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POST-TRAUMATIC STRESS DISORDER

DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers





Highlights of [GAO-06-397](#), a report to congressional committees

Why GAO Did This Study

Many servicemembers supporting Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have engaged in intense and prolonged combat, which research has shown to be strongly associated with the risk of developing post-traumatic stress disorder (PTSD). GAO, in response to the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, (1) describes DOD's extended health care benefit and VA's health care services for OEF/OIF veterans; (2) analyzes DOD data to determine the number of OEF/OIF servicemembers who may be at risk for PTSD and the number referred for further mental health evaluations; and (3) examines whether DOD can provide reasonable assurance that OEF/OIF servicemembers who need further mental health evaluations receive referrals.

What GAO Recommends

GAO recommends that DOD identify factors that its providers use in issuing referrals for further mental health evaluations. DOD concurred with GAO's recommendation, but disagreed with GAO's finding that DOD has not provided reasonable assurance that servicemembers who need referrals for further mental health evaluations receive them. DOD identified factors that may affect referrals, but did not provide data on how its providers apply these factors. VA concurred with the facts related to VA in the report.

www.gao.gov/cgi-bin/getrpt?GAO-06-397.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101 or bascettac@gao.gov.

POST-TRAUMATIC STRESS DISORDER

DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers

What GAO Found

DOD offers an extended health care benefit to some OEF/OIF veterans for a specified time period, and VA offers health care services that include specialized PTSD services. DOD's benefit provides health care services, including mental health services, to some OEF/OIF veterans for 180 days following discharge or release from active duty. Additionally, some veterans may purchase extended benefits for up to 18 months. VA also offers health care services to OEF/OIF veterans following their discharge or release from active duty. VA offers health benefits for OEF/OIF veterans at no cost for 2 years following discharge or release from active duty. After their 2-year benefit expires, some OEF/OIF veterans may continue to receive care under VA's eligibility rules.

Using data provided by DOD, GAO found that 9,145 or 5 percent of the 178,664 OEF/OIF servicemembers in its review may have been at risk for developing PTSD. DOD uses a questionnaire to identify those who may be at risk for developing PTSD after deployment. DOD providers interview servicemembers after they complete the questionnaire. A joint VA/DOD guideline states that servicemembers who respond positively to three or four of the questions may be at risk for PTSD. Further, we reviewed a retrospective study that found that those individuals who provided three or four positive responses to the four PTSD screening questions were highly likely to have been previously given a diagnosis of PTSD prior to the screening. Of the 5 percent who may have been at risk, GAO found that DOD providers referred 22 percent or 2,029 for further mental health evaluations.

DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need referrals receive them. According to DOD officials, not all of the servicemembers with three or four positive responses to the PTSD screening questions will need referrals for further mental health evaluations. DOD relies on providers' clinical judgment to decide who needs a referral. GAO found that DOD health care providers varied in the frequency with which they issued referrals to OEF/OIF servicemembers with three or more positive responses; the Army referred 23 percent, the Marines about 15 percent, the Navy 18 percent, and the Air Force about 23 percent. However, DOD did not identify the factors its providers used in determining which OEF/OIF servicemembers needed referrals. Knowing the factors upon which DOD health care providers based their clinical judgments in issuing referrals could help explain variation in the referral rates and allow DOD to provide reasonable assurance that such judgments are being exercised appropriately.

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Abbreviations

AMSA	Army Medical Surveillance Activity
CHCBP	Continued Health Care Benefit Program
DMDC	Defense Manpower Data Center
DOD	Department of Defense
NDAA	National Defense Authorization Act for Fiscal Year 2005
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PTSD	post-traumatic stress disorder
TAMP	Transitional Assistance Management Program
TRS	TRICARE Reserve Select
VA	Department of Veterans Affairs

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Congressional Committees

Servicemembers returning from the military conflicts in Afghanistan and Iraq—Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF),¹ respectively—have engaged in intense and prolonged combat, which research has shown to be strongly associated with the risk for developing PTSD.² PTSD can occur after experiencing or witnessing a life-threatening event and is the most prevalent mental health disorder resulting from combat. Mental health experts state that early identification and treatment of symptoms through education, peer and family support, therapy, or medications may lessen the severity of the condition and improve the overall quality of life for those with PTSD.

The Department of Defense (DOD) uses a questionnaire to screen OEF/OIF servicemembers after their deployment outside of the United States has ended.³ The questionnaire assesses servicemembers' physical and mental health and includes four questions that are used to identify those who may be at risk for developing PTSD. In conjunction with completion of the questionnaire, each OEF/OIF servicemember is interviewed by a DOD health care provider who reviews the completed questionnaire and discusses with the servicemember any deployment-related health concerns, including mental health concerns. From among those who may be at risk for PTSD or other mental health conditions, these DOD health care providers then determine which servicemembers need referrals for a further mental health evaluation. Providers use a section of the post-deployment screening questionnaire to indicate when a servicemember needs a referral.⁴

¹OEF/OIF servicemembers include National Guard and Reserve members.

²Hoge, Charles W., MD et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *The New England Journal of Medicine*, 351 (2004): 13-22.

³Servicemembers who are deployed for 30 or more continuous days to locations without permanent DOD treatment facilities are required to complete a post-deployment screening questionnaire.

⁴DOD's referrals are used to document DOD's assessment that servicemembers are in need of further mental health evaluations, including those for PTSD. In this report, we refer to such referrals as issued to or received by servicemembers.

OEF/OIF servicemembers can obtain mental health evaluations, as well as any necessary treatment for PTSD, while they are servicemembers—that is, on active duty—or when they transition to veteran status after being discharged or released from active duty.⁵ DOD provides mental health evaluations and treatment for PTSD to servicemembers, including OEF/OIF servicemembers, and the department also provides these mental health benefits for OEF/OIF veterans through an extended health care benefit created for this population. The Department of Veterans Affairs (VA) also provides mental health benefits to OEF/OIF veterans as part of health care services that it offers to these and other veterans. In this report, we use the term OEF/OIF servicemembers when we refer to those returning from the OEF/OIF conflicts who are screened for PTSD and may receive referrals during active duty. We use the term OEF/OIF veterans when we refer to those returning from the OEF/OIF conflicts who, after being discharged or released from active duty, are eligible for DOD and VA mental health benefits and could access the departments' services.

The Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 (NDAA)⁶ directed that we describe the mental health benefits available for OEF/OIF veterans. NDAA further directed that we examine the process DOD uses to refer OEF/OIF servicemembers who need further mental health evaluations. In this report, we (1) describe DOD's extended health care benefit for OEF/OIF veterans and VA's health care services for OEF/OIF veterans; (2) analyze DOD data to determine the number of OEF/OIF servicemembers who may be at risk for developing PTSD and the number of these servicemembers who were referred for further mental health evaluations; and (3) examine whether DOD can provide reasonable assurance that OEF/OIF servicemembers who need further mental health evaluations receive referrals for these evaluations.

To describe DOD's extended health care benefit and VA's health care services for OEF/OIF veterans, we reviewed DOD policies and the educational materials DOD provides to individuals on its health insurance benefits, including information on the length of coverage of these benefits.

⁵In this report, we use the term discharged to describe servicemembers who have completed their active duty service commitment and have not made a future service commitment. We use the term released to describe Reserve and National Guard servicemembers who have completed their active duty service commitment, made a future commitment to active duty, and therefore can be recalled to active duty.

⁶Pub. L. No. 108-375, § 598(b)(8), (9), 118 Stat. 1811, 1939-41 (2004).

We also interviewed DOD officials and the military service branches about these benefits. In addition, we reviewed VA's policies, directives, and educational information on its health care services, including the mental health services that VA has available for OEF/OIF veterans. We reviewed the types of mental health services available through VA's health care system for OEF/OIF veterans. We also interviewed VA headquarters officials about these services.

To determine the number of OEF/OIF servicemembers who may be at risk for developing PTSD and the number of these servicemembers referred for further mental health evaluations, we analyzed DOD computerized data. We obtained from DOD a list of OEF/OIF servicemembers who (1) were deployed in support of OEF/OIF from October 1, 2001, through September 30, 2004; (2) had since been discharged or released from active duty;⁷ (3) completed DOD's post-deployment screening questionnaire; and (4) had the record of their completed questionnaire available in a DOD computerized database. From this list, we identified 178,664 OEF/OIF servicemembers who answered the four PTSD screening questions on DOD's post-deployment screening questionnaire, the DD 2796.⁸ To determine the number of OEF/OIF servicemembers who may have been at risk for developing PTSD, we reviewed a clinical practice guideline for PTSD developed jointly by VA and DOD, which indicates that servicemembers who provide three or four positive responses to the four PTSD screening questions may be at risk for developing PTSD.⁹ We also reviewed a retrospective study that found that those individuals who provided three or four positive responses to the four PTSD screening questions were highly likely to have been previously given a diagnosis of PTSD prior to the screening.¹⁰ To determine the number of OEF/OIF

⁷We did not include military retirees in our analysis because the mandate specifies that we include servicemembers who have been discharged or released from active duty, not retired servicemembers. According to a DOD official, DOD does not include retirees in its definition of discharged servicemembers or servicemembers who have been released from active duty status.

⁸Department of Defense, *Department of Defense Post-Deployment Health Assessment DD-2796* (Washington, D.C.: April 2003).

⁹Department of Veterans Affairs and Department of Defense, *Veterans Health Administration/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress* (Washington, D.C.: January 2004).

¹⁰Prins, Annabel et al. "The Primary Care PTSD Screen (PC-PTSD): Development and Operating Characteristics," *Primary Care Psychiatry*, 9 (2004): 9-14. This study was conducted using VA primary care patients.

servicemembers who received referrals from a DOD health care provider, we used information from the post-deployment questionnaires of the 178,664 OEF/OIF servicemembers in our review. The questionnaires indicate whether a DOD health care provider issued a referral for a mental health or combat/operational stress reaction evaluation. We determined that DOD's data were sufficiently reliable for the purposes of the report.

To examine whether DOD can provide reasonable assurance that OEF/OIF servicemembers who need further mental health evaluations receive referrals, we reviewed DOD's policies and guidance, including guidance for DOD health care providers who use the DD 2796. We reviewed DOD's quality assurance program and spoke to a researcher about a DOD study on PTSD referrals to examine the extent to which DOD studies its providers' decisions to issue referrals. We interviewed DOD officials, including mental health clinicians involved with the DD 2796 and asked them about DOD's criteria for issuing referrals to those who may be at risk for developing PTSD.

NDAA also directed us to determine the number of OEF/OIF veterans who, because of their DOD provider-issued referrals, accessed DOD or VA health care services to obtain a further mental health or combat/operational stress reaction evaluation. However, as discussed with the committees of jurisdiction, we could not use data from OEF/OIF veterans' DD 2796 forms to determine if veterans accessed DOD or VA health care services because of their mental health referrals. DOD officials explained that the referral checked on the DD 2796 cannot be linked to a subsequent health care visit using DOD computerized data. Therefore, we could not determine how many OEF/OIF veterans accessed DOD or VA health care services for further mental health evaluations because of their referrals.

For a complete discussion of our scope and methodology, see appendix I. We conducted our work from December 2004 through April 2006 in accordance with generally accepted government auditing standards.

Results in Brief

DOD offers an extended health care benefit to some OEF/OIF veterans for a specific period of time, and VA offers health care services that include specialized PTSD services. DOD's benefit provides health care services, including mental health services, to some OEF/OIF veterans for 180 days following discharge or release from active duty. Additionally, veterans may purchase extended benefits for up to 18 months. VA also offers health care services to OEF/OIF veterans following their discharge or release from

active duty. VA's health benefits include health care services, as well as specialized PTSD services. These specialized PTSD services are delivered by clinicians who have concentrated their clinical work in the area of PTSD treatment. These clinicians work as a team to coordinate veterans' treatments and offer expertise in a variety of disciplines, such as psychiatry, psychology, social work, readjustment counseling, and nursing. VA offers its health care services to OEF/OIF veterans at no cost for 2 years following discharge or release from active duty. After their 2-year benefit expires, OEF/OIF veterans may continue to receive VA care under VA's eligibility rules but may be subject to copayments.

Using data provided by DOD from the DD 2796 forms, we found that about 5 percent of the OEF/OIF servicemembers in our review may have been at risk for developing PTSD, and over 20 percent of these servicemembers received a referral—that is, had a DD 2796 indicating that they needed a further mental health or combat/operational stress reaction evaluation. According to the clinical practice guideline jointly developed by VA and DOD, individuals who respond positively to three or four of the four PTSD screening questions may be at risk for developing PTSD. Using these criteria, we found that of the 178,664 OEF/OIF servicemembers in our study, DOD data indicate that 5 percent—9,145—may have been at risk for developing PTSD. Of these, we found that 2,029 or 22 percent were referred by DOD health care providers for further mental health or combat/operational stress reaction evaluations. Moreover, across the military service branches, DOD health care providers varied in the frequency with which they issued referrals to OEF/OIF servicemembers with three or more positive responses to the PTSD screening questions; the Army referred 23 percent, the Marines referred about 15 percent, Navy referred 18 percent, and the Air Force referred about 23 percent.

DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need referrals for further mental health or combat/operational stress reaction evaluations receive them. Determining who needs a referral occurs when DOD health care providers interview servicemembers after they complete the DD 2796. DOD's guidance for health care providers using the DD 2796 advises the health care providers to give particular attention during the interview to those who completed the DD 2796 and answered positively to three or four of the four PTSD screening questions. According to DOD officials, not all of the OEF/OIF servicemembers with three or four positive responses will need referrals for further mental health evaluations. As directed by DOD's guidance for using the DD 2796, health care providers are to rely on their clinical judgment to decide which of these servicemembers need further mental health evaluations. However,

DOD has not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. While DOD has taken steps to monitor the post-deployment process, these steps are not designed to identify the factors upon which DOD health care providers base their clinical judgments in issuing referrals for further mental health or combat/operational stress reaction evaluations. Knowing these factors could help explain the variation in the referral rates and allow DOD to provide reasonable assurance that such judgments are being exercised appropriately.

We recommend that DOD identify the factors that DOD health care providers use in issuing referrals for further evaluations for mental health or combat/operational stress reaction to explain provider variation in issuing referrals. In commenting on a draft of this report, DOD concurred with our conclusions and recommendation. DOD noted that it plans a systematic evaluation of referral patterns for the post-deployment health assessment through the National Quality Management Program. Despite its planned implementation of our recommendation, DOD disagreed with our finding that it has not provided reasonable assurance that OEF/OIF servicemembers receive referrals for further mental health evaluations when needed. Until DOD has better information on the factors its health care providers use when applying their clinical judgment, DOD cannot reasonably assure that servicemembers who need referrals receive them. DOD's plans to develop this information should lead to reasonable assurance that servicemembers who need referrals receive them. VA concurred with the facts in the draft report that related to VA services.

Background

PTSD can develop following exposure to combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who experience stressful events often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms may occur within the first 4 days after exposure to the stressful event or be delayed for months or years.¹¹ Symptoms that appear within the first 4 days after exposure to a stressful event are generally diagnosed as acute stress reaction or combat stress.

¹¹Because the symptoms of PTSD may be delayed, in October 2005, DOD began offering a post-deployment health reassessment for individuals 90 to 180 days after returning from deployment as part of OEF/OIF. These individuals could be servicemembers or veterans. The reassessment includes the same four PTSD screening questions that are found on the DD 2796.

Symptoms that persist longer than 4 days are diagnosed as acute stress disorder. If the symptoms continue for more than 30 days and significantly disrupt an individual's daily activities, PTSD is diagnosed. PTSD may occur with other mental health conditions, such as depression and substance abuse. Clinicians offer a range of treatments to individuals diagnosed with PTSD, including individual and group therapy and medication to manage symptoms. These treatments are usually delivered in an outpatient setting, but they can include inpatient services if, for example, individuals are at risk of causing harm to themselves.

DOD's Post-Deployment Process and Screening for PTSD

DOD's screening for PTSD occurs during its post-deployment process. During this process, DOD evaluates servicemembers' current physical and mental health and identifies any psychosocial issues commonly associated with deployments, special medications taken during the deployment, and possible deployment-related occupational/environmental exposures. The post-deployment process also includes completion by the servicemember of the post-deployment screening questionnaire, the DD 2796. DOD uses the DD 2796 to assess health status, including identifying servicemembers who may be at risk for developing PTSD following deployment.¹² In addition to questions about demographics and general health, including questions about general mental health, the DD 2796 includes four questions used to screen servicemembers for PTSD. The four questions are:

Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you

- have had any nightmares about it or thought about it when you did not want to?
- tried hard not to think about it or went out of your way to avoid situations that remind you of it?
- were constantly on guard, watchful, or easily startled?
- felt numb or detached from others, activities, or your surroundings?

The completed DD 2796 is reviewed by a DOD health care provider who conducts a face-to-face interview to discuss any deployment-related health

¹²The questionnaire is used to satisfy the requirement for post-deployment mental health assessments established by the National Defense Authorization Act for Fiscal Year 1998. Pub. L. No. 105-85, § 765(a)(1), 111 Stat. 1629, 1826, codified at 10 U.S.C. § 1074f(b) (2000).

concerns with the servicemember. Health care providers that review the DD 2796 may include physicians, physician assistants, nurse practitioners, or independent duty medical technicians—enlisted personnel who receive advanced training to provide treatment and administer medications. DOD provides guidance for health care providers using the DD 2796 and screening servicemembers' physical and mental health. The guidance gives background information to health care providers on the purpose of the various screening questions on the DD 2796 and highlights the importance of a health care provider's clinical judgment when interviewing and discussing responses to the DD 2796.

Health care providers may make a referral for a further mental health or combat/operational stress reaction evaluation by indicating on the DD 2796 that this evaluation is needed. When a DOD health care provider refers an OEF/OIF servicemember for a further mental health or combat/operational stress reaction evaluation, the provider checks the appropriate evaluation box on the DD 2796 and gives the servicemember information about PTSD. The provider does not generally arrange for a mental health evaluation appointment for the servicemember with a referral. See figure 1 for the portion of the DD 2796 that is used to indicate that a referral for a further mental health or combat/operational stress reaction evaluation is needed.

Figure 1: Portion of the DD 2796 Used by DOD Health Care Providers to Indicate a Referral for a Further Mental Health or Combat/Operational Stress Reaction Evaluation Is Needed

Health Assessment	
After my interview/exam of the service member and review of this form, there is a need for further evaluation as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in the service member's medical record.)	
REFERRAL INDICATED FOR:	
<input type="radio"/> None	<input type="radio"/> GI
<input type="radio"/> Cardiac	<input type="radio"/> GU
<input type="radio"/> Combat/Operational Stress Reaction	<input type="radio"/> GYN
<input type="radio"/> Dental	<input type="radio"/> Mental Health
<input type="radio"/> Dermatologic	<input type="radio"/> Neurologic
<input type="radio"/> ENT	<input type="radio"/> Orthopedic
<input type="radio"/> Eye	<input type="radio"/> Pregnancy
<input type="radio"/> Family Problems	<input type="radio"/> Pulmonary
<input type="radio"/> Fatigue, Malaise, Multisystem complaint	<input type="radio"/> Other _____
<input type="radio"/> Audiology	
Comments: _____ _____ _____	
I certify that this review process has been completed. Provider's signature and stamp:	This visit is coded by V70.5 __ 6 Date (dd/mm/yyyy) [][] / [][] / [][][][]
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
End of Health Review	
<div style="background-color: black; width: 20px; height: 20px; display: inline-block;"></div> DD FORM 2796, APR 2003	ASD(HA) APPROVED
	33348

Source: DOD.

DOD and VA Health Care Systems

DOD's health care system, TRICARE, delivers health care services to over 9 million individuals. Health care services, which include mental health services, are provided by DOD personnel in military treatment facilities or through civilian health care providers, who may be either network providers or nonnetwork providers. A military treatment facility is a military hospital or clinic on or near a military base. Network providers have a contractual agreement with TRICARE to provide health care services and are part of the TRICARE network. Nonnetwork providers may accept TRICARE allowable charges for delivering health care services or expect the beneficiary to pay the difference between the provider's fee and TRICARE's allowable charge for services.

VA's health care system includes medical facilities, community-based outpatient clinics, and Vet Centers. VA medical facilities offer services which range from primary care to complex specialty care, such as cardiac or spinal cord injury. VA's community-based outpatient clinics are an extension of VA's medical facilities and mainly provide primary care services. Vet Centers offer readjustment and family counseling, employment services, bereavement counseling, and a range of social services to assist veterans in readjusting from wartime military service to civilian life.¹³ Vet Centers are also community points of access for many returning veterans, providing them with information and referrals to VA medical facilities.

DOD's Quality Assurance Program

In January 2004, DOD implemented the Deployment Health Quality Assurance Program.¹⁴ As part of the program, each military service branch must implement its own quality assurance program and report quarterly to DOD on the status and findings of the program. The program requires military installation site visits by DOD and military service branch officials to review individual medical records to determine, in part, whether the DD 2796 was completed. The program also requires a monthly report from the Army Medical Surveillance Activity (AMSA), which maintains a database of all servicemembers' completed DD 2796s.¹⁵ DOD uses the information

¹³Readjustment counseling is intended to help veterans resolve war-related psychological difficulties and achieve a successful postwar readjustment to civilian life.

¹⁴We recommended in 2003 that DOD establish a quality assurance program. See GAO, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, [GAO-03-1041](#) (Washington, D.C.: Sept. 19, 2003).

¹⁵The Army has lead responsibility for DOD's medical surveillance and operates a centralized data repository.

from the military service branches, site visits, and AMSA to develop an annual report on its Deployment Health Quality Assurance Program.¹⁶

For Veterans, DOD Offers a Benefit for a Specific Period of Time and VA Offers Various Health Care Services

DOD offers an extended health care benefit to some OEF/OIF veterans for a specific period of time, and VA offers health care services that include specialized PTSD services. For some OEF/OIF veterans, DOD offers three health care benefit options through the Transitional Assistance Management Program (TAMP) under TRICARE, DOD's health care system. The three benefit options are offered for 180 days following discharge or release from active duty. In addition, OEF/OIF veterans may purchase health care benefits through DOD's Continued Health Care Benefit Program (CHCBP) for 18 months. VA also offers health care services to OEF/OIF veterans following their discharge or release from active duty. VA's health benefits include health care services, including specialized PTSD services, which are delivered by clinicians who have concentrated their clinical work in the area of PTSD treatment and who work as a team to coordinate veterans' treatment.

DOD Offers Mental Health Benefits to OEF/OIF Veterans for 180 Days or More

Through TAMP, DOD provides health care benefits that allow some OEF/OIF veterans to obtain health care services, which include mental health services, for 180 days following discharge or release from active duty.¹⁷ This includes services for those who may be at risk for developing PTSD. These OEF/OIF veterans can choose one of three TRICARE health care benefit options through TAMP. While the three options have no premiums, two of the options have deductibles and copayments and allow access to a larger number of providers. The options are

¹⁶Office of the Assistant Secretary of Defense, *DOD Deployment Health Quality Assurance Program 2004 Annual Report*, (Washington, D.C.: 2005).

¹⁷The Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Pub. L. No. 108-375, § 706(a)(1), 118 Stat. 1811, 1983 (2004), signed into law on October 28, 2004, extended the health care benefits offered under TAMP from 120 days to 180 days to help servicemembers with the transition from military service to civilian status. Dependents may also be included in these benefits. OEF/OIF veterans who are eligible for TAMP benefits are those who have involuntarily separated from active duty; separated from active duty after being involuntarily retained in support of a contingency operation; separated from active duty following a voluntary agreement to stay on active duty for less than 1 year in support of a contingency operation; and National Guard and Reserve members who have separated from active duty after being called up or ordered in support of a contingency operation and served for more than 30 days.

- TRICARE Prime—a managed care option that allows OEF/OIF veterans to obtain, without a referral, mental health services directly from a mental health provider in the TRICARE network of providers with no cost for services.
- TRICARE Extra—a preferred provider option that allows OEF/OIF veterans to obtain, without a referral, mental health services directly from a mental health provider in the TRICARE network of providers. Beneficiaries pay a deductible and a share of the cost of services.
- TRICARE Standard—a fee-for-service option that allows OEF/OIF veterans to obtain, without a referral, mental health services directly from any mental health provider, including those outside the TRICARE network of providers. Beneficiaries pay a deductible and a larger share of the costs of services than under the TRICARE Extra option.

See Table 1 for a description of the beneficiary costs associated with each TRICARE option.

Table 1: TRICARE Beneficiary Costs Through TAMP

	TRICARE Prime (managed care)	TRICARE Extra (preferred provider)	TRICARE Standard (fee-for-service)
Annual deductible	None	\$50-\$150 (individual) and \$100-\$300 maximum (family), depending on military rank	\$50-\$150 (individual) and \$100-\$300 maximum (family), depending on military rank
Cost share after deductibles for mental health visits	Outpatient: None	Outpatient: 15% of the fee negotiated by TRICARE contractor after the deductible is met	Outpatient: 20% of allowable charges for covered services after the deductible is met
	Inpatient: None	Inpatient: greater of \$20/day or \$25 minimum charge per admission	Inpatient: greater of \$20/day or \$25 minimum charge per admission

Source: DOD.

In addition, OEF/OIF veterans may purchase DOD health care benefits through CHCBP for 18 months.¹⁸ CHCBP began on October 1, 1994, and like TAMP, the program provides health care benefits, including mental health services, for veterans making the transition to civilian life. Although benefits under this plan are similar to those offered under TRICARE Standard, the program is administered by a TRICARE health care contractor and is not part of TRICARE. OEF/OIF veterans must purchase the extended benefit within 60 days after their 180-day TAMP benefit ends. CHCBP premiums in 2006 were \$311 for individual coverage and \$665 for family coverage per month.

Reserve and National Guard OEF/OIF veterans who commit to future service can extend their health care benefits after their CHCBP or TAMP benefits expire by purchasing an additional benefit through the TRICARE Reserve Select (TRS) program.¹⁹ As of January 1, 2006, premiums under TRS are \$81 for individual coverage and \$253 for family coverage per month.

DOD also offers a service, Military OneSource, that provides information and counseling resources to OEF/OIF veterans for 180 days after discharge from the military.²⁰ Military OneSource is a 24-hour, 7-days a week information and referral service provided by DOD at no cost to veterans. Military OneSource provides OEF/OIF veterans up to six free counseling sessions for each topic with a community-based counselor and also provides referrals to mental health services through TRICARE.

¹⁸OEF/OIF veterans who have ended TAMP coverage or who are not eligible for TAMP benefits may be eligible to enroll in CHCBP if they are no longer eligible for TRICARE benefits or other benefits under the military health care system. To be eligible, OEF/OIF veterans must have been discharged or released from active duty, either voluntarily or involuntarily, under other than adverse conditions and have been entitled to coverage under a military health care plan immediately prior to discharge or release. OEF/OIF veterans must enroll in CHCBP within 60 days after separation from active duty or loss of eligibility for military health care benefits.

¹⁹The National Defense Authorization Act for Fiscal Year 2005, Pub. L. No. 108-375, § 701, 118 Stat. 1980. Under TRS, these veterans must have been called or ordered to active duty for more than 30 consecutive days and have served continuously in active duty for 90 or more days under those orders. OEF/OIF Reserve and National Guard veterans can purchase TRICARE coverage for themselves and their dependents for a period of either 1 year for each consecutive period of 90 days of active duty they served, or the number of full years for which the individual agrees to continue service, whichever is less.

²⁰Active duty servicemembers and their dependents are also eligible, as well as members of the National Guard and Reserves who have been released from active duty. These groups can access Military OneSource beyond 180 days.

VA Offers Health Services, Including Specialized PTSD Services, to OEF/OIF Veterans

VA also offers health care services to OEF/OIF veterans, and these services include mental health services that can be used for evaluation and treatment of PTSD. VA offers all of its health care services to OEF/OIF veterans through its health care system at no cost for 2 years following these veterans' discharge or release from active duty.^{21, 22} VA's mental health services, which are offered on an outpatient or inpatient basis, include individual and group counseling, education, and drug therapy.

For those veterans with PTSD whose condition cannot be managed in a primary care or general mental health setting, VA has specialized PTSD services at some of its medical facilities. These services are delivered by clinicians who have concentrated their clinical work in the area of PTSD treatment. The clinicians work as a team to coordinate veterans' treatment and offer expertise in a variety of disciplines, such as psychiatry, psychology, social work, counseling, and nursing. Like VA's general mental health services, VA's specialized PTSD services are available on both an outpatient and inpatient basis. Table 2 lists the various outpatient and inpatient specialized PTSD treatment programs available in VA.

²¹See 38 U.S.C. § 1710(e)(1)(D), 1712A(a)(2)(B) (2000), and VHA Directive 2004-017, *Establishing Combat Veteran Eligibility*.

²²OEF/OIF veterans can receive VA health care services, including mental health services, without being subject to copayments or other cost for 2 years after discharge or release from active duty. After the 2-year benefit ends, some OEF/OIF veterans without a service-connected disability or with higher incomes may be subject to a copayment to obtain VA health care services. VA assigns veterans who apply for hospital and medical services to one of eight priority groups. Priority is generally determined by a veteran's degree of service-connected or other disability or on financial need. VA gives veterans in Priority Group 1 (50 percent or higher service-connected disabled) the highest preference for services and gives lowest preference to those in Priority Group 8 (no disability and with income exceeding VA guidelines).

Table 2: VA Specialized Outpatient and Inpatient PTSD Treatment Programs

Outpatient treatment program	Description of service	Number of facilities with specialized PTSD treatment program
PTSD Clinical Team	<ul style="list-style-type: none"> Group and one-on-one evaluation, education, counseling and psychotherapy 	152
Substance Use and PTSD Team	<ul style="list-style-type: none"> Education, evaluation, and counseling with a focus on veterans with both substance abuse and PTSD 	10
Women’s Stress Disorder Treatment Team/Military Sexual Trauma Team	<ul style="list-style-type: none"> Individual evaluation, counseling, and psychotherapy for women Group counseling and psychotherapy for women Mostly women, may include small number of men separate from women 	17
PTSD Day Hospital	<ul style="list-style-type: none"> Social, recreational, and vocational activities and counseling 	11
Inpatient treatment program		
Evaluation and Brief Treatment Unit	<ul style="list-style-type: none"> Evaluation, education, and psychotherapy for PTSD Duration of service: 14 to 28 days 	4
Specialized Inpatient PTSD Unit	<ul style="list-style-type: none"> Evaluation, education, and counseling for substance use and PTSD psychotherapy Duration of service: 28 to 90 days 	5
PTSD Residential Rehabilitation Program	<ul style="list-style-type: none"> Residential service providing evaluation, education, and counseling to help veterans resume a productive involvement in community life Duration of service: 28 to 90 days 	14
Women’s Trauma Recovery Program	<ul style="list-style-type: none"> Residential service with an emphasis on interpersonal skills for veterans with PTSD Duration of service: up to 60 days 	2
PTSD Domiciliary	<ul style="list-style-type: none"> Residential program providing integrated rehabilitative and restorative care with the goal of helping veterans with PTSD achieve and maintain the highest level of functioning and independence possible Duration of service: about 85 days 	8

Source: VA, March 2006.

In addition to the 2-year mental health benefit, VA’s 207 Vet Centers offer counseling services to all OEF/OIF veterans with combat experience, with no time limitation or cost to the veteran for the benefit. Vet Centers are also authorized to provide counseling services to veterans’ family members to the extent this is necessary for the veteran’s post-war readjustment to civilian life. VA Vet Center counselors may refer a veteran to VA mental health services when appropriate.

**Based on DOD Data,
About 5 Percent of
OEF/OIF
Servicemembers May
Have Been at Risk for
Developing PTSD and
Over 20 Percent
Received Referrals**

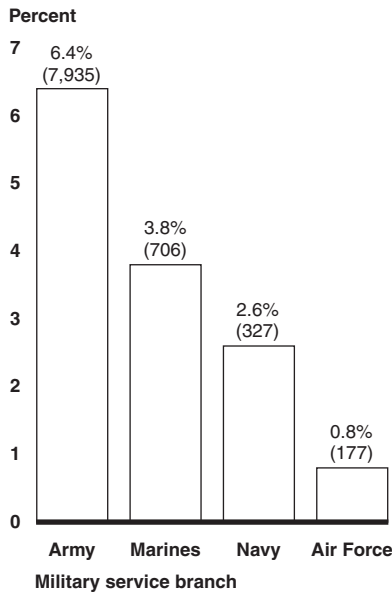
Using data provided by DOD from the DD 2796s, we found that about 5 percent of the OEF/OIF servicemembers in our review may have been at risk for developing PTSD, and over 20 percent received referrals for further mental health or combat/operational stress reaction evaluations. About 5 percent of the 178,664 OEF/OIF servicemembers in our review responded positively to three or four of the four PTSD screening questions on the DD 2796. According to the clinical practice guideline jointly developed by VA and DOD, individuals who respond positively to three or four of the four PTSD screening questions may be at risk for developing PTSD. Of those OEF/OIF servicemembers who may have been at risk for PTSD, 22 percent were referred for further mental health or combat/operational stress reaction evaluations.

**About 5 Percent of
OEF/OIF Servicemembers
May Have Been at Risk for
Developing PTSD**

Of the 178,664 OEF/OIF servicemembers who were deployed in support of OEF/OIF from October 1, 2001, through September 30, 2004, and were in our review, 9,145—or about 5 percent—may have been at risk for developing PTSD. These OEF/OIF servicemembers responded positively to three or four of the four PTSD screening questions on the DD 2796. Compared with OEF/OIF servicemembers in other service branches of the military, more OEF/OIF servicemembers from the Army and Marines provided positive answers to three or four of the PTSD screening questions—about 6 percent for the Army and about 4 percent for the Marines (see fig. 2). The positive response rates for the Army and Marines are consistent with research that shows that these servicemembers face a higher risk of developing PTSD because of the intensity of the conflict they experienced in Afghanistan and Iraq.²³

²³Hoge, Charles W., MD et al. “Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning From Deployment to Iraq or Afghanistan,” *Journal of the American Medical Association*, 295 (2006): 1023-1032. While this study reviewed screening for PTSD and referrals in addition to other mental health conditions, the results cannot be compared to ours because this study covered active duty servicemembers.

Figure 2: OEF/OIF Servicemembers Who May Have Been at Risk for Developing PTSD, by Military Service Branch



Source: GAO analysis of DOD data.

Note: This figure is based on the number of OEF/OIF servicemembers in our review who were deployed from October 1, 2001 through September 30, 2004 and answered positively to three or four of the four PTSD screening questions on the DD 2796.

We also found that OEF/OIF servicemembers who were members of the National Guard and Reserves were not more likely to be at risk for developing PTSD than other OEF/OIF servicemembers. Concerns have been raised that OEF/OIF servicemembers from the National Guard and Reserve are at particular risk for developing PTSD because they might be less prepared for the intensity of the OEF/OIF conflicts.²⁴ However, the percentage of OEF/OIF servicemembers in the National Guard and Reserves who answered positively to three or four PTSD screening questions was 5.2 percent, compared to 4.9 percent for other OEF/OIF servicemembers.²⁵

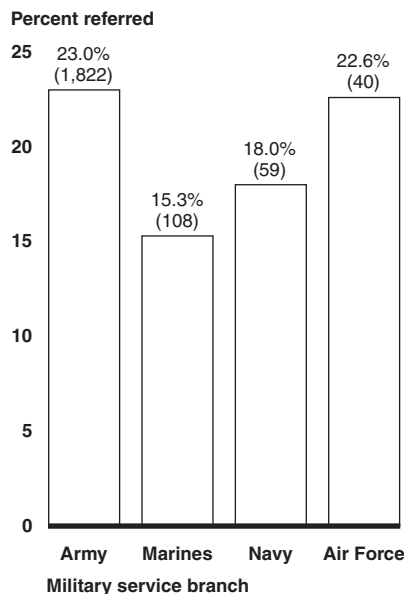
²⁴Friedman, Mathew J., "Veterans' Mental Health in the Wake of War," *The New England Journal of Medicine*, 352 (2005): 1287-1290.

²⁵DOD officials have stated that some OEF/OIF servicemembers may be reluctant to accurately report symptoms of PTSD because they could be delayed in returning home after deployment.

Twenty-two Percent Who May Have Been at Risk for Developing PTSD Received Referrals

Of the 9,145 OEF/OIF servicemembers who may have been at risk for developing PTSD, we found that 2,029 or 22 percent received a referral—that is, had a DD 2796 indicating that they needed a further mental health or combat/operational stress reaction evaluation. The Army and Air Force servicemembers had the highest rates of referral—23.0 percent and 22.6 percent, respectively (see fig. 3). Although the Marines had the second largest percentage of servicemembers who provided three or four positive responses to the PTSD screening questions (3.8 percent), the Marines had the lowest referral rate (15.3 percent) among the military service branches.

Figure 3: Referral Rates for Mental Health or Combat/Operational Stress Reaction Evaluation for OEF/OIF Servicemembers Who May Have Been at Risk for Developing PTSD, by Military Service Branch



Source: GAO analysis of DOD data.

Note: This figure is based on the number of OEF/OIF servicemembers in our review who were deployed from October 1, 2001 through September 30, 2004 and answered positively to three or four of the four PTSD screening questions on the DD 2796.

DOD Cannot Provide Reasonable Assurance That OEF/OIF Servicemembers Who Need Mental Health Referrals Receive Them

During the post-deployment process, DOD relies on the clinical judgment of its health care providers to determine which servicemembers should receive referrals for further mental health or combat/operational stress reaction evaluations. Following a servicemember's completion of the DD 2796, DOD requires its health care providers to interview all servicemembers. For these interviews, DOD's guidance for health care providers using the DD 2796 advises the providers to "pay particular attention to" servicemembers who provide positive responses to three or four of the four PTSD screening questions on their DD 2796s. According to DOD officials, not all of the servicemembers with three or four positive responses to the PTSD screening questions need referrals for further evaluations. Instead, DOD instructs health care providers to interview the servicemembers, review their medical records for past medical history and, based on this information, determine which servicemembers need referrals.²⁶

DOD expects its health care providers to exercise their clinical judgment in determining which servicemembers need referrals. DOD's guidance suggests that its health care providers consider, when exercising their clinical judgment, factors such as servicemembers' behavior, reasons for positive responses to any of the four PTSD screening questions on the DD 2796, and answers to other questions on the DD 2796. However, DOD has not identified whether these factors or other factors are used by its health care providers in making referral decisions. As a result, DOD cannot provide reasonable assurance that all OEF/OIF servicemembers who need referrals for further mental health or combat/operational stress reaction evaluations receive such referrals.

DOD has a quality assurance program that, in part, monitors the completion of the DD 2796, but the program is not designed to evaluate health care providers' decisions to issue referrals for mental health and combat/operational stress reaction evaluations. As part of its review, the Deployment Health Quality Assurance Program requires DOD's military service branches to collect information from medical records on, among other things, the percentage of DD 2796s completed in each military service branch and whether referrals were made. However, the quality assurance program does not require the military service branches to link

²⁶The DD 2796 is to be placed in the servicemember's medical record and a copy sent to AMSA. AMSA is DOD's centralized repository for DD 2796 information from all of the military service branches. It provides ongoing and special analyses and reports for policy makers, medical planners, and researchers.

responses on the four PTSD screening questions to the likelihood of receiving a referral. Therefore, the program could not provide information on why some OEF/OIF servicemembers with three or more positive responses to the PTSD screening questions received referrals while others did not.

DOD is conducting a study that is intended to evaluate the outcomes and quality of care provided by DOD's health care system. This study is part of DOD's National Quality Management Program. The study is intended to track those who responded positively to three or four PTSD screening questions on the DD 2796 and used the form as well to indicate they had other mental health issues, such as feeling depressed.²⁷ One of the objectives of the study is to determine the percentage of those who were referred for further mental health or combat/operational stress reaction evaluations, based on their responses on the DD 2796.

Conclusions

Many OEF/OIF servicemembers have engaged in the type of intense and prolonged combat that research has shown to be highly correlated with the risk for developing PTSD. During DOD's post-deployment process, DOD relies on its health care providers to assess the likelihood of OEF/OIF servicemembers being at risk for developing PTSD. As part of this effort, providers use their clinical judgment to identify those servicemembers whose mental health needs further evaluation.

Because DOD entrusts its health care providers with screening OEF/OIF servicemembers to assess their risk for developing PTSD, the department should have confidence that these providers are issuing referrals to all servicemembers who need them. Variation among DOD's military service branches in the frequency with which their providers issued referrals to OEF/OIF servicemembers with identical results from the screening questionnaire suggests the need for more information about the decision to issue referrals. Knowing the factors upon which DOD health care providers based their clinical judgments in issuing referrals could help explain variation in the referral rates and allow DOD to provide reasonable assurance that such judgments are being exercised appropriately. However, DOD has not identified the factors its health care providers used

²⁷In addition to the four PTSD screening questions, the DD 2796 contains other questions related to mental health, such as asking "Over the last 2 weeks how often have you been bothered by any of the following problems—feeling depressed or having thoughts of harming yourself?"

in determining why some servicemembers received referrals while other servicemembers with the same number of positive responses to the four PTSD screening questions did not.

Recommendation for Executive Action

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to identify the factors that DOD health care providers use in issuing referrals for further mental health or combat/operational stress reaction evaluations to explain provider variation in issuing referrals.

Agency Comments and Our Evaluation

In commenting on a draft of this report, DOD concurred with our conclusions and recommendation. DOD's comments are reprinted in appendix II. DOD noted that it plans a systematic evaluation of referral patterns for the post-deployment health assessment through the National Quality Management Program and that an ongoing validation study of the post-deployment health assessment and the post-deployment health reassessment is projected for completion in October 2006. Despite its planned implementation of our recommendation to identify the factors that its health care providers use to make referrals, DOD disagreed with our finding that it has not provided reasonable assurance that OEF/OIF servicemembers receive referrals for further mental health evaluations when needed.

To support its position, DOD identified several factors in its comments that it stated may explain why some OEF/OIF servicemembers with the same number of positive responses to the four PTSD screening questions are referred while others are not. For example, DOD health care providers may employ watchful waiting instead of a referral for a further evaluation for servicemembers with three or four positive responses to the PTSD screening questions. Additionally, DOD stated in its technical comments that providers may use the referral category of "other" rather than place a mental health label on a referral by checking the further evaluation categories of mental health or combat/operational stress reaction. DOD also stated in its technical comments that health care providers may not place equal value on the four PTSD screening questions and may only refer servicemembers who indicate positive responses to certain questions. Although DOD identified several factors that may explain why some servicemembers are referred while others are not, DOD did not provide data on the extent to which these factors affect health care providers' clinical judgments on whether to refer OEF/OIF servicemembers with three or four positive responses to the four PTSD screening questions.

Until DOD has better information on how its health care providers use these factors when applying their clinical judgment, DOD cannot reasonably assure that servicemembers who need referrals receive them. DOD's plans to develop this information should lead to reasonable assurance that servicemembers who need referrals receive them.

DOD also described in its written comments its philosophy of clinical intervention for combat and operational stress reactions that could lead to PTSD. Central to its approach is the belief that attempting to diagnose normal reactions to combat and assigning too much significance to symptoms when not warranted may do more harm to a servicemember than good. While we agree that PTSD is a complex disorder that requires DOD health care providers to make difficult clinical decisions, issues relating to diagnosis and treatment are not germane to the referral issues we reviewed and were beyond the scope of our work. Instead, our work focused on the referral of servicemembers who may be at risk for PTSD because they answered three or four of the four PTSD screening questions positively, not whether they should be diagnosed and treated.

Further, DOD implied that our position is that servicemembers must have a referral to access mental health care, but there are other avenues of care for servicemembers where a referral is not needed. We do not assume that servicemembers must have a referral in order to access these health care services. Rather, in this report we identify the health care services available to OEF/OIF servicemembers who have been discharged or released from active duty and focus on how decisions are made by DOD providers regarding referrals for servicemembers who may be at risk for PTSD. DOD also provided technical comments, which we incorporated as appropriate.

VA provided comments on a draft of this report by e-mail. VA concurred with the facts in the draft report that related to VA.

We are sending copies of this report to the Secretary of Veterans Affairs; the Secretary of Defense; the Secretaries of the Army, the Air Force, and the Navy; the Commandant of the Marine Corps; and appropriate congressional committees. We will also provide copies to others upon request. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff members have any questions regarding this report, please contact me at (202) 512-7101 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made major contributions to this report are listed in appendix III.



Cynthia A. Bascetta
Director, Health Care

List of Committees

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Larry E. Craig
Chairman
The Honorable Daniel K. Akaka
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

The Honorable Kay Bailey Hutchison
Chairman
The Honorable Dianne Feinstein
Ranking Minority Member
Subcommittee on Military Construction,
Veterans' Affairs, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Ted Stevens
Chairman
The Honorable Daniel K. Inouye
Ranking Minority Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Duncan L. Hunter
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The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Honorable Steve Buyer
Chairman
The Honorable Lane Evans
Ranking Minority Member
Committee on Veterans' Affairs
House of Representatives

The Honorable James T. Walsh
Chairman
The Honorable Chet Edwards
Ranking Minority Member
Subcommittee on Military Quality of Life and
Veterans Affairs and Related Agencies
Committee on Appropriations
House of Representatives

The Honorable C. W. Bill Young
Chairman
The Honorable John P. Murtha
Ranking Minority Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: Scope and Methodology

To describe the mental health benefits available to veterans who served in military conflicts in Afghanistan and Iraq—Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), we reviewed the Department of Defense (DOD) health care benefits and Department of Veterans Affairs (VA) mental health services available for these veterans. We reviewed the policies, procedures, and guidance issued by DOD’s TRICARE and VA’s health care systems and interviewed DOD and VA officials about the benefits and services available for post-traumatic stress disorder (PTSD). We defined an OEF/OIF veteran as a servicemember who was deployed in support of OEF or OIF from October 1, 2001, through September 30, 2004, and had since been discharged or released from active duty status. We classified National Guard and Reserve members as veterans if they had been released from active duty status after their deployment in support of OEF/OIF.

We interviewed officials in DOD’s Office of Health Affairs about health care benefits, including length of coverage, offered to OEF/OIF veterans who are members of the National Guard and Reserves and have left active duty status. We attended an Air Force Reserve and National Guard training seminar in Atlanta, Georgia, for mental health providers, social workers, and clergy to obtain information on PTSD mental health services offered to National Guard and Reserve members returning from deployment. To obtain information on DOD’s Military OneSource, we interviewed DOD officials and the manager of the Military OneSource contract about the services available and the procedures for referring OEF/OIF veterans for mental health services. We interviewed representatives from the Army, Air Force, Marines, and Navy about their use of Military OneSource.

We interviewed VA headquarters officials, including mental health experts, to obtain information about VA’s specialized PTSD services. We reviewed applicable statutes and policies and interviewed officials to identify the services offered by VA’s Vet Centers for OEF/OIF veterans. In addition, to inform our understanding of the issues related to DOD’s post-deployment process, we interviewed veterans’ service organization representatives from The American Legion, Disabled American Veterans, and Vietnam Veterans of America.

To determine the number of OEF/OIF servicemembers who may be at risk for developing PTSD and the number of these servicemembers who were referred for further mental health evaluations, we analyzed computerized DOD data. We worked with officials at DOD’s Defense Manpower Data Center to identify the population of OEF/OIF servicemembers from the Contingency Tracking System deployment and activation data files. We

then worked with officials from DOD's Army Medical Surveillance Activity (AMSA) to identify which OEF/OIF servicemembers had responded positively to one, two, three, or four of the four PTSD screening questions on the DD 2796 questionnaire. AMSA maintains a database of all servicemembers' completed DD 2796s. The DD 2796 is a questionnaire that DOD uses to identify servicemembers who may be at risk for developing PTSD after their deployment and contains the four PTSD screening questions that may identify these servicemembers. The four questions are:

Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you

- have had any nightmares about it or thought about it when you did not want to?
- tried hard not to think about it or went out of your way to avoid situations that remind you of it?
- were constantly on guard, watchful, or easily startled?
- felt numb or detached from others, activities, or your surroundings?

Because a servicemember may have been deployed more than once, some servicemembers' records at AMSA included more than one completed DD 2796. We obtained information from the DD 2796 that was completed following the servicemembers' most recent deployment in support of OEF/OIF. We removed from our review servicemembers who either did not have a DD 2796 on file at AMSA or completed a DD 2796 prior to DOD adding the four PTSD screening questions to the questionnaire in April 2003. In all, we reviewed DD 2796's completed by 178,664 OEF/OIF servicemembers. To determine the criteria we would use to identify OEF/OIF servicemembers who may have been at risk for developing PTSD, we reviewed the clinical practice guideline for PTSD developed jointly by VA and DOD, which states that three or more positive responses to the four questions indicate a risk for developing PTSD.¹ Further, we reviewed a retrospective study that found that those individuals who provided three or four positive responses to the four PTSD screening questions were highly likely to have been previously given a diagnosis of PTSD prior to the screening.² To determine the number of OEF/OIF

¹VA and DOD, *Veterans Health Administration/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress Disorders*.

²Prins, Annabel et al. "The Primary Care PTSD Screen (PC-PTSD): Development and Operating Characteristics."

servicemembers who may be at risk for developing PTSD and were referred for further mental health evaluations, we asked AMSA to identify OEF/OIF servicemembers whose DD 2796 forms indicated that they were referred for further mental health or combat/operational stress reaction evaluations by a DOD health care provider.

To examine whether DOD has reasonable assurance that OEF/OIF veterans who needed further mental health evaluations received referrals, we reviewed DOD's policies and guidance, as well as policies and guidance for each of the military service branches (Army, Navy, Air Force, and Marines). Based on electronic testing of logical elements and our previous work on the completeness and accuracy of AMSA's centralized database, we concluded that the data were sufficiently reliable for the purposes of this report.³

NDAAs also directed us to determine the number of OEF/OIF veterans who, because of their referrals, accessed DOD or VA health care services to obtain a further mental health or combat/operational stress reaction evaluation. However, as discussed with the committees of jurisdiction, we could not use data from OEF/OIF veterans' DD 2796 forms to determine if veterans accessed DOD or VA health care services because of their mental health referrals. DOD officials explained that the referral checked on the DD 2796 cannot be linked to a subsequent health care visit using DOD computerized data. Therefore, we could not determine how many OEF/OIF veterans accessed DOD or VA health care services for further mental health evaluations because of their referrals. We conducted our work from December 2004 through April 2006 in accordance with generally accepted government auditing standards.

³[GAO-03-1041](#).

Appendix II: Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

APR 13 2006

Ms. Cynthia Bascetta
Director, Health Care - Veterans'
Health and Benefits Issues
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Bascetta:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, "POST-TRAUMATIC STRESS DISORDER: DoD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers," dated March 20, 2006, GAO Code 290437/GAO-06-397.

Thank you for the opportunity to review your draft report. We commend the GAO team for their diligence in addressing a complex issue and the associated implications in two complex healthcare systems. We also wish to thank the Congressional Committees for their ongoing interest in the mental health of our military personnel.

Overall, I concur with the draft report's conclusions and recommendations. However, I nonconcur with GAO's premise that reasonable assurance is not available to support that Operation Iraqi Freedom/Operation Enduring Freedom servicemembers receive referrals when needed.

Specific comments are provided addressing various aspects of the report. A response to the recommendations is provided with technical comments for your consideration to help strengthen the report and make it more valuable to the Department.

Please direct any questions to my points of contact on this matter, Dr. Michael Kilpatrick (functional) at (703) 578-8510 and Mr. Gunther J. Zimmerman (Audit Liaison) at (703) 681-3492, extension 4065.


For William Winkenwerder, Jr., MD

Enclosures:
As stated

GAO DRAFT REPORT – DATED MARCH 20, 2006
(GAO CODE – 290437/GAO-06-397)

**“POST-TRAUMATIC STRESS DISORDER: DoD Needs to Identify the
Factors Its Providers Use to Make Mental Health Evaluation Referrals for
Servicemembers”**

DEPARTMENT OF DEFENSE COMMENTS

Overall Comments:

While DoD concurs with the recommendation to clearly identify the factors actually used by clinicians in making a referral decision, DoD non-concurs with the premise that reasonable assurance is not available to support the position that OIF/OEF servicemembers receive referrals when needed. DoD recommends that this statement be eliminated from the report, based on information in the specific comments above and in addition to the general comments that follow. Occupationally related health decisions are made by clinicians who are familiar with the occupational demands. Military deployments represent occupationally unique situations. Decisions are made based on knowledge of clinical concerns as well as occupational environment. All relevant factors need to be considered in the assessment and referral process.

Combat and Operational Stress Reactions (COSR), philosophy of intervention. Decades of experience have resulted in the currently accepted practice of rest and restoration as a method of intervention for COSR. In past conflicts, providers and line personnel discovered that it is very common to have a negative reaction to the stress and trauma of combat; it is just a part of human nature. If these normal reactions to an abnormal situation are immediately medicalized, the individual takes on a patient role and the symptoms that may normally dissipate with rest and restoration tend to persist. Therefore, the recommended action is to expect the symptoms to remit naturally and to offer social support through unit cohesion along with a few nights of restful sleep and restorative nutrition in a safe environment. This philosophy of treatment has served the military well in the more recent conflicts. Symptoms associated with COSR, adjustment difficulties or bereavement may spontaneously remit once the individual assimilates or processes the event, reduces fatigue and replenishes natural defensive processes. Over-pathologizing symptoms in the interim may do more harm than good. Clearly, if the symptoms impair an individual's ability to function in this demanding environment or if they do not remit after a period of rest, clinical intervention is certainly warranted. There is no reason to expose an individual to pain and suffering when medical care could remediate the problem. However, it is also not prudent to assume that a medical treatment is immediately warranted.

Timing of assessment. The PDHA is conducted immediately at the end of the deployment; most often before the servicemember leaves the theater of operation. At this point in time, servicemembers still feel as if they are in the combat environment, even if the threat is reduced. Symptoms associated with PTSD, such as hyperarousal, emotional numbing, trouble sleeping, compartmentalizing or trying to avoid thinking about the combat experience, nightmares and similar thoughts and feelings are not uncommon and may even be adaptive in the high-threat combat environment. To label those symptoms as denoting a disorder may not be appropriate at this time.

Symptoms that present clinically significant distress or functional impairment in the first few days after a traumatic event are generally diagnosed as Acute Stress Disorder. Only when symptoms persist for more than 30 days would PTSD be considered. While it is conceivable that a highly traumatic event could occur early in the deployment that generated symptoms, it is less likely that the nature of the symptoms could be discerned until after the individual left the environment. The timing of the assessment prior to arrival home does not lend itself to clinical diagnosis of PTSD.

Potential risks associated with false positives. No medical intervention is without risks. The general premise of medical practice is that the benefits should outweigh the risks. In terms of PTSD, the risks are associated with potentially issuing a diagnosis of PTSD for an individual who has no diagnosable mental health disorder. Individuals who experience a diagnosable mental health disorder are generally relieved to have a name to put to their symptoms. However, those without a disorder often respond with some anxiety and a sense of foreboding about what this diagnosis will mean to their lives and their military careers. While, for the most part, it is a false perception that mental health treatment will in itself ruin a military career, it is still a widely held perception that generates distress in itself, in addition to the distress associated with any symptoms the individual may have. In making a clinical determination associated with a mental health referral, the risks of false positive must always be weighed against the accuracy of clinical judgment. Watchful waiting may be more appropriate in situations in which the clinician is not sure about a diagnosis or the severity of the symptoms.

Watchful waiting. The concept of watchful waiting is common in medical practice. Symptoms may present for any number of reasons that do not reach clinical significance or cannot be readily diagnosed. Frequently, individuals are provided the advice that they should pay attention to the symptoms and return if they do not dissipate or if they get worse. Watchful waiting is a clinically relevant position to take in the case of PTSD-related symptoms at the point in time at which the PDHA assessment is conducted.

PDHA is not the only avenue to care. The position espoused by GAO in their report hinges on the concern that individuals who need mental health care may not get a referral, and therefore, may not get access to care they need to treat their condition. However, the PDHA is not the only avenue to care available to the veteran or servicemember. As the report indicates, numerous avenues to care are offered to active duty, Reserve, and

separated servicemembers both from DoD and from the VA. The absence of a referral does not preclude access to care.

Education and Clinical Health Risk Communication. PDHRA is a process that includes a mandatory medical threat debrief and benefits briefing and handouts. The medical threat debriefing includes signs and symptoms that may be associated with PTSD or other common deployment-related mental health conditions. It is not the case that PTSD is the primary or the only deployment-related mental health concern. Depression is equally common, equally distressing and clinically treatable. The educational process includes information on how to recognize mental health problems and where to go for help if these concerns arise at any time post-deployment. Since signs and symptoms may not immediately present, and given the fact that servicemembers may be reluctant to recognize or report these symptoms during the PDHA period, education is essential to alert them to things to watch for and what to do when they get back home. Based on recent research (Hoge, et al, JAMA, 2006), a high percentage of land combat troops, both soldiers and Marines, self-refer to mental health care during the first two months after they return home. This information provides a sense of assurance that our servicemembers are listening to the education our clinicians provide and are seeking care through the many avenues available to them rather than relying solely on a referral during the PDHA process.

**GAO DRAFT REPORT – DATED MARCH 20, 2006
(GAO CODE – 290437/GAO-06-397)**

**“POST-TRAUMATIC STRESS DISORDER: DoD Needs to Identify the
Factors Its Providers Use to Make Mental Health Evaluation Referrals for
Servicemembers”**

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATION: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to identify the factors that DoD health care providers use in issuing referrals for further mental health or combat/operational stress evaluations in order to explain provider variation in issuing referrals. (Page 24/GAO Draft Report)

DOD RESPONSE: Concur. The Department generally concurs with this recommendation, but notes that a systematic evaluation of referral patterns is planned for the Post Deployment Health Assessment (PDHA) through the National Quality Management Program (NQMP). In addition, a thorough program evaluation, including a validation of the PDHA and PDHRA (Post-Deployment Health Reassessment) procedures, is already in progress, which will include all the mental health scales and provider referrals arising from use of the information in those scales in their clinical decision-making. The validation study is projected for completion in October 2006.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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