.

(2) All VA medical facilities must have specialized outpatient PTSD capability and the ability to provide care and support for Veterans with PTSD.

(3) All CBOCs should have the capacity to provide diagnostic evaluations and treatment planning for PTSD through onsite full-time or part-time staff (PTSD specialists) or by telemental health with parent VA medical facilities.

b. **Access Requirements for all Programs.** All new patients requesting or referred for mental health services must have an initial assessment within 24 hours and their first full evaluation appointment within 14 days. Established patients require follow-up appointments within 30 days. This is the same for Veterans of all service eras and all diagnoses.

11. SPECIALIZED OUTPATIENT PTSD CARE

a. **PTSD Clinical Team (PCT) or PTSD Specialists.** PTSD specialists have expertise in PTSD, but serve at sites where workload does not warrant a full PCT. PCTs and PTSD specialists provide a resource of expertise for their entire facility including CBOCs, and for inpatient and residential care general mental health units that lack specialized PTSD inpatient and residential care programs. PCTs and PTSD specialists are key points of contact for Veteran centers, facility MST programs, and OEF and OIF care programs in facilities that lack a Mental Health OEF and OIF Team.

(1) **Requirements for VA Medical Facilities and CBOCs.** All VA medical facilities are required to have either a PCT or PTSD specialist, based on locally determined patient population needs. All CBOCs must make PCTs or PTSD specialists available for consultation or care for Veterans who may have PTSD; either on-site, by referral to nearby VA medical facilities, or by telemental health.

(2) **Patients Served.** Criteria for care by PCT and PTSD specialists include patients with new on-set, severe, or complex PTSD.

(3) **Staffing.** PCTs include a minimum of three full-time equivalent (FTE) employee mental health clinicians with expertise in PTSD and may have one support person. Having at least part-time psychiatrist staffing in the PCT staffing mix is recommended. The number of PTSD Specialists at a site without a PCT is based on workload.

(4) **Length of Stay (LOS) or Duration of Care.** The LOS or duration of care is clinically determined based on patient symptoms and functioning.

(5) **Capacity Requirements.** Current data suggests an appropriate "panel size" is 120-200 per clinician FTE. This ratio needs to be used to estimate numbers of PTSD specialists at smaller VA medical centers or in CBOCs. **NOTE:** *OMHS continues to evaluate the patient-clinician ratio and provide updated guidance to the field, as necessary.*

b. **PTSD Day Hospitals (DH) and Psychosocial Rehabilitation and Recovery Centers (PRRCs).** PTSD DHs are intensive outpatient programs, which provide a specialized form of care that falls between full hospitalization and the more traditional models of ambulatory care. These programs are characterized by intensive treatment of patients for limited periods of time (3 to 6 weeks is an approximation of the time required for this level of care based on previous experience in these programs). Modeled after general mental health DH programs, they are designed to offer an intensive alternative to inpatient services to reflect VHA's greater emphasis on outpatient care. They may also serve as a step-down program from inpatient care. The nature of clinical services provided in PTSD DHs is transforming these programs into a PRRC format (see VHA Handbook 1160.01). PRRCs must provide a therapeutic and supportive learning

environment for Veterans in the program, which is designed to maximize functioning in all domains.

(1) **Requirements for VA Medical Facilities or CBOCs.** VA medical facilities or CBOCs can refer Veterans to a PTSD DH based on assessment of the Veteran's clinical needs, and PCTs' or general Mental Health Clinics' (MHCs) or CBOCs' need to follow these Veterans after they complete the DH Program. The Veteran's level of PTSD severity determines whether these services are provided by a PCT, specialist, or MHC staff provider.

(2) **Patients Served.** The patients served in PTSD DH are Veterans in need of intensive treatment for fixed periods of time (3 to 6 weeks), but do not need the security or structure of an inpatient or residential program

(3) **LOS or Duration of Care.** LOS or duration of care is based on clinical improvement mutually determined by patient and program staff. At the time of discharge, the Veteran is expected to have gained mastery over key mental health challenges and acquired or mastered skills enabling him or her to function in the community.

c. **Serving Returning Veterans-Mental Health (SeRV-MH) Teams.** Beginning in fiscal year (FY) 2005, VA's OMHS initiated programs designed to contact returning OEF and OIF Veterans, assess their needs, promote healthy coping with the stress of war, and return to society through early identification and correction of problems. The original title for these programs was "Returning Veterans Outreach, Education and Care" (RVOEC).

(1) **Participation.** In collaboration with Veteran Centers, SeRV-MH teams participate in:

(a) Outreach activities, such as contacting returning troops, including members of the National Guard and Reserves and their families, in forums to present preventive health and educational briefings that allow for informal sharing of information about stress-related disorders and coping mechanisms, and the availability of a range of VA psychosocial support services;

(b) Other activities carried out by VA medical facilities, such as stand-downs, which present the opportunity for SeRV-MH teams and Veteran center staff to engage OEF and OIF Veterans and their families;

(c) Regular consultation and liaison with medical, surgical, and rehabilitation units serving OEF and OIF Veterans, using the same approaches as outlined; and

(d) Clinical care for Veterans including follow-up to consultation and liaison activities.

(2) **Location.** A number of SeRV-MH teams are co-located with primary care clinicians or link with CBOCs. SeRV-MH teams provide mental health services to primary care post-deployment health clinics. This approach fosters the integration of mental health care with other medical care. *NOTE: Most SeRV-MH programs are associated with facility PTSD programs, but the evolving orientation of the SeRV-MH and PTSD programs is towards a comprehensive care for the range of problems presented by Veterans, rather than a limited focus on PTSD alone.*

(3) **Patients Served.** These SeRV-MH teams were designed to serve returning OEF and OIF Veterans; however, they could conceivably work with those who have been engaged in other current or future "Global War on Terror" combat activities.

(4) **Staffing.** Currently, between two to four clinicians, mostly from the psychology, and social work disciplines make up the team, although some psychiatrists, and nurses, including advanced practice nurses are on teams. Neuropsychologist time is also often included given concerns about mild TBI in the OEF and OIF population. *NOTE: OMHS continues to evaluate staffing levels to determine the most clinically-effective team size and composition. Additional guidance is provided to the field as necessary.*

(5) **LOS or Duration of Care.** LOS or duration of care is determined by the Veteran's clinical (symptom or functional) status. Patients may require further care by specialty PTSD if they suffer severe de-compensation.

(6) **Requirements for VA Medical Facilities or CBOCs.** VA medical facilities or CBOCs should have the capacity to assess and treat the mental health needs of OEF and OIF Veterans, either through formal SeRV-MH teams or through services of PCTs or PTSD specialists and MHC staff.

12. SPECIALIZED INPATIENT AND RESIDENTIAL PTSD CARE

All VISNs must have specialized inpatient or residential care programs for Veterans with PTSD.

a. **Specialized Inpatient Care Settings.** Specialized inpatient care settings include:

(1) **Specialized Inpatient PTSD Units (SIPUs).** SIPUs are stand alone inpatient units designed to offer comprehensive treatment aimed at resolution of war-related problems, resumption of personal development, restoration of ability to deal with close relationships, social participation, employment, and other aspects of productive living. There are five SIPUs left with a significantly shorter LOS than the original programs. Longer-term care has largely been taken over by PTSD Residential Rehabilitation Programs (PRRPs). The need to establish a SIPU care format is based on assessment of the needs of the population served by the facility.

(2) **Evaluation and Brief Treatment PTSD Units (EBTPUs).** EBTPUs are short-term acute PTSD inpatient programs with 5 to 15 beds. The average LOS is 10 to 20 days. Patients completing treatment in an EBTPU must receive follow-up care in a PCT, Veteran center, MHC, or primary care clinic. Because of its limited number of beds, an EBTPU is not a free-standing unit, but rather a component of an existing inpatient psychiatry unit.

(3) **Patients Served.** The patients served are those Veterans whose PTSD is clinically determined to require the inpatient level of security and intensity of services. Hospitalization is based on medical necessity; at a minimum, this is Veterans with PTSD who have urgent care needs (e.g., danger to self or others, or inability to care for self).

(4) **LOS or Duration of Care.** The LOS or duration of care is clinically determined based on the patient's symptoms and functioning.

(5) **Requirements for VA Medical Facilities or CBOCs.** VA medical facilities, CBOCs, and all mental health inpatient units should have the capability to treat Veterans with PTSD. This may be provided by outpatient PTSD specialists on-site or through consultation if the VA medical center PTSD population does not warrant an EBTPU or SIPU type program. The need for an EBTPU or SIPU at a facility is based on the facility or VISN assessment of the clinical needs and size of the population of Veterans with PTSD.

b. **Specialized PTSD Residential Care Settings.** PTSD Residential Rehabilitation Programs (PRRPs) and PTSD domiciliary programs are designed to provide a semi-structured therapeutic environment before the Veteran's full community re-entry. Rehabilitation efforts involve continuing PTSD treatment; sobriety maintenance efforts, where indicated; and efforts directed at securing employment and at establishing housing and support systems in the community. The essential difference between SIPUs and PRRPs or PTSD domiciliaries is the residential programs' active focus on rehabilitation applied to a cohort of Veterans who have better self care and self control capabilities than those who require inpatient care.

(1) **Patients Served.** The patients served are Veterans with PTSD, including those with co-occurring SUD, in need of rehabilitation for these disorders and who have better self care and self control capabilities than those requiring inpatient care.

(2) **LOS or Duration of Care.** LOS or duration of care is determined by clinical improvement of the Veteran and the Veteran's development of skills to function safely and effectively in the community.

(3) **Capacity Requirements.** Every VISN must provide timely access to residential programs to meet the needs of Veterans with PTSD either through a specialized PRRP or PTSD domiciliary program or specific PTSD care tracks in a general residential program. The needs for some types of subspecialty care, (e.g., women with PTSD or Veterans with co-occurring PTSD and SUD may be limited) and regional or national resources may be needed.

(4) **Requirements for VA Medical Facilities or CBOCs.** VA medical facilities or CBOCs can refer patients to residential care programs. VA medical facilities provide support for medical needs of residential patients and in case of mental disorder exacerbation can provide inpatient clinical services. CBOCs can provide follow-up after discharge based upon the needs of the patient and capacity for the CBOC to provide specialized outpatient PTSD care.

13. WOMEN'S PTSD SERVICES

a. **Outpatient Women Veteran Stress Disorder Treatment Teams (WSDTT) and Trauma Recovery Tracks.** Outpatient WSDTTs are modeled after PCTs, providing ambulatory care and consultation liaison services for women Veterans, including, but not limited to those who have experienced sexual assault or harassment. Increasingly, given the changing role of women in the armed forces, women Veterans have experienced psychological combat trauma and the mental health sequelae of physical wounds of war including amputation,

Polytrauma and TBI. Currently, a WSDTT with a full workload includes three mental health clinicians and one administrative staff person. **NOTE:** *Facilities that do not have the workload need in their population for a full WSDTT can develop a trauma recovery track for women Veterans with fewer clinicians. OMHS continues to evaluate staffing levels to determine the most clinically appropriate team size and composition. Additional guidance is provided to the field as necessary.*

b. **Inpatient Services.** In an effort to meet the residential care needs of traumatized women Veterans, specialized Women's Treatment Rehabilitation Programs (WTRPs) have been established. Rehabilitation efforts involve continuing PTSD treatment; sobriety maintenance efforts, where indicated; and efforts directed at securing employment and at establishing housing and support systems in the community.

(1) **Patients Served.** The patients served are women Veterans in need of treatment for PTSD related to trauma, sexual harassment or assault, combat, etc. Inpatient and residential versus outpatient care is to be determined by clinical severity and complexity.

(2) **LOS or Duration of Care.** The LOS or duration of care is determined by the Veteran's clinical (symptom or functional) status.

(3) **Requirements for VA Medical Facilities or CBOCs.** Each VISN must have a residential program available to meet the needs of women Veterans. National or regional resources should be utilized if the number of patients needing these services does not meet the threshold for a facility in each VISN. Every VA medical center should have the ability to treat women Veterans suffering from PTSD; CBOCs should have this capability, which can be provided by telemental health.

14. DUAL DIAGNOSIS (CO-OCCURRING PTSD AND SUD)

a. VA program evaluation indicates that 30 percent of Veterans treated for PTSD in specialized outpatient PTSD programs have co-occurring SUD. Rates among inpatients are even higher. The concurrent treatment of PTSD and SUD is considered an evidence-based practice and is being instituted across the system.

b. At a minimum, each VA medical center must have an addictions specialist attached to the outpatient PTSD care operation. Based on facility assessment of need, larger SUD-PTSD teams (SUPT) may be needed. In inpatient and residential PTSD programs, concurrent treatment of SUD can be achieved either by having staff as part of the unit staff, or through coordination with facility outpatient PTSD and SUD operations.

(1) **Patients Served.** The patients served are Veterans with co-occurring PTSD and SUD.

(2) **LOS or Duration of Care.** The LOS or duration of care is determined by the Veteran's clinical (symptom or functional) status.

(3) **Requirements for VA Medical Facilities or CBOCs.** Every VA medical center should have the capacity to provide concurrent outpatient treatment of co-occurring PTSD and SUD.

Services should be available in CBOCs, which can be embedded by VA staff, telemental health, referral to community-based providers, or non-VA fee-basis to the extent the Veteran is eligible. Each VISN must have a residential program available to meet the needs of Veterans with co-occurring PTSD and SUD. National or regional resources need to be utilized if the number of patients needing these services does not meet the threshold for a facility in each VISN.

15. PTSD IN GENERAL MENTAL HEALTH SETTINGS

a. NEPEC data indicates that one-half to two-thirds of PTSD care in any given year is provided in general MHCs. Most VA clinicians are familiar with, and can manage, stabilized or low-severity PTSD. This is true of mental health clinicians in CBOCs, although specialty PTSD services should be available at least by consultation in person or telemental health as noted.

b. Veterans who have been treated in PCTs, or other specialized PTSD programs, may be stabilized sufficiently to be followed over the long term in general mental health settings. Inpatient general mental health units must anticipate having Veterans with PTSD and their staff must be able to manage their care, consultation, and in some cases treatment as required by the facility's PTSD specialists. Assessment for suicidal or violent behavior, generally required for all patients admitted for inpatient care, must at a minimum, always be performed for Veterans with PTSD upon admission and immediately prior to their discharge.

(1) **Patients Served.** The patients served are Veterans with stabilized, low-severity, uncomplicated PTSD.

(2) **LOS or Duration of Care.** All new patients requesting, or referred, to mental health services must receive an initial evaluation within 24 hours, and a more comprehensive evaluation and treatment plan within 14 days. Duration of care is determined by the Veteran's clinical (symptom and functional) status. Patients may require further care by specialty PTSD program if they suffer severe de-compensation.

(3) **Requirements for VA Medical Facilities and CBOCs.** Clinics and medical facilities and very large CBOCs (more than 10,000 Veterans seen per year) must offer a full range of services during evening hours at least 1 day a week. Additional evening, early morning, or weekend hours must be offered when required to meet the needs of the facility's patient population. *NOTE: Other CBOCs are strongly encouraged to provide evening and weekend hours.*

16. INTEGRATING MENTAL HEALTH IN POLYTRAUMA SITES

a. SeRV-MH teams, PCTs, and PTSD specialists must work with facility Polytrauma and rehabilitation staff to provide coordinated assessment and clinical care to Veterans who are survivors of multiple injuries. TBI, PTSD, SUD, and depression are examples of mental disorders that may be anticipated in this population, as well as sub-diagnostic behavioral problems, such as impulsivity, agitation, or cognitive impairment.

b. Staff from general mental health clinics, consultation or liaison services, or specialized clinics, (e.g., affective disorders clinics) may also be engaged in services for Veterans with

multiple injuries based on facility capabilities and clinical need. Mental health services provided in the Polytrauma clinical area in concert with the Polytrauma staff, may be more acceptable and convenient for the Veterans. Services must be available on an inpatient and outpatient basis and may include the use of telemental health or support for home health care activities.

(1) **Patients Served.** The patients served are Veterans suffering from multiple injuries, which may include TBI, blindness, or amputations, and who are manifesting cognitive, behavioral, or emotional problems; psychosocial difficulties (e.g., with family); or diagnosed mental disorders.

(2) **Staffing.** Staff can come from existing SeRV-MH teams, PTSD or SUD programs, consultation or liaison teams, or a general MHC.

(3) **LOS or Duration of Care.** The LOS or duration of care is determined by the Veteran's clinical (symptom or functional) status.

(4) **Requirements for VA Medical Facilities and CBOCs.** PTSD services must be available in all VA medical facilities and CBOCs serving Polytrauma Veterans. Whenever possible, services should be provided in the rehabilitation or primary care environment to facilitate patient access and reduce stigma.

c. All new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. Services can be facilitated by having mental health staff as part of the Polytrauma team's evaluation of new patients.

17. PRIMARY CARE POST DEPLOYMENT HEALTH CLINICS

VA's primary care service initiated post-deployment health clinics (PDHCs) in approximately ninety VA medical facilities in fiscal year FY 2008 and 2009. The Seattle, Washington, PDHC is the core model for these programs. Mental health support for these programs is provided by existing SeRV-MH Teams, PCTs, or PTSD specialist staff in facilities that lack a formal SeRV-MH team. Comprehensive and coordinated services for the physical and mental health, and psychosocial needs of the Veteran are the goals of the PDHC.

a. The benefits of the PDHC:

(1) Provides expedited primary care access for returning combat Veterans;

(2) Provides returning combat Veterans with medical intake and assessment with combat risk assessment mental health evaluation or triage, as necessary TBI screening or triage; establishes preliminary medical and behavioral diagnoses; begins initial treatment as appropriate;

(3) Serves as triage contacts for combat Veterans needing referral to other facilities for more specialized care (Polytrauma, PTSD in-patient units, war-related illnesses, injury study centers, etc); and

(4) Ensures the accomplishment of clinical reminder and screening templates, expedited care mandates, etc. *NOTE: Mental health services delivered in the primary care environment have the potential for reducing stigma which may be associated with delivery in an identified mental health setting and increasing convenience for patients, both of which can increase patient participation and compliance with treatment.*

b. **Patients Served.** The patients served are OEF and OIF Veterans who present to the PDHC for assessment and care.

c. **Staffing.** Staff can come from existing SeRV-MH OEF and OIF teams, PCTs or PTSD specialist staff, or general MHC staff.

d. **LOS or Duration of Care.** LOS or duration of care is determined by the Veteran's clinical (symptom or functional) status.

e. **Access Requirements.** All new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days.

18. MENTAL HEALTH IN SETTINGS SERVING OLDER VETERANS WITH PTSD

a. **Community Living Centers (CLCs) and Veterans in Palliative Care.** PTSD symptoms may initially come or recur late in life. Accordingly, regular assessment, management, and treatment services must be available to older Veterans. Moreover, it is important to recognize the interaction of PTSD and aging can impact the manifestation and course of PTSD.

(1) **Patients Served.** The patients served are Veterans requiring care in a CLC or palliative care setting with symptoms of PTSD.

(2) **Staffing.** Full-time, integrated mental health providers are required in each CLC. Palliative Care Consult Teams are also required to have a mental health provider. These mental health providers may provide assessment, management, and treatment services for PTSD. Specialty PTSD consultative support for assessment, management, and treatment must be available and appropriate to augment integrated mental health care capacity.

(3) **LOS and Duration of Care.** The LOS and duration of care is determined by the Veteran's clinical (symptom or functional) status.

b. **Home-based Primary Care (HBPC).** Approximately 26,000 Veterans are served each year in HBPC, and have complex chronic disabling conditions due to medical, functional, and psychological impairments. Approximately 20 percent of Veterans in HBPC have a diagnosis of PTSD. The manifestation and course of PTSD in HBPC patients may be impacted by medical comorbidity and physical disability. Moreover, PTSD symptoms may impact physical health and medical adherence. Therefore, attention to detection, management, and treatment of PTSD in HBPC patients is important.

(1) **Patients Served.** The patients served are Veterans treated by HBPC.

(2) **Staffing.** Each HBPC team has a full-time mental health provider. The HBPC mental health provider can provide a variety of assessment, management, and treatment services for PTSD. Specialty PTSD referral services and consultative support for assessment, management, and treatment should be available as needed, (e.g., when clinically appropriate and when such services are not available from HBPC).

(3) **LOS and Duration of Care.** The LOS and duration of care are determined by the Veteran's clinical (symptom or functional) status.

(4) **Requirements for VA Medical Facilities and CBOCs.** PTSD treatment must be available at those VA medical facilities with HBPC programs.

19. REFERENCES

a. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), Washington, DC, p. 424, 2005.

b. Kulka RA, et al., Contractual Report of Finding from the National Vietnam Veterans Readjustment Study (NVVRS). Research Triangle Park, NC. Research Triangle Institute, 1988.

c. Fontana A and Rosenheck R. Women Under Stress: Evaluation of the Department of Veterans Affairs Woman's Stress Disorder Treatment Teams. West Haven, CT., Northeast Program Evaluation Center, July 21, 1997.

d. Fontana A. and Rosenheck R. Treatment of Post-traumatic Stress Disorder in the Department of Veterans Affairs: Fiscal Year 2007 Service Delivery and Performance (LJH XVI). West Haven, CT. Northeast Program Evaluation Center, March, 2008.

e. Scurfield RM, "Post-traumatic Stress Disorder in Vietnam Veterans," International Handbook of Traumatic Stress Syndromes. Wilson JR and Raphael R, eds. Plenum Press, New York and London, 285-295, 1993.

f. Hoge C, Castro C, Messer s, McGurk D, Cotting D and Koffman R. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. New England Journal of Medicine, 351; 1, July 1, 2004.

g. VA and DOD PTSD Clinical Practice Guideline, Module A, 2004.

h. Long Journey Home. Volume XVI, March 2008.

i. Useful Web sites include:

(1) Mental Health Clinical Practice Guidelines, (i.e., Current Clinical Practice Guidelines for Mental Health Diagnoses) can be found at:

<http://vaww.oqp.med.va.gov/> under Clinical Practice Guidelines. *NOTE: This is an internal Web site and not available to the public.* These include:

- (a) Major Depressive Disorder (MDD);
 - (b) PTSD;
 - (c) Psychosis; and
 - (d) SUD.
- (2) Informational Web site: National Center for PTSD at www.ncptsd.va.gov .
- (3) VA and DOD PTSD Clinical Practice Guidelines for PTSD available on the internet, at http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp

**SUMMARY OF REPORTING CODES FOR POST-TRAUMATIC STRESS DISORDER
(PTSD) PROGRAMS**

	Program Name	DSS	Tr Spec	MPCR*
Prog #	PTSD (Post Traumatic Stress Disorder)	ID #	Code	Account
All	Telephone and PTSD	542		2780
2)	PTSD Group	516		2310
2)	PTSD Individual	562		2311
3)	Active Duty Sex Trauma	524		2311
3)	Non-Active Duty Sex Trauma	589		2311
4)	PCT Post Traumatic Stress-Individual	540		2313
4)	PCT-Post Traumatic Stress, group	561		2313
5)	Women's Stress Disorder Teams	525		2311
6)	Substance Use Disorder and PTSD teams	519		2317
7)	SeRV-MH Individual	571		
8)	SeRV-MH Group	572		
9)	PTSD Day Hospital	580		2310
10)	PTSD Day Treatment	581		2310
11)	PRRP (PTSD Residential Rehabilitation Program)		88	1512
12)	Domiciliary-based PRRP		88	1512
13)	PTSD CWT and TR		38	1716
12)	SIPU (Specialized Inpatient PTSD Unit)		79	1314
14)	EBPTU (Evaluation & Brief Treatment PTSD Unit)		91	1315

* *MPCR refers to the Monthly Program Cost Report used to allocate staffing costs.*