

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

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive revises policy for a continuum of programs for the treatment of eligible Veterans with post-traumatic stress disorder (PTSD) within the Mental Health Services (MHS).
- 2. SUMMARY OF MAJOR CHANGES:** Revisions reflect conformity with VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics. References to Services for Returning Veterans-Mental Health (SeRV-MH) programs have been removed from the previous policy. The responsible office has changed from The Office of Patient Care Services, Mental Health Services (10P4M) to Office of Mental Health and Suicide Prevention (10NC5).
- 3. RELATED ISSUES:** VHA Directive 1162.02 and VHA Handbook 1160.01.
- 4. RESPONSIBLE OFFICE:** Office of Mental Health and Suicide Prevention (10NC5) is responsible for the contents of this directive. Questions may be addressed at 202-461-4174.
- 5. RESCISSION:** VHA Handbook 1160.03, dated March 12, 2010, is rescinded.
- 6. RECERTIFICATION:** This VHA directive is scheduled to be recertified on or before the last working day of November 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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**DISTRIBUTION:** Emailed to the VHA Publications Distribution List on November 17, 2017.

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

### 1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for a continuum of post-traumatic stress disorder (PTSD) care for all eligible Veterans. This directive is intended to complement VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics. **NOTE:** *This directive is not intended to describe all outpatient mental health programming that could be appropriate and effective.* **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

### 2. BACKGROUND

- a. VHA operates an internationally recognized network of more than 180 specialized programs for the treatment of PTSD. Through its medical facilities and clinics, VHA provides a continuum of care from integrated primary care behavioral health, general mental health, specialized outpatient PTSD clinical teams (PCT) through specialized PTSD residential rehabilitation programs and general mental health inpatient units around the country. VA's Strategic Goal of empowering Veterans to improve their well-being includes a commitment to radically transforming health care to promote Veterans whole health, not just their physical health.
- b. All VA providers should be able to work with Veterans with a diagnosis of PTSD. Every VA medical facility has PTSD specialty capability as do an increasing number of community-based outpatient clinics (CBOC). 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 (SUD), or those who are survivors of military sexual trauma (MST). Mental health programs, especially those for Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) Veterans, have ties to the national, regional, and local rehabilitation programs for polytrauma and traumatic brain injury (TBI).
- c. A critical component of VHA's PTSD care is the system of Readjustment Counseling Service Veteran Centers, otherwise known as Vet Centers. These centers are community-based counseling centers that provide a wide range of social and psychological services to Veterans, active duty Service members, and family members of these individuals. PTSD clinics across the country have built strong relationships with their local Vet Centers, offer consultation when needed, and have developed referral agreements. Vet Centers are particularly able to provide a source of continued support for Veterans who want that level of care as well as offering counseling and support for family members. **NOTE:** *For information on Vet Centers see VHA Directive 1500, Readjustment Counseling Service (RCS) Vet Center Program, dated September 8, 2010, or subsequent policy.*
- d. In addition to responsibility for PTSD clinical care, VHA's Office of Mental Health and Suicide Prevention (OMHSP) oversees several centers dedicated to promoting research and education on PTSD. They include the VA's National Center for PTSD (NCPTSD); various Mental Illness Research, Education and Clinical Centers (MIRECC)

and three centers of excellence in mental health care with particular emphasis on PTSD in VA medical facilities at Waco, Texas; Canandaigua, New York; and San Diego, California.

### 3. POLICY

It is VHA policy to provide PTSD services to eligible Veterans at VA medical facilities as clinically needed.

### 4. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for:

(1) Ensuring that VA facilities comply with this directive.

(2) Overseeing the development and implementation of VHA PTSD programs and policies.

(3) Ensuring that the necessary resources are provided to facilities for the operation of PTSD services.

b. **VHA Office of Mental Health and Suicide Prevention (OMHSP).** VHA OMHSP, is responsible for:

(1) Developing national policy and procedures for PTSD programming based on relevant laws, regulations, and VHA's mission, goals, and objectives.

(2) Providing policy and operational consultation and guidance to Veterans Integrated Service Networks (VISN) and VA medical facility for the development and operation of PTSD services.

(3) Reviewing all VA medical facility PTSD program change requests and providing consultation and recommendations to program, medical facility, VISN and VHA leadership.

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

(5) Developing and analyzing program monitoring and outcome data including social determinants of health in collaboration with the Northeast Program Evaluation Center (NEPEC).

c. **Veterans Integrated Service Network (VISN) Director.** Each VISN Director is responsible for:

(1) Ensuring that PTSD treatment services are accessible to all eligible Veterans. The entire continuum of clinical services may not be present in a single VA medical facility, but must be available to all Veterans treated within a VISN. **NOTE:** *Some components of the continuum may be provided through telemental health and Community Care programs or in coordination with neighboring VISNs.*

(2) Ensuring that programs are operated in compliance with relevant policy and procedures defined by the Office of Mental Health and Suicide Prevention (OMHSP).

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

(1) Ensuring that VA medical facilities have the necessary resources to have specialized outpatient PTSD capability and the ability to provide care and support for Veterans with PTSD.

(2) Providing and maintaining program oversight of the PTSD treatment program(s) to ensure access, quality services, and compliance with VHA policy and procedures as defined by OMHSP, and VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, or subsequent policy. This oversight includes ensuring mental health staff members receive training and consultation in evidence-based psychotherapies for PTSD. Additionally oversight includes review of mental health metrics on the MH SAIL Dashboard and other applicable metrics and how they relate to the delivery of PTSD treatment.

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

(4) Ensuring the timely completion of all mandated reporting, monitoring, and other requirements of the PTSD treatment program, such as the MH SAIL Dashboard metrics and NEPEC reports, as defined by OMHSP and as communicated to facilities and network directors through 10N.

## **5. RECOVERY OF VETERANS WITH PTSD**

a. 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 should be recovery-oriented, patient-centered, and should focus on remission of PTSD symptoms. Progress toward treatment goals should be regularly assessed through outcomes measurement and shared with the Veteran. It is widely acknowledged that optimal diagnosis and treatment of PTSD requires specialized knowledge and skill. Accordingly, PTSD treatment, particularly for Veterans suffering from acute, severe, or complicated PTSD (with various comorbidities), is optimally delivered by PTSD specialized teams, such as PTSD Clinical Teams and/or PTSD residential programs. However, not all Veterans who need PTSD treatment have acute, severe, or complicated PTSD presentations. Many Veterans receive treatment in general mental health clinics and across the continuum of care.

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 in VA and the Department of Defense (DoD) Clinical Practice Guideline for PTSD (see [http://www.healthquality.va.gov/Post\\_Traumatic\\_Stress\\_Disorder\\_PTSD.asp](http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp)).

c. All VHA points of service must provide EBP services for the treatment of PTSD, specifically CPT or PE, in person or via telemental health by clinicians who have been trained in these interventions or through referral to Vet Centers or to Community Care providers to the extent that the Veteran is eligible and that these providers are trained in EBPs. Other interventions with the strongest evidence as recommended by the PTSD Clinical Practice Guideline may be offered if there are staff resources to provide them, and in accordance with Veteran preferences. Evidence-based pharmacotherapy treatments should also be discussed. Recommendations about treatment options must be discussed in a shared decision making conversation with the Veteran or, if the Veteran lacks decision-making capacity the Veteran's surrogate and the Veteran's preferences must be considered and documented. CPT may be provided in individual or group settings. PE should only be provided in individual settings. Both CPT and PE can be delivered through telemental health, which is a particularly appropriate approach for Veterans living in remote areas.

d. Over the past few years VHA has disseminated CPT and PE throughout the VA health care system through extensive training and ongoing consultation of VA mental health providers. More recently, VHA has worked to ensure that EMDR is available in clinics that treat PTSD. Although there is a less robust evidence base for pharmacotherapy of PTSD, data indicates that medications, such as selective serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (SNRI), are effective for PTSD. Also, research discourages use of benzodiazepines for the treatment of PTSD as a best practice. Veterans' treatment preferences for psychotherapy and pharmacotherapy must be considered and documented.

e. Family Services.

(1) Feeling alienated from others is a core symptom of PTSD; recovery from PTSD is often facilitated through connecting with others. It is strongly recommended that VHA points of service help Veterans with PTSD connect with family members through the provision of family education, brief Veteran-centered family consultation, marital or family counseling, or other family services as clinically appropriate. Each VHA administrative parent facility should have staff with training and expertise in couples and family therapies to serve the Veterans diagnosed with PTSD, their partners (married or non-married committed partners regardless of sexual orientation) and other concerned loved ones. Education relating to PTSD and impact on relationships should be made available to Veterans with PTSD or sub-threshold PTSD and their family members or other primary social supports. In addition, evidence-based couple's therapies, including cognitive-behavioral therapy for PTSD should be available to all Veterans with PTSD and their partners, regardless of marital status.

(2) Veterans with PTSD who are parenting children under the age of 18 should be provided with information about the impact of PTSD on families, children, and parenting, and they should be provided with access to evidence-based interventions to improve parenting if clinically appropriate.

f. Complementary and Integrative Health Services. VHA is committed to empowering Veterans to improve their well-being through a Whole Health model of care and recognizes the importance of:

- (1) Care centered around what matters most to the Veteran in terms of their life goals, values, and mission;
- (2) Partnering with the Veteran in the development of their personal health plan;
- (3) Exploring and addressing self-care needs; and
- (4) Including complementary and integrative health (CIH) in the services offered to Veterans with PTSD. Examples of CIH include mindfulness, meditation, yoga, tai-chi and acupuncture.

g. Cultural Competency Tenets of Treatment. Incorporate relevant cultural competency tenets into the treatment for appropriate vulnerable Veteran groups along the lines of racial or ethnic; gender; age; geographic location; religion; socioeconomic status; military era; sexual orientation; mental health; disability status including cognitive, sensory, and physical; and other characteristics historically linked to discrimination or exclusion.

## 6. PTSD CONTINUUM OF CARE

a. Provision of a PTSD continuum of care implies matching the unique needs of a Veteran with the level of care required at the time, as well as ongoing evaluation of whether the Veteran should receive a greater or lesser level of care as circumstances develop and discussions between the provider and Veteran about progress towards mutually determined treatment goals. Based on a Veteran's needs and preferences, outpatient, residential or inpatient services may be recommended. **NOTE:** *VHA Handbook 1160.01 establishes the requirements for services that must be provided when clinically indicated at VA medical facilities and CBOCs.*

### b. Screening.

(1) A Veteran who is enrolled in care is required to be screened for the presence of symptoms of PTSD using the Primary Care-PTSD screening tool (PC-PTSD - See Informational Bulletin in 12.f). This does not always occur during the first visit, as the provider may choose to focus that initial visit on the Veteran's presenting complaint, but should occur as soon as possible when clinically appropriate. 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 5 years post separation date and every 5 years thereafter. If the Veteran has multiple activations with multiple separation dates, the requirement for annual screening for the first 5 years post separation gets restarted with each new separation date. For further information, see the Informational Bulletin 12.f.

(2) If a Veteran screens positive for PTSD, which is a score of 3 or greater on the PC-PTSD, either the Primary Care provider, mental health clinician or another acceptable provider should conduct a suicide risk evaluation by the end of the next business day and document that an evaluation of the Veteran's suicide risk was completed. Acceptable providers are defined in the eTechnical Manual, <http://vaww.rs.rtp.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPerforman>

[ce+Reports%2fMeasure+Management%2fMeasureCatalog&rs%3aCommand=Render](#)

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

(3) Additionally, the provider is to document the disposition of Veterans with a positive screen no later than the end of the next business day.

c. A spectrum of treatment options must be available to Veterans with PTSD in all VA medical facilities. These options may be in person or via telehealth. 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. The full continuum of care must be available for all Veterans, regardless of birth sex or self-identified gender identity. If a Veteran is not best served in a mixed-gender environment, VHA points of service must offer an alternative treatment option, on the basis of a clinically informed discussion between the Veteran and provider. These services can take many forms, including but not limited to: individual therapy, single-gender group therapy, telemental health, non-VA mental health services, or referral to Vet Center or community services that have gender-specific services available. Veterans may also be offered, when clinically appropriate, individual support and skills training to increase comfort with a mixed-gender treatment environment as part of a stepped care recovery approach towards healthy interactions with other-gendered individuals. There are Veterans for whom treatment in an intensive inpatient or residential setting is a medical necessity. There are times when a Veteran whose primary diagnosis is PTSD may also require other psychiatric services in addition to those found in specialized PTSD settings. Examples of these services include, but are not limited to:

(1) Emergencies, such as suicidal behavior, which may require care in an acute inpatient mental health unit; or

(2) Specialized Substance Use Disorder (SUD) treatment in conjunction with PTSD treatment. **NOTE:** For further discussion of SUD, see VHA Handbook 1160.04, VHA Programs for Veterans with Substance Use Disorders (SUD), dated March 7, 2012, or subsequent policy.

(3) PTSD programs must be able to address trauma-related symptoms associated with MST.

d. Services provided need to be based on the individual Veteran's clinical preferences and needs. Not all Veterans require the entire continuum of services. Veterans must be able to move among the levels of the continuum as is clinically appropriate, with minimal disruption in treatment, and in a manner that facilitates positive treatment outcomes. SUD must not be a barrier to PTSD treatment and PTSD must not be a barrier to SUD treatment, though stabilization of acute symptoms may be indicated.

e. All new and established Veterans requesting or referred for mental health services must meet the requirements of VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016, or subsequent policy.



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

(1) Early identification and intervention;

(2) Assessment, triage, and referral;

(3) Acute stabilization and intervention, including hospitalization;

(4) Treatment and rehabilitation; short-term (30 days or less) 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.

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

(1) Health care services, including mental health services for PTSD and non-PTSD comorbid diagnoses;

(2) Education and counseling for eligible family members as authorized by law or VA/VHA policy;

(3) Screening for social determinants of health including domestic violence and offering counseling and other relevant services as needed;

(4) Educational, vocational, and employment services, including Compensated Work Therapy (CWT) and/or Vocational Rehabilitation and Employment (VR&E);

(5) Social and independent living skills; and

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

## 7. SPECIALIZED MENTAL HEALTH PTSD SERVICES

a. 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 complicated, (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 may be served by these programs.

b. 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. This requirement can be accomplished by establishing units or tracks with staff trained to address the needs of acutely ill Veterans with PTSD; female Veterans requiring same gender treatments; or making care or consultation from members of a PCT or PTSD specialist available to inpatients.

(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.

(a) All CBOCs must provide PTSD evaluations and treatment planning for those who need them through full- or part-time staffing or by telemental health.

(b) When there are no nearby VHA points of service, CBOCs must provide needed services via telemental health or by referral to Vet Centers or community-based providers using Community Care to the extent that the Veteran is eligible.

(4) PCTs or PTSD Specialists must be available for consultation and care for Veterans who may have PTSD, either on-site, by referral to nearby VA medical facilities, or by telemental health.

(a) All CBOCs must provide PTSD treatment for those who need them through full- or part-time staffing or by telemental health with its administrative parent. Very large CBOCs must provide these services on-site.

(b) When there are no nearby VHA points of service, CBOCs must provide needed services via telemental health or by referral to Vet Centers with capability to treat PTSD, or to community-based providers using Community Care to the extent that the Veteran is eligible.

## **8. SPECIALIZED OUTPATIENT PTSD CARE**

PTSD specialty care includes PTSD Clinical Teams (PCT) and/or clinicians designated as PTSD specialists. These specialists have expertise in PTSD, but serve at sites where workload does not warrant a full PCT. A PTSD specialist refers to a licensed independent provider with training in one of the PTSD evidence-based treatments that are required to be offered to all Veterans, (Prolonged Exposure (PE) or Cognitive Processing Therapy (CPT)). 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 tracks. They should be knowledgeable of assessment and diagnosis of PTSD and should have knowledge of military culture. PCTs and PTSD specialists are key points of contact for Vet Centers, the facility, MST programs, and Transition and Care Management programs. Each PCT team must have evidence-based

psychopharmacology treatment capacity, either as part of the team or via a BHIP team. It is strongly recommended that each team have at least a part-time psychiatrist, physician assistant or advanced practice nurse associated with the team to ensure guideline concordant psychopharmacology.

a. **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 Veteran 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.

b. **Veterans Served.** Criteria for care by PCT and PTSD specialists include, but are not limited to, Veterans with new onset, severe, or complex PTSD.

c. **Staffing.** PCTs mental health clinicians with expertise in PTSD and PTSD EBPs and may have support personnel. Staffing should be allocated based on clinical need. Having at least part-time psychiatrist staffing in the PCT staffing mix is recommended or available through BHIP. The number of PTSD Specialists at a site without a PCT is based on workload. A PTSD specialist must be trained and be providing or be available to provide PTSD EBPs. A PTSD specialist spends 50 percent of their time treating PTSD, diagnosing or consulting. Accommodating request for same-gender provider must be considered in staffing mix.

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

e. **Capacity Requirements.** Mental Health managers should be monitoring clinician productivity to determine appropriate workload for PTSD providers. One way to do this is to:

(1) Outline the treatments that one expects to be delivered in a PTSD specialty program;

(2) Estimate the workload associated with provision of the treatment to one patient; and

(3) Estimate the number of patients per year that will need these treatments.

***NOTE:*** From there, total expected workload for the PTSD specialty program can be calculated, and then divide that by average productivity values to estimate FTE needs. The case load will also need to be adjusted for PTSD specialists at smaller VA medical facility or in CBOCs.

## **9. PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTERS (PRRC)**

Psychosocial Rehabilitation and Recovery Centers (PRRC) 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, including Veterans with PTSD. 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 facilities and in the community. Specific requirements for PRRC programs are provided by VHA Handbook 1163.03, Psychosocial Rehabilitation and Recovery Centers (PRRC), dated July 1, 2011, or subsequent policy.

## **10. SPECIALIZED RESIDENTIAL PTSD CARE**

Residential Recovery Treatment Programs and Domiciliary PTSD (Dom PTSD) programs are designed to provide a 24/7 supervised, structured, and supportive environment for the provision of treatment and rehabilitation services. Within the broader continuum of services for PTSD, Veterans with PTSD or significant trauma-related readjustment problems, who lack stable or safe housing, those with minimal safe coping skills, those with either co-occurring SUD or at risk for relapse when engaging in PTSD treatment, and those who have not responded to outpatient level of care would be most appropriate for specialized residential PTSD care. Specific requirements for Dom PTSD programs are provided by VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), dated December 22, 2010, or subsequent policy.

## **11. PTSD SERVICES IN SPECIFIC POPULATIONS**

### **a. Co-occurring PTSD and Substance Use Disorder (SUD).**

(1) VA program evaluation indicates that 20 percent of Veterans treated for PTSD in specialized outpatient PTSD programs have co-occurring SUD. PTSD evaluation data of residential programs showed that of those Veterans discharged from specialized PTSD residential programs, an average of 60 percent received either psychotherapy or pharmacotherapy for SUD. The concurrent treatment of PTSD and SUD is considered an evidence-based practice and has been instituted across the system.

(2) At a minimum, each VA medical facility must have a SUD-PTSD clinician experienced in treating co-occurring SUD 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.

**b. Veterans with PTSD Co-Occurring with Other Injuries/TBI.** PCTs and PTSD specialists work with facility polytrauma and rehabilitation staff to provide coordinated assessment and clinical care to Veterans who have sustained multiple injuries. TBI, PTSD, SUD, and depression are examples of co-occurring disorders that may be anticipated in this population, as well as sub-diagnostic behavioral problems, such as impulsivity, agitation, or cognitive impairment. Interdisciplinary 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 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. Current research suggests that Veterans with PTSD who have mild or moderate TBI can benefit from EBPs for PTSD and therefore TBI or other mild neurocognitive disorders should not rule out a Veteran from receiving an evidence-based treatment for PTSD.

c. **Older Veterans with PTSD.** PTSD symptoms may initially present or recur late in life. It is important to recognize that the interaction of PTSD and biological, psychological, and social aspects of aging can impact the manifestation and course of PTSD. Research suggests that the majority of older Veterans with PTSD respond similarly well to EBPs for PTSD as other populations and, in most cases, few modifications to standardized protocols must be made. Occasionally, special considerations must be made for sensory and cognitive changes in this population, including auditory and visual challenges. For normal age-related cognitive changes and mild cognitive impairment, it appears that few modifications to EBP protocols are required; adding more structure, using memory aids, and conducting longer sessions may be helpful. For Veterans with dementia or other major neurocognitive disorders, EBPs are likely not appropriate and, rather, it is important to educate caregivers and focus on environmental interventions to minimize PTSD triggers and optimize engagement in positive activities.

d. **Veterans with Advanced Illness and in Hospice and Palliative Care Settings.** PTSD symptoms may increase in the context of advanced illness and interfere with the cognitive, emotional and social processes that support positive coping near the end of life. Most Veterans receive end of life care outside of VHA settings, sometimes in collaboration with VA providers. For those who do receive end of life care in VA, regular PTSD assessment, management, and treatment services must be available to Veterans who are, in Community Living Centers (CLCs), Home Based Primary Care (HBPC) programs, and other outpatient, inpatient, and home-based hospice and palliative care settings.

## 12. REFERENCES

a. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016, or subsequent policy.

b. VHA Directive 1500, Readjustment Counseling Service (RCS) Vet Center Program, dated September 8, 2010, or subsequent policy.

c. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, or subsequent policy.

d. VHA Handbook 1160.04, VHA Programs for Veterans with Substance Use Disorder (SUD), dated March 7, 2012, or subsequent policy.

e. VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), dated December 22, 2010, or subsequent policy.

**November 16, 2017**

**VHA DIRECTIVE 1160.03**

f. PTSD VA/DoD Mental Health Clinical Practice Guideline can be found at <http://www.healthquality.va.gov>

g. National Center for PTSD at [www.ptsd.va.gov](http://www.ptsd.va.gov)