TREATMENT FOR VETERANS WITH POSTTRAUMATIC STRESS DISORDER

1. SUMMARY OF MAJOR CHANGES: Major changes are as follows:

a. Updated requirement: Responsibilities and administrative time allocation for Veterans Integrated Service Network (VISN) PTSD Mentor; Model of Accelerated Services Delivery; and Complexity Level 1 Facilities requirements to have a PTSD clinical team (PCT).

b. Added responsibilities for the Assistant Under Secretary for Health for Clinical Services in paragraph 2.b.

c. Added responsibilities for Executive Director of Office of Mental Health and Suicide Prevention in paragraph 2.c.

d. Updated responsibilities for Assistant Under Secretary for Health for Operations in paragraph 2.c., Veterans Integrated Services Network Director in paragraph 2.e., VISN Chief Mental Health Officer in paragraph 2.f., VA Medical Facility Director in paragraph 2.h., Chief of VA Medical Facility Mental Health Services in paragraph 2.j. and PTSD Clinical Team Lead in paragraph 2.m.

e. Added paragraph 4, Specialty PTSD Care staffing.

f. Added paragraph 5, Principles of Care.

2. RELATED ISSUES: VHA Directive 1010(1), Case Management of Transitioning Service Members and Post-911 Era Veterans, dated February 23, 2022; VHA Directive 1115(1), Military Sexual Trauma (MST) Program, dated May 21, 2018; VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019; VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019; VHA Directive 1500(3), Readjustment Counseling Service, dated January 26, 2021; VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023; VHA Directive 1160.04, VHA Programs for Veterans Substance Use Disorders (SUD), dated December 8, 2022; VHA Directive 1160.06, Inpatient Mental Health Services, dated September 27, 2023.

3. POLICY OWNER: The Office of Mental Health and Suicide Prevention (11MHSP) is responsible for the contents of this directive. Questions may be referred to 11MHSP at VHA11MHSPMentalHealthExec@va.gov.

4. RESCISSION: VHA Directive 1160.03(1), Programs for Veterans with Post-Traumatic Stress Disorder (PTSD), dated November 16, 2017, is rescinded.

5. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of October, 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

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

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on October 17, 2023.

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TREATMENT FOR VETERANS WITH POSTTRAUMATIC STRESS DISORDER

TREATMENT FOR VETERANS WITH POSTTRAUMATIC STRESS DISORDER

1. POLICY

It is Veterans Health Administration (VHA) policy to provide clinically appropriate posttraumatic stress disorder (PTSD) care and services to eligible Veterans and other eligible beneficiaries. ***NOTE:*** *This directive establishes requirements for a continuum of PTSD care for all eligible Veterans. This directive does not address other clinically appropriate mental health care.* **AUTHORITY:** 38 U.S.C. 7301(b).

2. RESPONSIBILITIES

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

b. Assistant Under Secretary for Health for Clinical Services. The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the Office of Mental Health and Suicide Prevention with implementation and oversight of this directive.

c. Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer. The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for supporting the implementation of this directive with Patient Care Services program offices and providing clinical practice oversight and support as appropriate.

d. Assistant Under Secretary for Health for Operations. The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each Veterans Integrated Service Network (VISN).

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

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

(4) Collaborating with VISN Directors to resolve problems with the regional provision of a Model of Accelerated Service Delivery (MASD) to ensure the needs of Veterans are met in each VISN.

e. Executive Director, Office of Mental Health and Suicide Prevention. The Executive Director for the Office of Mental Health and Suicide Prevention is responsible for:

(1) Overseeing the development of national policy for PTSD programming based on relevant laws, regulations, and VHA's mission, goals, and objectives.

(2) Overseeing the National Center for PTSD (NCPTSD) and Mental Illness Research, Education and Clinical Centers and Centers of Excellence (MIRECCs) that have a PTSD focus.

(3) Providing operational consultation to VISNs and VA medical facilities regarding PTSD services, including policy alignment and waivers. This may occur in conjunction with the NCPTSD Mentoring program. ***NOTE:*** *For more information on the NCPTSD Mentoring Program, see VA Dissemination and Education - PTSD: National Center for PTSD at: https://www.ptsd.va.gov/about/work/initiatives_dissemination_ed.asp.*

(4) Overseeing the development of Strategic Analytics for Improvement and Learning (SAIL) and Northeast Program Evaluation Center (NEPEC) metrics related to provision of PTSD care, ensuring that metrics are appropriately normed and validated with diverse populations.

(5) Overseeing the monitoring of PTSD utilization and outcome data in conjunction with NEPEC, which is part of the Office of Mental Health and Suicide Prevention (OMHSP).

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

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Communicating the contents of this directive to each of the VA medical facility Directors.

(3) Ensuring that each VA medical facility Director has the sufficient resources to fulfill the terms of this directive in all VA medical facilities within that VISN.

(4) Coordinating with the other VISN Directors to ensure at least one virtual outpatient program that must be organized as part of a PCT and is providing a MASD is available within the each of the four regions:

(a) West: VISN 17, VISN 19, VISN 20, VISN 21, and VISN 22.

(b) Midwest: VISN 10, VISN 12, VISN 15, and VISN 23.

(c) Northeast: VISN 1, VISN 2, VISN 4, and VISN 5.

(d) South: VISN 6, VISN 7, VISN 8, VISN 9, and VISN 16.

(5) Ensuring that programs are operated in compliance with all relevant policy and procedures related to PTSD care.

(6) Communicating with the VISN Chief Mental Health Officer (CMHO) to determine if the MASD program meets the needs of Veterans within the VISN.

(7) Collaborating with the Executive Director, Office of Mental Health and Suicide Prevention and Assistant Under Secretary for Health for Operations to resolve issues that prevent the MASD from meeting the needs of Veterans within the VISN.

g. VISN Chief Mental Health Officer. The VISN Chief Mental Health Officer (CMHO) is responsible for:

(1) Designating at least one VISN PTSD Mentor to be engaged with the VISN Mental Health (MH) Integrated Clinical Community and serve as a PTSD subject matter expert.

(2) Approving nominations for two VISN PTSD Mentors in conjunction with the NCPTSD Mentoring Program. ***NOTE:*** *Facility complexity must be considered when selecting mentors to ensure that as many complexity level facilities as possible are represented.*

(3) Ensuring 10% of weekly hours are protected, administrative time for VISN PTSD Mentoring activities (the protected time can be assigned to one VISN PTSD Mentor or split between two VISN PTSD Mentors).

(4) Monitoring PTSD measurement-based care (MBC) implementation and PTSD evidence-based psychotherapy (EBP), Reach and other metrics (e.g., SAIL).

(a) Coordinating with the VISN Director to evaluate the virtual outpatient MASD in each of the four VISN regions to assess whether this program meets the needs of the Veterans within the VISN. If the needs of Veterans within the VISN are not being met, the VISN CMHO must communicate the problem to the VISN Director. ***NOTE:*** *The four VISN regions are West (VISN 17, VISN 19, VISN 20, VISN 21, and VISN 22), Midwest (VISN 10, VISN 12, VISN 15, and VISN 23), Northeast (VISN 1, VISN 2, VISN 4, and VISN 5), and South (VISN 6, VISN 7, VISN 8, VISN 9, and VISN 16).*

h. VISN PTSD Mentors. The VISN PTSD Mentors are responsible for:

(1) Consulting with VISN CMHO, VA medical facility PCT program leadership, PTSD Specialists and mental health leaders in the VISN (e.g., consultation about access to PTSD Specialty Care, MBC implementation and MASD).

(2) Providing data (e.g., PTSD MBC) to the VISN CMHO regarding PTSD care within the VISN.

(3) Participating fully in the NCPTSD PTSD Mentoring Program.

i. VA Medical Facility Director. The VA Medical Facility Director is responsible for:

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

(2) Ensuring that VA medical facilities have the necessary resources to provide PTSD services across the continuum of care including PTSD Specialty Care.

(3) Ensuring the timely completion of all mandated reporting, monitoring, and other requirements of the PTSD Specialty Care, such as the NEPEC requirements, as defined by OMHSP.

j. VA Medical Facility Chief of Staff. The VA medical facility Chief of Staff (COS) is responsible for:

(1) Ensuring, in collaboration with the Associate Director of Patient Care Services, that the VA Medical facility provides access to evidenced based MH treatment as needed to Veterans with a PTSD diagnosis.

(2) Ensuring that Veterans are screened for PTSD as outlined in Appendix A.

(3) Ensuring that scheduling and clinical practices allow for the effective and efficient implementation of first-line (i.e., “strongly recommended”) VA/Department of Defense (DoD) Clinical Practice Guideline (CPG) treatment for PTSD. It is essential that scheduling practices be appropriately flexible to enable clinicians to deliver full courses of these recommended treatments.

(4) Ensuring that the Chief of Mental Health Services provides the appropriate allocation of time so that PCT staff can participate in team-based care.

k. Associate Director, Patient Care Services. The Associate Director of Patient Care Services (ADPCS) is responsible for:

(1) In collaboration with the VA Medical Facility COS, ensuring that the VA Medical facility provides access to evidence-based MH treatment as needed to Veterans with a PTSD diagnosis.

(2) Ensuring that clinical practices follow clinical practice guidelines, screening and evidence-based practice for MH treatment

(3) Ensuring that the Associate Chief Nurse for Mental Health Services or an equivalent nursing leader for Mental Health Services, provides the appropriate allocation of time so that PCT staff can participate in team-based care.

l. Chief, VA Medical Facility Mental Health Services. The Chief of VA medical facility Mental Health Services is responsible for:

(1) Overseeing PTSD services to ensure Veterans have access to PTSD care, and that services are in compliance with VHA policy and with procedures as specified by OMHSP. This oversight includes:

(a) Ensuring mental health staff members receive training and consultation in first-line (i.e., "strongly recommended") VA/DoD CPG recommended treatment for PTSD, including with diverse populations.

(b) Reviewing mental health metrics on the MH SAIL Dashboard and other applicable metrics and how they relate to the delivery of PTSD treatment.

(c) Designating reserved time (labor mapping) in the PCT Lead's schedule to allow for administrative duties.

(2) Ensuring that Veterans with PTSD have access to required MH services across the continuum of care and peer support services as needed. When specific services (e.g., residential or inpatient) are not available at the facility level, collaborating with VISN CMHO and/or VISN Director to ensure access to care.

(3) Ensuring that PCT clinicians and PTSD Specialists are able to schedule episodes of care that are consistent with delivery intervals for first-line (i.e., "strongly recommended") treatments for PTSD as recommended in the VA/DoD CPG.

(4) Ensuring that PCT clinicians and PTSD Specialists serve as liaisons to other clinics regarding PTSD care (e.g., Vet Centers, Women's Health, Transition and Care Management programs, behavioral health interdisciplinary program (BHIP) and Community Living Centers).

(5) Ensuring that the PCT is adequately staffed.

(6) Ensuring that the PCT has an identified designated PTSD Lead who is an active member of the PCT.

(7) Ensuring the Substance Use Disorder (SUD)-PTSD Specialist is part of the PCT or other mental health teams that treat PTSD. The SUD-PTSD Specialist provides direct patient care or support for clinical staff working with Veterans diagnosed with co-occurring PTSD and SUD. ***NOTE:*** *For further information, see VHA Directive 1160.04, VHA Programs for Veterans Substance Use Disorders, dated December 8, 2022.*

(8) Collaborating with VISN leadership to ensure the availability of at least one virtual outpatient program that must be organized as part of a PCT and is providing a MASD within the each of the four VISN regions.

(9) Ensuring that Veterans with comorbid diagnoses (e.g., sequelae of Traumatic Brain Injury, Substance Use Disorders, and Severe Mental Illness) receive PTSD treatment.

(10) Ensuring all special populations of Veterans (e.g., geriatric, transgender) receive PTSD treatment that aligns with the Veteran's preferences, values and cultural context.

(11) Ensuring that Veterans are referred to Readjustment Counseling Services as appropriate. ***NOTE:*** *Specific eligibility requirements for Readjustment Counseling Services are provided by VHA Directive 1500(3), Readjustment Counseling Service, dated January 26, 2021.*

(12) Ensuring Veterans are referred to community care when they are eligible for community care. ***NOTE:*** *For further information, see https://www.va.gov/communitycare/.*

(13) Ensuring Veterans and their eligible family members have access to family services, including psychoeducation (e.g., https://www.ptsd.va.gov). ***NOTE:*** *For further information, see VHA Directive 1163.04, Family Services in Mental Health, dated June 17, 2019.*

(14) Ensuring Veterans with a diagnosis of PTSD have access to complementary and integrative health (CIH) services and other adjunctive services (e.g., recreation therapy, music therapy, chaplaincy) which, in most cases, would be provided outside of PTSD specialty care.

(15) Ensuring there are no barriers to accessing specialty PTSD treatment when PTSD is the primary diagnosis (e.g., service-connected status for PTSD, co-occurring SUD, traumatic stressor type experienced).

m. Lead, PTSD Clinical Team. The Lead of the PCT is responsible for:

(1) Making decisions regarding the clinical operations of the program and day-to-day programmatic functioning of PCT staff.

(2) Participating in NEPEC mandatory monitoring.

(3) Ensuring specialty PTSD workload and MBC is appropriately coded and captured within the Veteran's medical record.

(4) Utilizing their administrative time for duties such as leading team meetings, program development, consulting with providers, data tracking/management, responding to consults, and providing consultation.

(5) Ensuring that team members provide PTSD specialty services that are Veteran-centric, that include evaluation to guide treatment planning, and aid in determining both appropriate treatment in specialty care based on the primary presenting symptoms diagnosis and treatment goals.

(6) Ensuring that care provided in the PCT is time limited and focuses on the reduction of PTSD symptoms.

(7) Ensuring that all Veterans receiving care in a PCT are offered at least one of the first-line ("strongly recommended") treatments for PTSD as detailed in the latest VA/DoD CPG for PTSD. All Complexity Level One facilities must be able to offer at least two of the first-line ("strongly recommended") treatments for PTSD. All providers must engage in shared decision making. These treatments may be provided in person or virtually by clinicians who have been trained in these interventions. ***NOTE:*** *see https://www.healthquality.va.gov for guidance.*

(8) Prioritizing the provision of VA/DoD CPGs PTSD first-line ("strongly recommended") treatments. Other evidence-based interventions as recommended by the VA/DoD CPGs for PTSD (see https://www.healthquality.va.gov/) may only be offered if there are sufficient staff resources to provide them, and in accordance with Veteran preferences.

(9) Implementing all of the components of the clinical model of MBC in the PCT (i.e., collect, share, act) to enhance clinical outcomes, as well as help guide when the Veteran needs to transition across the continuum of care.

(10) Ensuring PCT providers and PTSD Specialists have the ability to treat Veterans with complex presentations and comorbidities when PTSD is the primary diagnosis.

(11) Engaging in consultation with the VISN PTSD mentor.

(12) Ensuring access to medication management services. Veterans receiving care in the PCT must have access to medication management when clinically indicated and based on Veteran preference, which, in most cases, would be provided outside of PTSD specialty care. If medication management services are offered in the PCT, these services must be offered on a time-limited basis (e.g., change in medication for complex medication management).

3. CONTINUUM OF PTSD CARE

The full continuum of PTSD care must be provided to all eligible Veterans and other beneficiaries through evidenced-based recovery-oriented, culturally informed and patient-centered services that align with the Veterans' preferences and values. The continuum consists of:

a. Self-care. Veterans are provided with information (e.g., PTSD Coach app and other mobile apps, PTSD Treatment Decision Aid, AboutFace) in order to take charge of their care.

b. Primary Care Mental Health Integration. Primary Care Mental Health Integration (PCMHI) is problem-focused, solution-oriented and patient-focused. PTSD services in Primary Care can include assessment and screening, PTSD education,

motivational enhancement, and brief protocols for PTSD, e.g., Prolonged Exposure for Primary Care.

c. General Mental Health/Behavioral Health Interdisciplinary Program. The General Mental Health (GMH)/ behavioral health interdisciplinary program (BHIP) level of care provides assessment and treatment and serves as the "home" for all mental health patients whose mental health care needs cannot be managed in Patient Aligned Care Teams and require treatment at a higher intensity of care. Treatment may include provision of EBP for PTSD (availability permitting) and medication management. When individual non-trauma psychotherapy is preferred by Veterans with a primary PTSD diagnosis, in most cases this treatment would be provided by non-specialty PTSD care (e.g., PCMHI/GMH/BHIP). Veterans who are assigned a BHIP team may be referred for an episode of more intensive PTSD care at a higher level of the continuum as needed.

d. Specialty Outpatient PTSD Services. Veterans must have access to EBP for PTSD. Specialty outpatient PTSD services are time-limited and can be offered in a PCT or by a PTSD Specialist.

(1) The PCT provides a distinct level of care focusing on the provision of PTSD specialty care and provides specialty level of care at most VA medical facilities. The PCT must be able to provide services to Veterans who have PTSD regardless of the traumatic stressor type experienced (e.g., military stressor, sexual trauma, childhood abuse).

(2) PTSD Specialists have expertise in PTSD, but serve at sites where workload does not warrant a full PCT.

(3) Specialty PTSD services must include evaluation and treatment for PTSD which is concordant with the VA/DoD CPG recommendations. A structured diagnostic interview and additional assessment measures may be considered on an as-needed basis for diagnostic clarity. The evaluation must not serve as a barrier to care and must be personalized to the needs of the Veteran. The evaluation must be conducted for the purpose of informing Veteran's treatment.

(4) All Veterans with PTSD must have access to at least one first-line (i.e., "strongly recommended") VA/DoD CPG treatments for PTSD; Complexity Level One facilities need to offer at least two first-line VA/DoD CPG "strongly" recommended treatments for PTSD (see https://www.healthquality.va.gov). PCTs and PTSD Specialists must prioritize the provision of VA/DoD CPGs PTSD first-line ("strongly" recommended) treatments.

(5) Each of the four VISN regions must have at least one virtual outpatient program that must be part of a PCT and is providing a MASD within the region. The virtual outpatient program providing a MASD must have the capacity to provide in-person care and care to other Veterans within each of the four VISN regions.

e. Mental Health Residential Rehabilitation Treatment Program. While not all facilities have Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) which include Domiciliary PTSD, there must be access to such programs within the VISN. These programs are designed to provide a 24/7 supervised, structured and supportive environment for the provision of treatment and rehabilitation services. These programs must have staff with training and expertise in VA/DoD CPG-concordant PTSD service delivery. ***NOTE:*** *Specific requirements for Dom PTSD programs are provided by VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019.*

f. Inpatient Services. Veterans with PTSD must be able to access inpatient mental health services for acute care and stabilization. While receiving VA inpatient care, staff must engage Veterans with PTSD in shared decision making regarding PTSD services and treatments within the continuum of care. ***NOTE:*** *Specific requirements for Inpatient programs are provided by VHA Directive 1160.06, Inpatient Mental Health Services, dated September 27, 2023*.

4. SPECIALTY PTSD CARE STAFFING

a. **PCT Staffing.** PCTs require availability of assigned staff with clinical competence to provide evidence-based interventions to Veterans with more severe PTSD, or with clinical complexity. PCTs must have the capacity to identify co-occurring mental and physical conditions and arrange appropriate follow-up either within the program or by referral to the extent that the Veteran is eligible. Staff for PCT must include, at a minimum, three clinical full-time employee equivalents with expertise in PTSD who are able to fully participate in all activities of team-based care (e.g., team consultation and team meetings).

(1) At least two of these clinical staff must be licensed practitioners (e.g., Social worker, Psychologist, Licensed Professional Mental Health Counselor (LPMHC), Marriage and Family Therapist (MFT)) with competencies in delivery of evidence-based interventions for PTSD that are recommended in the VA/DoD CPG for PTSD (See https://www.healthquality.va.gov). PCT clinicians must be able to practice to the top of their license.

(2) PCT staffing must be allocated based on PTSD population-based coverage in conjunction with the entire continuum of care. The number of PCT staff must be based on workload and clinical complexity of patients being treated to assure timely access to recommended treatment.

b. **PTSD Specialist.** PTSD Specialists have expertise in PTSD, but serve at sites where workload does not warrant a full PCT. A PTSD Specialist is a licensed practitioner who must be trained to provide at least one first-line (“strongly”) recommended treatment as recommended in the VA/DoD PTSD CPG (see https://www.healthquality.va.gov). There must be a minimum of one licensed practitioner filling the roll of PTSD Specialist at sites without PCTs and 50% of their

FTEE clinical time must be devoted to PTSD specialty care. Each PTSD Specialist has an identified role within the facility. PTSD Specialists provide a resource of expertise for their entire facility including Community Based Outpatient Clinics, and for inpatient and residential care units that lack specialized PTSD tracks. They are knowledgeable in the assessment and diagnosis of PTSD and have knowledge of military culture.

c. **SUD-PTSD Specialist.** The SUD-PTSD Specialist has expertise in providing direct patient care to Veterans with comorbid PTSD and SUD and is part of the PCT or other mental health teams that treat PTSD. ***NOTE:*** *For further information, see VHA Directive 1160.04, VHA Programs for Veterans Substance Use Disorders, dated December 8, 2022.*

5. PRINCIPLES OF CARE

a. All VA medical facilities are required to have a specialty PTSD level of care, fulfilled by either a PCT or PTSD Specialist, based on locally determined Veteran population needs. All PCTs or PTSD Specialists must be available for consultation or care for Veterans who may have PTSD and are receiving care at Community-Based Outpatient Clinics (CBOCs).

b. The goal of PTSD treatment is always to assist the Veteran in achieving the fullest possible degree of psychosocial functioning and quality of life of which they are capable, provided in the least restrictive setting. Treatment goals must be recovery-oriented, patient-centered, and focused on remission of PTSD symptoms.

c. Treatment options that are consistent with first-line (i.e., “strongly recommended”) recommendations in the VA/DoD Clinical Practice Guidelines (see https://www.healthquality.va.gov) must be available to Veterans with PTSD at all VHA points of service (facility, CBOC). These options may be provided in person or virtually by clinicians who have been trained in these interventions or through referral to Vet Centers or to Community Providers. Other interventions with the strongest evidence as recommended by the latest VA/DoD PTSD Clinical Practice Guideline (See https://www.healthquality.va.gov) may be offered if there are staff resources to provide them, and in accordance with Veteran preferences. In most cases these other interventions would be provided in non-PTSD Specialty Care (e.g., PCMHI/GMH/BHIP).

d. Relevant cultural competency tenets must be incorporated into shared decision making and treatment for all Veteran groups through evidence-based, recovery-oriented, and patient-centered services that align with the Veterans’ preferences and values. Veterans' gender identity, pronouns, and chosen name must be honored by all VHA personnel. PCT clinicians must participate in team-based care which includes discussion of care/clinical case conceptualization in order to ensure that Veterans’ treatment needs are being met, and that changes are made to treatment plans as needed.

e. The entire continuum of clinical services may not be present in every VA medical facility but must be available to all Veterans receiving care within a VISN. Every VISN is

required to have residential PTSD programs in sufficient locations and numbers to meet the needs of Veterans in their catchment area. This requirement can be accomplished by establishing units or tracks with staff trained to address the needs of Veterans with PTSD. All VA medical facilities must have specialized outpatient PTSD capability (i.e. PCT or PTSD Specialist) and the ability to provide PTSD evidenced based care for Veterans with PTSD. All Complexity Level 1 facilities are required to have a PCT.

6. WAIVER PROCESS

a. OMHSP has established a process for accepting, approving and monitoring waiver requests in accordance with requirements in VHA Notice 2022-01, Waivers to VHA National Policy, dated February 10, 2022. If noncompliance with all or part of this policy is discovered, the OMHSP process must be followed until a resolution to the noncompliance can be made.

b. If noncompliance is identified and it is determined that it can be corrected within 30 days of identification, notification to the National Point of Contacts (POC(s)) for this policy is required via email. Once it is acknowledged by the National POC(s), this notification will act as a temporary waiver expiring 30 days from acknowledgement. Information in the notification includes:

(1) Policy Number and section.

(2) Reason for noncompliance.

(3) Risk mitigation strategy until compliance can be achieved.

(4) Overall plan to resolve the noncompliance.

c. Noncompliance that is identified and determined to be uncorrectable within 30 days of identification or is not corrected within the temporary waiver timeframe must follow the OMHSP process to ensure the mitigation of the risk and meet the intent of the policy as written. This process is outlined on the SharePoint site https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/WAIVERS.aspx.
NOTE: *This is an internal VA website that is not available to the public.*

7. TRAINING

There are no formal training requirements associated with this directive.

8. RECORD MANAGEMENT

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

9. BACKGROUND

a. Through its medical facilities and clinics, VHA provides a continuum of care, including self-care, primary care mental health integration, GMH/ BHIP, specialized outpatient care (including PCT), residential rehabilitation programs (including specialized PTSD programs) and GMH inpatient units.

b. Evidence-based psychotherapies (EBP), including trauma-focused psychotherapies such as cognitive processing therapy (CPT), prolonged exposure therapy (PE), and eye movement desensitization and reprocessing (EMDR), are effective for PTSD and are highly recommended as first-line ("strongly recommended") treatments in VA and the DoD Clinical Practice Guideline (CPG) for PTSD (see https://www.healthquality.va.gov).

c. PTSD care is supported by the Mental Illness Research, Education and Clinical Centers and Centers of Excellence (MIRECCs/CoEs) and the National Center for PTSD (NCPTSD). The mission of the MIRECCs/CoEs is to generate new knowledge about the causes and treatments of mental disorders, apply new findings to model clinical programs, and widely disseminate new findings through education to improve the quality of Veterans' lives and their daily functioning in their recovering from mental illness. The mission of the NCPTSD is to advance the clinical care and social welfare of America's Veterans and others who have experienced trauma, or who suffer from PTSD, through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders.

d. The PTSD Mentoring Program is a NCPTSD program that supports the effective delivery of PTSD treatment by offering administrative support to the PTSD Specialty level of care within VHA through coordination of VISN PTSD Mentors and collaboration with OMHSP.

10. DEFINITIONS

a. **Complementary and Integrative Health.** Complementary and integrative health (CIH) is a group of diverse medical and health care approaches and practices that are not considered to be part of conventional or allopathic medicine.

b. **Evidence-Based Clinical Practice Guidelines.** Evidence-based clinical practice guidelines, including the VA/DoD CPGs, are statements that include recommendations intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

c. **Integrated Clinical Community**. Integrated Clinical Communities (ICCs) create streamlined communication flows that amplify the voices of frontline employees and allow for efficient decision-making. ICCs provide a structure to endorse and consistently implement best clinical practices.

d. **Model of Accelerated Services Delivery.** Model of Accelerated Services Delivery (MASD) is a method of delivering VA/DoD CPG recommended PTSD treatments. In this model, Veterans must receive a minimum of three or more individual PTSD EBP sessions per week, and any additional treatment must be in support of the individual EBP. The PCT staff providing these services must be licensed practitioners (e.g., Social Work, Psychologist, LPMHC, MFT) with expertise in delivery of PTSD EBPs and competence to identify and address co-occurring mental health conditions. All outpatient programs providing a MASD must be organized as part of a PCT.

e. **Measurement-Based Care.** Measurement-based care (MBC) is a clinical process using valid instruments before or during clinical encounters in which the systematic evaluation of patient symptoms and other important outcomes such as quality of life and functioning are used to inform behavioral health treatment. The essential components of MBC are “collect, share, act”: collection of patient-reported outcome measures throughout care to track progress over time (collect); the clinical provider’s review of the patient-generated data; sharing of the results and discussing with the patient to ensure a shared understanding (share); and a collaborative reevaluation of the treatment plan and modification if indicated (act).

f. **Military Sexual Trauma.** Military sexual trauma is a health condition which, in the judgment of a VA health care provider, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on duty, regardless of duty status or line of duty determination.

g. **PTSD Continuum of Care.** A PTSD continuum of care is a system that provides a comprehensive range of health services specific to PTSD, so that care can evolve with the patient over time. With the understanding that a patient’s health may be most vulnerable during gaps in care, the continuum of care exists to ensure those gaps are filled. Veterans may receive different levels of care at different times based on needs and discussions between the provider and Veteran about mutually determined treatment goals.

h. **Shared Decision Making.** For the purposes of this directive, shared decision making (SDM) is a formal communication process for consensus-building between a VA health care provider and patient when multiple evidence-based treatment alternatives exist to treat the patient’s condition or problem. The provider and patient jointly participate in the process to arrive at a clinical decision or treatment plan. SDM requires three components: 1) clear, accurate and unbiased medical evidence about reasonable alternatives, including no intervention and the risk and benefits of each; 2) clinician expertise in communicating and tailoring the evidence for individual patients; and 3) patient values, goals, informed preferences and concerns, which may include treatment burden.

i. **Time-limited Care.** Time-limited care is a discrete episode of care targeting symptoms. The length of the episode is clinically determined and may be extended based on continued evaluation of treatment progress and goals.

11. REFERENCES

a. 38 U.S.C. § 7301(b).

b. VHA Directive 1160.04, VHA Programs for Veterans with Substance Use Disorders, dated December 8, 2022.

c. VHA Directive 1160.06, Inpatient Mental Health Services, dated September 27, 2023.

d. VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019.

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

f. VHA Directive 1500(3), Readjustment Counseling Service, dated January 26, 2021.

g. VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023.

h. PTSD VA/DoD Mental Health Clinical Practice Guideline, available at: https://www.healthquality.va.gov.

i. National Center for PTSD, www.ptsd.va.gov.

j. VA Benefits and Health Care, Community Care Overview, available at: https://www.va.gov/communitycare/.

k. VA Dissemination and Education - PTSD: National Center for PTSD, available at: https://www.ptsd.va.gov/about/work/initiatives_dissemination_ed.asp.

POSTTRAUMATIC STRESS DISORDER SCREENING

1. Veterans enrolled in Department of Veterans Affairs (VA) health care must be screened for the presence of symptoms of posttraumatic stress disorder (PTSD) as outlined using the Primary Care-PTSD (PC-PTSD) screening tool. This does not always occur during the first visit because the provider may choose to focus that initial visit on the Veteran's presenting complaint, but screening must occur as soon as is clinically appropriate.

2. A national clinical reminder is provided as a tool to support the screening requirements. For PTSD, the minimal screening requirement is annually for the first five years post separation date and every five years thereafter. If the Veteran has multiple activations with multiple separation dates, the requirement for annual screening for the first five years post separation gets restarted with each new separation date.

3. If a Veteran screens positive for PTSD, which is a score of four or greater on the PC-PTSD, a disposition must be documented. Dispositions can include: 1) No further intervention is needed at this time; 2) Already receiving needed treatment; 3) Patient is interested in further evaluation and treatment, referral has been placed; and 4) Patient declines further intervention or evaluation at this time. If a Veteran is interested in evaluation or treatment, facilities must follow local guidance or procedures on the referral process to connect Veterans with care. If clinically indicated, additional screening including suicidal risk and assessment must occur.