

GAO

Report to the Ranking Democratic
Member, Committee on Veterans'
Affairs, House of Representatives

February 2005

VA HEALTH CARE

VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services



Contents

Letter		1
	Summary	3
	Recommendation for Executive Action	4
	Agency Comments and Our Evaluation	4
Appendix I	Briefing Slides	8
Appendix II	The 24 Special Committee Recommendations in Our Review	41
Appendix III	Scope and Methodology	44
Appendix IV	GAO's Analysis of the Implementation Status of 24 Special Committee Recommendations	46
Appendix V	Comments from the Department of Veterans Affairs	53
Appendix VI	GAO Contact and Staff Acknowledgments	58
	GAO Contact	58
	Acknowledgments	58
Tables		
	Table 1: The Special Committee's Clinical Care and Education Recommendations in Our Review	41
	Table 2: Fourteen Recommendations that GAO Determined Were Partially Met by VA	46
	Table 3: Ten Recommendations that GAO Determined Were Not Met by VA	51

Abbreviations

DOD	Department of Defense
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PTSD	post-traumatic stress disorder
VA	Department of Veterans Affairs

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United States Government Accountability Office
Washington, DC 20548

February 14, 2005

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

Post-traumatic stress disorder (PTSD), which is caused by an extremely stressful event, can develop after military combat and exposure to the threat of death or serious injury. Mental health experts estimate that the intensity of warfare in Iraq and Afghanistan could cause more than 15 percent of servicemembers returning from these conflicts to develop PTSD.^{1,2} Symptoms of PTSD can be debilitating and include insomnia; intense anxiety; and difficulty coping with work, social, and family relationships. Left untreated, PTSD can lead to substance abuse, severe depression, and suicide. Symptoms may appear within months of the traumatic event or be delayed for years. While there is no cure for PTSD, experts believe early identification and treatment of PTSD symptoms may lessen their severity and improve the overall quality of life for individuals with this disorder.

The Department of Veterans Affairs (VA) is a world leader in PTSD treatment and offers PTSD services to eligible veterans. To inform new veterans about the health care services it offers, VA has increased outreach efforts to servicemembers returning from the Iraq and Afghanistan conflicts. Outreach efforts, coupled with expanded access to VA health care for these new veterans, are likely to result in greater numbers of veterans with PTSD seeking VA services.

¹Servicemembers include active duty members of the Army, Marines, Air Force, and Navy and members of the Reserves and National Guard.

²Based on data under the broad definition of PTSD provided in Charles W. Hoge, 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.

Congress highlighted the importance of VA PTSD services more than 20 years ago when it required the establishment of the Special Committee on Post-Traumatic Stress Disorder (Special Committee) within VA, primarily to aid Vietnam-era veterans diagnosed with PTSD.³ A key charge of the Special Committee is to make recommendations for improving VA's PTSD services. The Special Committee issued its first report on ways to improve VA's PTSD services in 1985 and its latest report, which includes 37 recommendations for VA, in 2004.⁴ The Special Committee reports also include evaluations of whether VA has met or not met the recommendations made by the Special Committee in prior reports. We did not conduct an analysis to determine the merits of each recommendation since VA generally concurred in concept with the recommendations made by the Special Committee. In some cases, VA provided further information that it believed would meet the intent of the Special Committee's recommendations.

You asked us to determine whether VA has addressed the Special Committee's recommendations to improve VA's PTSD services. We focused our review on 24 recommendations related to clinical care and education⁵ made by VA's Special Committee on PTSD in its 2004 report to determine (1) the extent to which VA has met each recommendation related to clinical care and education and (2) VA's time frame for implementing each of these recommendations.

To determine the extent to which VA has met each recommendation related to clinical care and education, we (1) reviewed and analyzed the criteria used by the Special Committee to determine whether a recommendation was met and obtained information from members of the Special Committee on the information and process the Special Committee used to designate a recommendation as met, (2) interviewed VA officials

³VA was the Veterans' Administration in 1984.

⁴Department of Veterans Affairs Under Secretary for Health's Special Committee on Post-traumatic Stress Disorder, *Fourth Annual Report of the Department of Veterans Affairs: Under Secretary for Health's Special Committee on Post-traumatic Stress Disorder: 2004*.

⁵We focused on the recommendations related to clinical care and education because implementation of these recommendations most directly affects the provision of PTSD services. We excluded 2 clinical care and education recommendations because one relates to VA's role during a national emergency and the Special Committee stated that the other requires a legislative change in order for VA to fully implement the recommendation. See app. II for a table summarizing each of the 24 Special Committee recommendations included in our review.

responsible for implementing the Special Committee's recommendations to determine the status of each recommendation, and (3) analyzed VA's written responses to each of the recommendations in the Special Committee's 2004 report. We made our determination of the extent to which VA has met each recommendation based on documented evidence that VA has implemented all (fully met) or some (partially met) components of a recommendation, or has not implemented any (not met) components of a recommendation. To determine VA's time frames for implementing each Special Committee recommendation, we (1) determined when the Special Committee initially made the recommendation by reviewing Special Committee reports from 1985 to 2004 and (2) reviewed VA's planning documents, including VA's draft mental health strategic plan. We conducted our review from September 2004 through February 2005 in accordance with generally accepted government auditing standards. On February 1, 2005, we briefed your staff on the results of our work. This letter formally conveys our findings, conclusions, and recommendation provided during the briefing. Appendix I contains the briefing slides, appendix II lists the Special Committee recommendations included in our review, and appendix III contains a more detailed discussion of our scope and methodology.

Summary

In summary, we determined that VA has not fully met any of 24 Special Committee recommendations in our review related to clinical care and education. Specifically, we determined that VA has not met 10 recommendations and has partially met 14 of these 24 recommendations. For example, the Special Committee recommended that VA develop, disseminate, and implement a best practice treatment guideline for PTSD. The Special Committee designated the recommendation as met because VA had developed and disseminated the guideline. However, because we found that VA does not have documentation to show that the treatment part of the guideline is being implemented at its medical facilities and community-based clinics, we designated the recommendation as partially met. We also determined that VA does not plan to fully implement 23 of 24 recommendations until fiscal year 2007 or later. Ten of these are long-standing recommendations that were first made in the Special Committee report issued in 1985.

VA's delay in fully implementing the recommendations raises questions about VA's capacity to identify and treat veterans returning from military combat who may be at risk for developing PTSD, while maintaining PTSD services for veterans currently receiving them. This is particularly important because we reported in September 2004 that officials at six of

seven VA medical facilities stated that they may not be able to meet an increase in demand for PTSD services. In addition, the Special Committee reported in its 2004 report that VA does not have sufficient capacity to meet the needs of new combat veterans while still providing for veterans of past wars. If servicemembers returning from military combat do not have access to PTSD services, many mental health experts believe that the chance may be missed, through early identification and treatment of PTSD, to lessen the severity of the symptoms and improve the overall quality of life for these combat veterans with PTSD. Moreover, VA has identified geographic areas of the country where large numbers of servicemembers are returning from the current conflicts in Iraq and Afghanistan. VA could consider focusing first on ensuring service availability at facilities in areas that are likely to experience the most demand for PTSD services.

Recommendation for Executive Action

To help ensure that VA has the capacity to diagnose and treat veterans returning from the Iraq and Afghanistan conflicts, as well as to maintain these services for other veterans, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to prioritize those recommendations needed to improve PTSD services and to expedite VA's time frames for fully implementing those recommendations.

Agency Comments and Our Evaluation

In commenting on a draft of this report, VA disagreed with our assessment of its progress in implementing the recommendations made by its Special Committee and disagreed with our recommendation. VA stated that our report does not accurately portray the actual provision of PTSD services to veterans by VA over the past 20 years or VA's ability to provide future PTSD services to veterans. VA's comments are reprinted in appendix V. VA also provided technical comments, which we incorporated as appropriate.

VA stated that this report will leave the average reader with the impression that VA's services to veterans with PTSD are woefully inadequate. The adequacy of services was not within the scope of our review. Instead, our analysis addresses the status of VA's implementation of the Special Committee's 24 recommendations and VA's planned time frames for fully implementing them.

VA also said that our report misrepresents VA's ability to provide care to returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. VA cited as evidence its provision of PTSD services to 6,400 OEF and OIF veterans to date, and added that VA has

sufficient capacity because this is a small percentage of the more than 244,000 veterans treated for PTSD in its health care system. We disagree with VA's conclusion. First, we do not know if the 6,400 veterans treated by VA represent all OEF and OIF veterans seeking VA PTSD services. In fact, there could be unmet need because VA's data for the fourth quarter of fiscal year 2004 show that less than half of veterans accessing VA health care are screened for PTSD. Second, although 6,400 veterans is a relatively small percentage of 244,000, VA has not presented evidence of its capacity to absorb increasing numbers of veterans needing treatment for PTSD in the future. Given that we reported in September 2004 that officials at six of seven medical centers told us that they may not be able to meet an increase in demand for PTSD services and that the VA Inspector General found that VA's PTSD capacity data are error-prone and inadequately supported, we believe our report appropriately raises questions about VA's capacity to meet veterans' needs for PTSD services. Moreover, the Special Committee in its 2004 report concluded that "VA must meet the needs of new combat veterans while still providing for veterans of past wars. Unfortunately, VA does not have sufficient capacity to do this. VA PTSD services had been steadily losing capacity even before OEF/OIF began."⁶

VA commented that the co-chairs of the Special Committee reviewed VA's draft mental health strategic plan and concurred that the Special Committee's recommendations are fully addressed in the plan and that the implementation time frames are appropriate. We did not assess whether the Special Committee's recommendations are fully addressed in VA's draft mental health strategic plan. Instead, we relied on VA's comparison of the Special Committee's recommendations and its draft mental health strategic plan to determine the time frames VA targeted for implementation of a recommendation. Moreover, we did not determine whether the time frames targeted in the draft mental health strategic plan for full implementation of the recommendations are appropriate. We found, however, that none of the 24 recommendations included in the Special Committee's 2004 report is fully met—14 recommendations are partially met and 10 recommendations are not met—even though they range from 4 to 20 years old. This continues to concern us in light of the potential increase in demand for PTSD services predicted by mental health experts.

⁶*Fourth Annual Report of the Department of Veterans Affairs: Under Secretary for Health's Special Committee on Post-traumatic Stress Disorder: 2004*, pg. 5.

VA also stated that our report significantly discounts the progress made on each of the Special Committee recommendations and ignores relevant information provided by VA experts. During our exit briefing with VA officials and mental health experts, a co-chair of the Special Committee stated that our findings were a fair representation of the status of the 24 recommendations. Subsequently, VA submitted two letters signed by the Special Committee co-chairs who wrote that our report fails to address the many efforts undertaken by VA and the members of the Special Committee to improve the care delivered to veterans with PTSD. However, some of the efforts cited in the Special Committee co-chairs' letters are included in our analysis of those recommendations that are partially implemented. Other efforts cited by VA and the Special Committee co-chairs address recommendations not within the scope of our review. The two letters signed by the Special Committee co-chairs are reproduced in appendix V.

VA requested that we include, as part of its comments, the Secretary's 2004 Special Committee report transmittal letter to the Ranking Democratic Member, House Committee on Veterans' Affairs, the executive summary, and excerpts from the Special Committee's 2004 report, including the Special Committee's table designating the status of all 37 of its recommendations and the Under Secretary for Health's responses to 7 priority actions. One action is a recommendation included in our review, which the Special Committee highlighted in its 2004 report. However, VA did not include as part of the excerpts its responses to the recommendations we reviewed that the Special Committee designated as not met. We did not reprint this material from VA because we believe our report better captures the status of VA's implementation of the Special Committee's recommendations. To obtain a copy of the Special Committee's 2004 report, contact VA's Office of Public Affairs at (202) 273-6000.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days after its date. We will then send copies of this report to the Secretary of Veterans Affairs and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please call me at (202) 512-7101. Another contact and key contributors are listed in appendix VI.

Sincerely yours,



Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: Briefing Slides



VA HEALTH CARE: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services

Briefing for the Staff of
Representative Lane Evans
Ranking Democratic Member
House Committee on Veterans' Affairs

February 1, 2005



VA HEALTH CARE: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services

- Briefing contents
 - Introduction
 - Objectives
 - Scope and methodology
 - Results in brief
 - Background
 - GAO findings
 - Conclusions
 - Recommendation



Introduction

- Post-traumatic stress disorder (PTSD), which is caused by an extremely stressful event, can develop after military combat and exposure to the threat of death or serious injury. Mental health experts estimate that the intensity of warfare in Iraq and Afghanistan could cause more than 15 percent of servicemembers returning from these conflicts to develop PTSD.^{1, 2}
- Symptoms of PTSD can be debilitating and include insomnia; intense anxiety; and difficulty coping with work, social, and family relationships. Left untreated, PTSD can lead to substance abuse, severe depression, and suicide. Symptoms may appear within months of the traumatic event or be delayed for years.

¹Servicemembers include active duty members of the Army, Marines, Air Force, and Navy and members of the Reserves and National Guard.

²Based on data under the broad definition of PTSD provided in Charles W. Hoge, 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.



Introduction

- While there is no cure for PTSD, mental health experts believe early identification and treatment of PTSD symptoms may lessen their severity and improve the overall quality of life for individuals with this disorder.
- The Department of Veterans Affairs (VA) is a world leader in PTSD treatment and offers PTSD services to eligible veterans. To inform new veterans about the health care services it offers, VA has increased outreach efforts to servicemembers, including members of the National Guard and Reserves,³ returning from the Iraq and Afghanistan conflicts. Outreach efforts, coupled with expanded access to VA health care for these new veterans, are likely to result in a greater number of veterans with PTSD seeking VA services.

³Veterans serving in any conflict after November 11, 1998, are eligible for health care services for 2 years from the date of separation from military service, even if the condition is not determined to be attributable to military service.



Introduction

- In September 2004, we reported that VA does not have a reliable estimate of the total number of veterans it currently treats for PTSD and lacks the information it needs to determine whether it can meet an increased demand for PTSD services.⁴
- We concluded that VA could use demographic data from the Department of Defense (DOD) to estimate which VA medical facilities might experience an increase in demand for PTSD services. We also concluded that in light of experts' predictions on the percentage of returning servicemembers likely to develop PTSD, VA would be able to broadly project the number of returning servicemembers needing VA PTSD services. VA concurred with our conclusions.

⁴GAO, *VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services*, GAO-04-1069 (Washington, D.C.: Sept. 20, 2004).



Introduction

- Congress highlighted the importance of PTSD services more than 20 years ago when it required the establishment of the Special Committee on PTSD (Special Committee) within VA, primarily to aid Vietnam-era veterans diagnosed with PTSD.⁵ A key charge of the Special Committee is to carry out an ongoing assessment of VA's capacity to diagnose and treat PTSD and to make recommendations for improving VA's PTSD services. The Special Committee first issued a report on ways to improve PTSD services in 1985. The Special Committee's 2004 report includes 37 recommendations to improve VA's PTSD services in the areas of clinical care, education, research, and benefits.⁶
- In 2004, you asked us to determine whether VA has addressed the Special Committee's recommendations to improve its PTSD services.

⁵Veterans' Health Care Act of 1984, Pub. L. No. 98-528, § 110(b)(1), 98 Stat. 2686, 2691.

⁶All 37 recommendations in the Special Committee's 2004 report were included in prior Special Committee reports.



Objectives

- We focused our review on 24 recommendations related to clinical care and education⁷ made by VA's Special Committee on PTSD in its 2004 report to determine
 - 1) the extent to which VA has met each recommendation related to clinical care and education and
 - 2) VA's time frame for implementing each of these recommendations.

⁷The Special Committee's 2004 report designated 26 of 37 recommendations as PTSD clinical care and education issues. We excluded 2 of 26 recommendations, however, because one relates to VA's role during a national emergency and the Special Committee stated that the other requires a legislative change in order for VA to fully implement the recommendation. See app. II for a list of the 24 Special Committee recommendations included in our review.



Scope and Methodology

- To determine the extent to which VA met each of the Special Committee's recommendations in the areas of clinical care and education, we
 - reviewed and assessed the information and process used by the Special Committee to determine whether a recommendation was met and obtained information from members of the Special Committee on the process it used to designate a recommendation as met,
 - interviewed VA officials responsible for implementing the Special Committee's recommendations to determine the status of each recommendation, and
 - analyzed VA's written responses to recommendations in the Special Committee's 2004 report.
-



Scope and Methodology

- Unlike the Special Committee, which used two categories—met or not met—to designate the implementation status of each recommendation, we made our determinations based on the following three categories:
 - Fully met—VA has documented evidence that it has fully implemented all components of a recommendation.
 - Partially met—VA has documented evidence that it has implemented some but not all components of a recommendation.
 - Not met—VA has not implemented any components of a recommendation.
 - We did not conduct an analysis to determine the merits of each recommendation since VA generally concurred in concept with the recommendations made by the Special Committee. In some cases, VA provided further information that it believed would meet the intent of the Special Committee’s recommendations.
-



Scope and Methodology

- To determine VA's time frame for implementing each Special Committee recommendation, we
 - determined when the Special Committee initially made each of 24 recommendations in the 2004 Special Committee report by reviewing Special Committee reports from 1985 to 2004 and
 - reviewed VA's planning documents, including VA's draft mental health strategic plan, which addresses PTSD services.
 - Our work was conducted from September 2004 through February 2005 in accordance with generally accepted government auditing standards. See appendix III for a more detailed discussion of our scope and methodology.
-



Results in Brief

- We determined that VA has not fully met any of the Special Committee's 24 recommendations related to clinical care and education in our review, but has partially met 14 of the 24 recommendations.
 - Additionally, our analysis shows that VA may not fully implement 23 of 24 recommendations until fiscal year 2007 or later.
 - Ten of the 24 recommendations are long-standing and were first made in the Special Committee's 1985 report. Based on VA's targeted time frames in its draft mental health strategic plan, which includes PTSD services, it may take VA until fiscal year 2007 or later to implement recommendations that it agreed 20 years ago were needed to improve the provision of PTSD services to veterans.
-



Results in Brief

- VA officials have cited resource constraints as the primary reason for not implementing many of the recommendations.



Background

- Congress required the establishment of VA's Special Committee on PTSD in 1984.
 - The Special Committee consists of VA PTSD experts and is charged with
 - assessing VA's capacity to diagnose and treat veterans with PTSD;
 - advising VA on the development of policies and providing guidance and coordination of services related to the diagnosis and treatment of PTSD; and
 - providing guidance on VA's education, employee training, and research regarding PTSD.
-



Background

- Since 1985, the Special Committee has issued 15 reports containing numerous recommendations to improve VA's PTSD services.⁸
- Although VA is not statutorily required to implement the Special Committee's recommendations, VA is required to review the recommendations and forward VA's written comments on the recommendations, if any, to the House and Senate Committees on Veterans' Affairs.
 - VA has generally concurred in concept with the recommendations made by the Special Committee. In some cases, VA provided further information that it believed would meet the intent of the Special Committee's recommendations.

⁸The Special Committee did not issue a report in every year.



Background

- In July 2004, VA drafted a mental health strategic plan that, according to VA, includes PTSD services and will serve as a guide to the future course of VA mental health services.⁹ The plan, though reviewed by VA's Secretary, has not been officially approved pending review by the Office of Management and Budget.

⁹According to VA, its July 2004 draft mental health strategic plan was developed in response to recommendations in a July 2003 report by the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

- We determined that VA has not fully met any of the Special Committee's 24 recommendations related to clinical care and education.¹⁰
 - Specifically, we found that VA has partially met 14 recommendations and not met 10 recommendations.

¹⁰See app. IV for summary information on the current implementation status of the Special Committee's 24 recommendations included in our review.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

- We determined 10 of 24 recommendations were not met because VA has not fully implemented any components of the recommendations.
 - The Special Committee designated 12 recommendations as not met.
- We determined 14 recommendations were partially met because VA has implemented at least some component of each recommendation.
 - The Special Committee did not categorize any recommendations as partially met, but instead designated recommendations as met if VA had taken any action to implement them.
 - For example, the Special Committee recommended that VA develop, disseminate, and implement a treatment guideline for PTSD. We determined the recommendation was partially met because VA does not have documentation that shows the treatment part of the guideline is being implemented. The Special Committee designated the recommendation as met because VA had completed two components of the recommendation—development and dissemination of the guideline.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

- We determined that VA has partially met 14 of the 24 Special Committee recommendations related to PTSD clinical care and education.

Recommendation	GAO analysis of VA's actions not completed
Develop and implement procedures to prevent closure of PTSD programs without authorization from VA headquarters	We determined these recommendations were partially met because VA headquarters has not received any closure requests, yet VA data shows that in at least two instances, VA facilities did not follow procedures and closed PTSD programs without authorization in fiscal year 2003. Moreover, VA does not know whether these facilities have reinvested resources from the closed PTSD programs into other PTSD programs.
Reinvest resources from closed PTSD programs into other PTSD programs	
Improve VA collaboration with DOD on PTSD education	We determined this recommendation was partially met because although VA and DOD collaborated to develop educational materials, such as the PTSD clinical practice guideline, VA and DOD are still formalizing their future plans for PTSD education.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

Recommendation	GAO analysis of VA's actions not completed
Implement a network director performance measure on PTSD capacity	We determined this recommendation was partially met because VA cites its annual report on capacity to provide PTSD services as support for meeting this recommendation. However, the annual report on capacity does not address the care delivered to all veterans treated by VA for PTSD. In addition, the VA Inspector General found that data supporting the number of VA specialized PTSD programs are incorrect.
Coordinate PTSD care with VA community-based clinics	We determined this recommendation was partially met because a VA official acknowledged that they need to develop referral mechanisms to provide PTSD services when these services are not available at VA community-based clinics. In addition, although VA developed and disseminated a clinical practice guideline for PTSD, VA does not have documentation to show the extent of treatment provided in accordance with the guideline at VA medical facilities and community-based clinics.
Provide increased access to PTSD services	We determined this recommendation was partially met because although VA has increased the number of veterans it treats for PTSD, it has not developed referral mechanisms in all community-based clinics that do not offer mental health services.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

Recommendation	GAO analysis of VA's actions not completed
Develop and implement an integrated clinical approach for assisting aging veterans with PTSD	We determined this recommendation was partially met because VA's study conducted to determine the access that aging veterans have to primary care, including veterans with PTSD, was the first step toward developing an integrated approach for assisting aging veterans with PTSD. However, VA has not implemented this integrated approach.
Recognize specialized PTSD programs as an important component of care	We determined this recommendation was partially met because VA is collecting data on the results of its efforts to annually screen all veterans to identify those at risk for PTSD. However, VA's Office of Quality and Performance told us that VA uses the data on PTSD screening as a supporting indicator, an interim step in the development of a performance measure. Research shows that quality is highest in areas where VA has established performance measures and actively monitors performance. VA cites its annual report on capacity to provide PTSD services as support for meeting this recommendation. However, the annual report on capacity does not address the care delivered to all veterans treated by VA for PTSD. VA has recently demonstrated the importance of PTSD programs through, for example, adding 50 positions at Vet Centers to be filled by veterans from the current conflicts to perform outreach and requiring community-based clinics treating more than 1,500 veterans to provide mental health services.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

Recommendation	GAO analysis of VA’s actions not completed
Develop more effective treatment approaches for veterans with PTSD and coexisting substance abuse	We determined these recommendations were partially met because the existing clinical practice guideline addresses two of these issues—PTSD and coexisting substance abuse and the rehabilitation approach (recovery model)—to some extent. Treatment approaches are now being developed and evaluated for veterans with PTSD and coexisting substance abuse and VA needs to continue its efforts to implement the recovery model through training of staff on this approach to PTSD treatment. The clinical practice guideline mentions a few special needs of the aging veteran and veterans in various cultural groups and special populations, such as women and the homeless. In addition, other educational materials are available for clinicians on a VA Web site.
Develop and implement a rehabilitation approach to PTSD and coexisting conditions	
Develop guidelines for aging veterans, various cultural groups, and other special populations	



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

Recommendation	GAO analysis of VA’s actions not completed
Develop, disseminate, and implement a best practice treatment guideline for PTSD	We determined these recommendations were partially met because although VA developed and disseminated a clinical practice guideline for PTSD, it does not have documentation to show that the clinical practice guideline, specifically the treatment part of the guideline, is being implemented at VA medical facilities and community-based clinics. Additionally, VA does not have documentation to show that its community-based clinics have developed referral mechanisms for veterans who need PTSD services when those services are not available. However, VA has started collecting data to monitor use of one of the assessment tools for PTSD in the clinical practice guideline—a four-question screening tool. VA’s fourth quarter data for fiscal year 2004 indicate that 47 percent of veterans were screened for PTSD using this tool. However, this calculation includes those already diagnosed with PTSD.
Establish a PTSD screening and referral mechanism in every VA community-based clinic	
Develop and implement a national standardized set of tools for assessment of PTSD	

Source: GAO.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

- We determined that VA has not met 10 of the 24 Special Committee recommendations related to PTSD clinical care and education.
 1. Provide sustained treatment settings for PTSD and coexisting psychiatric and medical conditions.
 2. Extend efforts to monitor productivity and quality of specialized services across the PTSD continuum of care.
 3. Utilize Vet Center appointments to satisfy VA performance standards for PTSD follow-up care.
 4. Expand PTSD treatment to include family assessment and treatment services.
 5. Designate a PTSD coordinator in each VA network.¹¹

¹¹VA medical facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, that were structured to manage and allocate resources to VA medical facilities.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

6. Improve VA medical facility and Vet Center collaboration.
 7. Develop a national PTSD education plan for VA.
 8. Develop credentialing standards for VA clinicians specializing in PTSD.
 9. Establish electronic clinical records that follow veterans across VA's system of care.
 10. Improve the continuum of care for PTSD.
- The Special Committee designated 12 recommendations as not met.¹²

¹²The Special Committee designated the following two recommendations as not met: provide increased access to PTSD services and improve VA collaboration with DOD on PTSD education. We determined that these two recommendations were partially met.



VA Has Not Fully Met Any of the 24 Special Committee Recommendations

- VA officials have cited resource constraints as the primary reason for not implementing many of the recommendations.



VA Does Not Plan to Fully Implement Many Special Committee Recommendations until Fiscal Year 2007 or Later

- We determined that based on the time frames in VA's draft mental health strategic plan, 23 of the 24 recommendations may not be fully implemented until fiscal year 2007 or later. The remaining recommendation is targeted for full implementation by fiscal year 2005, 4 years after the Special Committee first recommended it.¹³

¹³See app. IV for VA's implementation time frames.



VA Does Not Plan to Fully Implement Many Special Committee Recommendations until Fiscal Year 2007 or Later

- Ten of the 24 recommendations are long-standing recommendations consistent with recommendations first made in 1985. They are not scheduled for full implementation until fiscal year 2007 or later, even though VA agreed 20 years ago that these recommendations would improve the provision of PTSD services to veterans.
 1. Develop and implement a national standardized set of tools for assessment of PTSD.
 2. Establish electronic clinical records that follow veterans across VA's system of care.
 3. Improve the continuum of care for PTSD.¹⁴
 4. Improve VA medical facility and Vet Center collaboration.
 5. Provide increased access to PTSD services.
 6. Develop a national PTSD education plan for VA.
 7. Extend efforts to monitor productivity and quality of specialized services across the PTSD continuum of care.
 8. Develop more effective treatment approaches for veterans with PTSD and coexisting substance abuse.
 9. Improve VA collaboration with DOD on PTSD education.
 10. Develop, disseminate, and implement the best practice treatment guideline for PTSD.

¹⁴VA targeted this recommendation for full implementation in fiscal year 2006 or 2007.



VA Does Not Plan to Fully Implement Many Special Committee Recommendations until Fiscal Year 2007 or Later

- The other 14 recommendations we reviewed appeared for the first time in the Special Committee's 2001 report.
 - VA may take up to 6 years or longer to fully implement 13 of these 14 recommendations (fiscal years 2001-2007).
 - VA may take up to 4 years to fully implement 1 of these 14 recommendations (fiscal years 2001-2005).
 1. Provide sustained treatment settings for PTSD and coexisting psychiatric and medical conditions.



VA Does Not Plan to Fully Implement Many Special Committee Recommendations until Fiscal Year 2007 or Later

- The 13 recommendations VA may take up to 6 years or more to fully implement:
 1. Develop and implement procedures to prevent closure of PTSD programs without authorization from VA headquarters.
 2. Reinvest resources from closed PTSD programs into other PTSD programs.
 3. Implement a network director performance measure on PTSD capacity.
 4. Coordinate PTSD care with VA community-based clinics.
 5. Establish a PTSD screening and referral mechanism in every VA community-based clinic.
 6. Develop and implement an integrated clinical approach for assisting aging veterans with PTSD.
-



VA Does Not Plan to Fully Implement Many Special Committee Recommendations until Fiscal Year 2007 or Later

7. Recognize specialized PTSD programs as an important component of care.
8. Develop and implement a rehabilitation approach to PTSD and coexisting conditions.
9. Develop guidelines for aging veterans, various cultural groups, and other special populations.
10. Utilize Vet Center appointments to satisfy VA performance standards for PTSD follow-up care.
11. Expand PTSD treatment to include family assessment and treatment services.
12. Designate a PTSD coordinator in each VA network.
13. Develop credentialing standards for VA clinicians specializing in PTSD.



Conclusions

- VA has not fully implemented any of the 24 Special Committee recommendations.
 - VA's delay in fully implementing the recommendations raises questions about VA's capacity to identify and treat veterans returning from the Iraq and Afghanistan conflicts who may be at risk for developing PTSD, while maintaining PTSD services for veterans currently receiving them.
 - Moreover, VA outreach efforts, coupled with expanded access to VA health care for many new combat veterans, could result in a greater number of veterans with PTSD seeking VA services.
-



Conclusions

- It is critical that VA's PTSD services be available when servicemembers return from military combat, particularly since mental health experts believe that early identification and treatment of PTSD may lessen the severity of the symptoms and improve the overall quality of life for individuals with PTSD.
 - Moreover, VA has identified geographic areas of the country where large numbers of servicemembers are returning from the Iraq and Afghanistan conflicts. VA could consider focusing first on ensuring service availability at facilities in areas that are likely to experience the most demand for PTSD services.
-



Recommendation

- To help ensure that VA has the capacity to diagnose and treat veterans returning from the Iraq and Afghanistan conflicts, as well as to maintain these services for other veterans, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to prioritize those recommendations needed to improve PTSD services and to expedite VA's time frames for fully implementing those recommendations.

Appendix II: The 24 Special Committee Recommendations in Our Review

The Special Committee’s 2004 report contains 37 recommendations related to PTSD clinical care, education, research, and benefits. We focused our review on 24 of the 26 recommendations that the Special Committee designated as clinical care and education issues. We excluded 2 of the 26 recommendations because one relates to VA’s role during a national emergency and the Special Committee stated that the other requires a legislative change in order for VA to fully implement the recommendation. Table 1 lists the 24 recommendations in our review.

Table 1: The Special Committee’s Clinical Care and Education Recommendations in Our Review

Recommendation short title	Special Committee recommendation
Recognize specialized PTSD programs as an important component of care	VA should recognize specialized PTSD programs as a critically important component of VA expertise and service. In addition to meeting a core need of VA (provision of mental health services for veterans suffering from PTSD, which is the single most prevalent mental disorder arising from combat), these programs maintain America’s readiness to deal with survivors of future wars, disasters, and acts of terrorism and mass destruction.
Develop and implement procedures to prevent closure of PTSD programs without authorization from VA headquarters	VA headquarters needs to develop, announce, and apply clear and prompt consequences when VA network leaders close PTSD programs without VA headquarters authorization.
Reinvest resources from closed PTSD programs into other PTSD programs	VA should establish systemwide administrative mechanisms to ensure that when PTSD programs are closed, the resources freed up by the closure are reinvested in other PTSD programs. This will ensure that VA does not reduce its capacity to treat PTSD.
Implement a VA network director performance measure on PTSD capacity	The Committee will work with VA headquarters officials to develop a network director’s performance measure aimed at maintaining capacity to treat PTSD within each network and ensuring that PTSD resources, when reassigned, remain within the PTSD continuum of care.
Develop and implement a national standardized set of tools for assessment of PTSD	VA should develop and implement a national standardized set of tools for assessment of PTSD.
Establish a PTSD screening and referral mechanism in every VA community-based clinic	Every VA community-based clinic should have a PTSD screening mechanism in place and should define how veterans who screen positive for PTSD will gain access to PTSD services.
Establish electronic clinical records that follow veterans across VA’s system of care	The clinical database derived from the standardized assessment tools and the medical record of the veteran with PTSD must follow the veteran across the VA system. The Committee should work with VA medical record specialists and computer experts to develop a system for sharing pertinent clinical data across the entire PTSD continuum of care, including Vet Centers.
Improve the continuum of care for PTSD	The present continuum of care established to treat PTSD in VA needs better coordination and further refinement, which should include early identification and intervention; assessment, triage, and referral; acute stabilization and intervention (including option for hospitalization in a general psychiatric unit or a specialty PTSD unit as clinically appropriate); treatment and rehabilitation, involving short- or longer-term care on an outpatient or residential basis; and other outpatient care, encompassing continuing care, monitoring, and relapse prevention for those who also have substance use disorders.

**Appendix II: The 24 Special Committee
Recommendations in Our Review**

Recommendation short title	Special Committee recommendation
Provide sustained treatment settings for PTSD and coexisting psychiatric and medical conditions	Because PTSD is a chronic condition with frequent coexisting psychiatric and medical conditions, sustained treatment settings of varying intensities are required.
Utilize Vet Center appointments to satisfy VA performance standards for PTSD follow-up care	Vet Center appointments should satisfy VA performance standards for follow-up care.
Improve VA medical facility and Vet Center collaboration	VA medical facilities and Vet Centers need to work together to ensure full collaboration in the service of veterans with PTSD. The Committee recognizes the unique contributions of VA medical facilities and Vet Centers and the critical importance of maintaining their distinct identities. At the same time, we advocate innovations, including (but not limited to) a common PTSD database for each veteran with PTSD, joint access to clinical notes relevant to PTSD treatment across the two systems, and joint assessment of local and national needs within each system that could be addressed by sharing clinical resources through such programs as collocation and telemedicine.
Develop, disseminate, and implement best practice treatment guidelines for PTSD	VA should disseminate and implement “best practice” PTSD treatment guidelines.
Develop PTSD guidelines for aging veterans, various cultural groups, and other special populations	VA should develop special guidelines for work with aging veterans; for ethnic and cultural groups shown to have different risks and needs with respect to PTSD; for veterans of peacekeeping missions; for female and male survivors of sexual and other noncombat trauma in the military; and for other populations for whom specific needs are identified.
Develop more effective treatment approaches for veterans with PTSD and coexisting substance abuse	More effective treatment approaches are needed for veterans with PTSD and coexisting substance abuse. These include improved methods of identifying PTSD among substance abusers.
Develop and implement a rehabilitation approach to PTSD and coexisting conditions	In addition to aiming at decreasing PTSD severity, treatment efforts should be directed toward decreasing the effects of coexisting conditions, improving function, and improving social support systems. This “rehabilitation” perspective (recovery model) is more appropriate in dealing with a chronic and complex disorder.
Develop and implement an integrated clinical approach for assisting aging veterans with PTSD	The medical problems of our aging population of veterans with PTSD require an integrated approach of primary care, geriatric, and PTSD experts.
Coordinate PTSD care with VA community-based clinics	VA needs to improve coordination of care between specialized PTSD programs and VA clinics, including community-based clinics. The goal is to improve health habits and to identify and manage coexisting medical disorders. This will improve health-related quality of life and lower unnecessary health care costs.
Provide increased access to PTSD services	VA needs to increase access to PTSD services. This can be facilitated through the continued expansion of Vet Centers, community-based clinics (with specialized PTSD services), and telemedicine services into underserved geographic areas.
Extend efforts to monitor productivity and quality of specialized services across the PTSD continuum of care	VA should extend its efforts to monitor the productivity and quality of specialized PTSD services across the PTSD continuum of care, including measures of functionality, quality of life, and social support.
Expand PTSD treatment to include family assessment and treatment services	VA must expand the focus of PTSD treatment to include family assessment and intervention, in order to help veterans and their families deal with the symptoms of PTSD.
Develop a national PTSD education plan for VA	VA should create a national PTSD education plan for VA staff with consistent access across the system.
Develop credentialing standards for VA clinicians specializing in PTSD	VA should develop multidisciplinary credentialing standards for VA clinicians specializing in PTSD.

**Appendix II: The 24 Special Committee
Recommendations in Our Review**

Recommendation short title	Special Committee recommendation
Improve VA collaboration with DOD on PTSD education	VA should improve educational collaboration with DOD.
Designate a PTSD coordinator in each VA network	VA should designate a PTSD coordinator in each VA network to ensure implementation of the PTSD continuum of care in each network.

Source: VA Special Committee on PTSD.

Appendix III: Scope and Methodology

VA's Special Committee on PTSD has submitted 15 reports to Congress since 1985 with recommendations on how VA could improve the provision of PTSD services to veterans. In its 2004 report, the Special Committee made 37 recommendations to VA related to PTSD clinical care, education, research, and benefits. Twenty-six of these recommendations relate to PTSD clinical care and education. We focused our review on 24 of these 26 recommendations and excluded 2 recommendations because one relates to VA's role during a national emergency and the Special Committee stated that the other requires a legislative change in order for VA to fully implement the recommendation. Our objectives were to determine (1) the extent to which VA has met each recommendation related to clinical care and education and (2) VA's time frame for implementing each of these recommendations.

To determine the extent to which VA has met each recommendation related to clinical care and education, we reviewed the Special Committee's 2004 report to determine whether the Special Committee had designated a recommendation as having been met or not met, and interviewed members of the Special Committee to determine the information and process they used to make a designation. We also reviewed VA policy documents, memorandums, and reports related to VA's provision of PTSD services, including reports by the VA Inspector General. Furthermore, we analyzed VA's written responses to recommendations contained in the Special Committee's 2004 report and interviewed VA officials responsible for implementing the recommendations and DOD officials responsible for working on joint VA/DOD efforts recommended by the Special Committee.

Based on our review of VA documents and our discussions with VA officials, we determined that the information we obtained was sufficient to analyze the extent to which VA met each recommendation. We did not conduct an analysis to determine the merits of each recommendation since VA generally concurred in concept with the recommendations made by the Special Committee. In some cases, VA provided further information that it believed would meet the intent of the Special Committee's recommendations. Unlike the Special Committee, which used two categories—met or not met—to designate the implementation status of each recommendation, we made our determinations based on the following three categories:

- Fully met. We determined that a recommendation was fully met if VA has documented evidence that it has fully implemented all components of a recommendation.

- Partially met. We determined that a recommendation was partially met if VA has documented evidence that it has implemented some but not all components of a recommendation.
- Not met. We determined that a recommendation was not met if VA has not implemented any components of a recommendation.

We decided the implementation status of each recommendation by determining whether any of the components of the recommendation had been fully implemented. For example, the components for one recommendation—to improve VA medical facility and Vet Center collaboration—include a common database for veterans with PTSD, joint access to clinical notes across the two systems, and a joint medical center and Vet Center assessment of local and national needs within each system that could be addressed by sharing resources through collocation and telemedicine. All three components of this recommendation had to be fully implemented for us to make a determination that the recommendation was fully met; one of the three components had to be fully implemented for a determination of partially met; and if none of the components were fully implemented, we determined that the recommendation was not met.

To determine VA's time frames for implementing each of 24 Special Committee recommendations in our review, we analyzed 15 Special Committee reports from 1985 to 2004 to determine when a recommendation was first made.¹ We also reviewed VA planning documents, including its draft mental health strategic plan, which contains VA's planned activities and associated targeted time frames to improve mental health services, including those for PTSD.² We obtained VA's comparison of the recommendations in the Special Committee's 2004 report with the planned activities and their associated time frames in VA's draft mental health strategic plan. We used this comparison to determine the time frames that VA had targeted to implement each recommendation. We calculated the total number of years it may take VA to implement a recommendation as the difference between the date the recommendation was first made and the date targeted for full implementation in VA's draft mental health strategic plan.

Our work was conducted from September 2004 through February 2005 in accordance with generally accepted government auditing standards.

¹The Special Committee did not issue a report in every year.

²We reviewed a draft of VA's mental health strategic plan dated July 2004.

Appendix IV: GAO's Analysis of the Implementation Status of 24 Special Committee Recommendations

This appendix summarizes our analysis of the extent to which VA has met each of 24 clinical care and education recommendations included in our review. Table 2 provides information on the 14 recommendations that we determined were partially met by VA because VA has implemented some component of each recommendation. Table 3 provides information on the 10 recommendations we determined that VA has not met because VA has not fully implemented any component of the recommendation.

Table 2: Fourteen Recommendations that GAO Determined Were Partially Met by VA

Recommendation	Year recommendation initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO analysis of VA's actions not completed
Develop and implement procedures to prevent closure of PTSD programs without authorization from VA headquarters	2001	2006-2007	We determined these recommendations were partially met because VA headquarters has not received any closure requests, yet VA data shows that in at least two instances VA facilities did not follow procedures and closed PTSD programs without authorization in fiscal year 2003. Moreover, VA does not know whether these facilities have reinvested resources from the closed PTSD programs into other PTSD programs. The Special Committee designated these recommendations as met because VA issues an annual report on its capacity to provide specialized PTSD programs for seriously mentally ill veterans, a subset of the veterans receiving VA PTSD services.
Reinvest resources from closed PTSD programs into other PTSD programs	2001	2006-2007	We determined this recommendation was partially met because VA's study conducted to determine the access that aging veterans have to primary care, including veterans with PTSD, was the first step toward developing an integrated approach for assisting aging veterans with PTSD. However, VA has not implemented this integrated approach. The Special Committee designated this recommendation as met because the study was completed.
Develop and implement an integrated clinical approach for assisting aging veterans with PTSD	2001	2008 or later	

**Appendix IV: GAO's Analysis of
the Implementation Status of 24
Special Committee
Recommendations**

Recommendation	Year recommendation initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO analysis of VA's actions not completed
Implement a VA network director performance measure on PTSD capacity	2001	2006-2007	We determined this recommendation was partially met because VA cites its annual report on capacity to provide PTSD services as support for meeting this recommendation. However, the annual report on capacity does not address the care delivered to all veterans treated by VA for PTSD. In addition, the VA Inspector General found that data supporting the number of VA specialized PTSD programs are incorrect. The Special Committee designated this recommendation as met because VA issues an annual report on its capacity to provide specialized PTSD programs for seriously mentally ill veterans, a subset of the veterans receiving VA PTSD services.
Coordinate PTSD care with VA community-based clinics	2001	2008 or later	We determined this recommendation was partially met because a VA official acknowledged that they need to develop referral mechanisms to provide PTSD services when these services are not available at VA community-based clinics. In addition, although VA developed and disseminated a clinical practice guideline for PTSD, VA does not have documentation to show the extent of treatment provided in accordance with the guideline at VA medical facilities and community-based clinics. The Special Committee designated this recommendation as met because VA developed and disseminated the clinical practice guideline for PTSD.

**Appendix IV: GAO's Analysis of
the Implementation Status of 24
Special Committee
Recommendations**

Recommendation	Year recommendation initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO analysis of VA's actions not completed
Develop, disseminate, and implement best practice treatment guidelines for PTSD	2001	2006-2007	We determined these recommendations were partially met because although VA has developed and disseminated a clinical practice guideline for PTSD, it does not have documentation to show that the clinical practice guideline, specifically the treatment part of the clinical practice guideline, is being implemented at VA medical facilities and community-based clinics. Additionally, VA does not have documentation to show that its community-based clinics have developed referral mechanisms for veterans who need PTSD services when those services are not available. However, VA has started collecting data to monitor use of one of the assessment tools for PTSD in the clinical practice guideline—a four-question screening tool. VA's fourth quarter data for fiscal year 2004 indicate that 47 percent of veterans were screened for PTSD using this tool. However, this calculation includes those already diagnosed with PTSD. The Special Committee designated these recommendations as met because the clinical practice guideline on PTSD that includes standardized assessment tools for PTSD was developed and disseminated at VA medical facilities and community-based clinics.
Establish a PTSD screening and referral mechanism in every VA community-based clinic	1985	2008 or later	
Develop and implement a national standardized set of tools for assessment of PTSD	1985	2008 or later	

**Appendix IV: GAO's Analysis of
the Implementation Status of 24
Special Committee
Recommendations**

Recommendation	Year recommendation initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO analysis of VA's actions not completed
Recognize specialized PTSD programs as an important component of care	2001	2006-2007	We determined this recommendation was partially met because VA is collecting data on the results of its efforts to annually screen all veterans to identify those at risk for PTSD. However, VA's Office of Quality and Performance told us that VA uses the data on PTSD screening as a supporting indicator, an interim step in the development of a performance measure. Research shows that quality is highest in areas where VA has established performance measures and actively monitors performance. VA cites its annual report on capacity to provide PTSD services as support for meeting this recommendation. However, the annual report on capacity does not address the care delivered to all veterans treated by VA for PTSD. VA has recently demonstrated the importance of PTSD programs through, for example, adding 50 positions at Vet Centers to be filled by veterans from the current conflicts to perform outreach and requiring community-based clinics treating more than 1,500 veterans to provide mental health services. The Special Committee designated this recommendation as met because VA issues an annual report on its capacity to provide PTSD services to seriously mentally ill veterans, a subset of veterans receiving VA PTSD services.
Improve collaboration with DOD on PTSD education	1985	2008 or later	We determined this recommendation was partially met because although VA and DOD collaborated to develop educational materials, such as the PTSD clinical practice guideline, VA and DOD are still formalizing their future plans for PTSD education. The Special Committee designated this recommendation as not met because VA has not provided a list of all the joint VA/DOD ongoing educational efforts and has not provided information on its plans for improving its collaboration on PTSD with DOD.
Develop more effective treatment approaches for veterans with PTSD and coexisting substance abuse	1985	2008 or later	We determined these recommendations were partially met because the existing clinical practice guideline addresses two of these issues—PTSD and coexisting substance abuse and the rehabilitation approach (recovery model)—to some extent. Treatment approaches are now being developed and evaluated for veterans with PTSD and coexisting substance abuse and VA needs to continue its efforts to implement the recovery
Develop and implement a rehabilitation approach to PTSD and coexisting conditions	2001	2008 or later	

**Appendix IV: GAO's Analysis of
the Implementation Status of 24
Special Committee
Recommendations**

Recommendation	Year recommendation initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO analysis of VA's actions not completed
Develop PTSD guidelines for aging veterans, various cultural groups, and other special populations	2001	2008 or later	model through training of staff on this approach to PTSD treatment. The clinical practice guideline mentions a few special needs of the aging veteran and veterans in various cultural groups and special populations, such as women and the homeless. In addition, other educational materials are available for clinicians on a VA Web site. The Special Committee designated these recommendations as met because VA developed and disseminated the PTSD clinical practice guideline.
Provide increased access to PTSD services	1985	2008 or later	We determined this recommendation was partially met because although VA has increased the number of veterans it treats for PTSD, it has not developed referral mechanisms in all community-based clinics that do not offer mental health services. The Special Committee designated this recommendation as not met because PTSD services are not widely available in VA's community-based clinics.

Source: GAO analysis.

**Appendix IV: GAO's Analysis of
the Implementation Status of 24
Special Committee
Recommendations**

Table 3: Ten Recommendations that GAO Determined Were Not Met by VA

Recommendation	Year recommendagtion initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO's analysis actions not completed
Provide sustained treatment settings for PTSD and coexisting psychiatric and medical conditions	2001	2004-2005	We agree with the Special Committee that this recommendation is not met because VA has not established a mechanism to ensure the continuity of treatment across various treatment settings for veterans with PTSD. Further, not all community-based clinics have mental health services available or referral mechanisms in place to ensure that veterans who need specialized PTSD treatment services are transferred to these settings. We also reported in September 2004 that not all veterans may have access to PTSD services because officials at six of seven VA medical facilities we visited stated that they may not be able to meet an increase in demand for PTSD services.
Extend efforts to monitor productivity and quality of specialized services across the PTSD continuum of care	1985	2008 or later	We agree with the Special Committee that this recommendation is not met because according to VA's response to the Special Committee's 2004 report, VA has developed a functional measure, which is expected to include a scale for quality of life and social support, but has not completed the testing of this new measure. Although VA collects information on employment status and incidents of violent behavior for veterans treated for PTSD, it does not collect data on other measures of functionality and productivity, such as the amount of social support a veteran receives from community sources.
Expand PTSD treatment to include family assessment and treatment services	2001	2008 or later	We agree with the Special Committee that this recommendation is not met because VA has not developed or implemented a plan to provide services to the families of veterans with PTSD at VA medical facilities.
Improve VA medical facility and Vet Center collaboration	1985	2008 or later	We agree with the Special Committee that this recommendation is not met because VA medical facilities and Vet Centers do not have a common database for veterans with PTSD, do not have joint access to clinical notes across the two systems, and have not completed a joint assessment of local and national needs within each system that could be addressed by sharing resources by collocation and telemedicine.

**Appendix IV: GAO's Analysis of
the Implementation Status of 24
Special Committee
Recommendations**

Recommendation	Year recommendagtion initially made by Special Committee	VA's targeted time frame (fiscal year) for implementing planned actions associated with recommendation	GAO's analysis actions not completed
Establish electronic clinical records that follow veterans across VA's system of care	1985	2008 or later	We agree with the Special Committee that this recommendation is not met because VA medical facilities and Vet Centers maintain separate clinical records. Medical facility staff cannot electronically access Vet Center clinical records.
Designate a PTSD coordinator in each VA network	2001	2008 or later	We agree with the Special Committee that this recommendation is not met because VA has not assigned PTSD coordinators in its networks.
Improve the continuum of care for PTSD	1985	2006-2007	We agree with the Special Committee that this recommendation is not met because VA has not developed or implemented a plan of action to improve the continuum of care for PTSD.
Develop a national PTSD education plan for VA	1985	2008 or later	We agree with the Special Committee that this recommendation is not met because VA has not developed a comprehensive national education plan for VA staff. Furthermore, our analysis shows that while VA has undertaken various educational initiatives, these do not constitute a national approach as recommended by the Special Committee.
Develop credentialing standards for VA clinicians specializing in PTSD	2001	2008 or later	We agree with the Special Committee that this recommendation is not met because VA has not developed credentialing standards for its clinicians specializing in PTSD.
Utilize Vet Center appointments to satisfy VA performance standards for PTSD follow-up care	2001	2008 or later	We agree with the Special Committee that this recommendation is not met because VA has not modified its performance standard to allow Vet Center appointments to satisfy the VA requirement for follow-up care.

Source: GAO analysis.

Appendix V: Comments from the Department of Veterans Affairs



THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 8, 2005

Ms. Cynthia A. Bascetta
Director
Health Care Team
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA HEALTH CARE: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services***, (GAO-05-287). As the report acknowledges, VA is a world leader in treating post-traumatic stress disorder (PTSD). Regrettably this fact is lost by GAO's uneven depiction of the Department's achievements in PTSD services. To the average reader, this report implies that VA services for veterans with PTSD is woefully inadequate, and undermines the quality of VA care. VA disagrees with GAO and does not concur with its conclusions and recommendation.

Enclosure 1 discusses the Department's disagreement with GAO and provides numerous points of clarification. Enclosure 2 is a copy of VA's transmittal letter to Congress and excerpts detailing VA's actions as related to the fourth annual report of the VA Special Committee on PTSD. Enclosure 3 provides copies of letters signed by the Co-Chairs of the Under Secretary's Special Committee on PTSD that outline support for VA's implementation of the Committee's recommendations. VA believes enclosure 2 and 3 are fundamental to the Department's comments and should be included as part of VA's published response to GAO's draft report. Due to the extremely short period to comment on GAO's draft report, VA will provide a detailed refutation of this report when responding to the final report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "G. Mansfield", written over a horizontal line.

Gordon H. Mansfield

Enclosures

Enclosure 1

THE DEPARTMENT OF VETERANS AFFAIRS (VA) COMMENTS
TO GOVERNMENT ACCOUNTABILITY OFFICE (GAO)
FINAL REPORT

***VA HEALTH CARE: VA Should Expedite the Implementation of
Recommendations Needed to Improve
Post-Traumatic Stress Disorder Services***
(GAO-05-287)

To help ensure that VA has the capacity to diagnose and treat veterans returning from the Iraq and Afghanistan conflicts, as well as to maintain these services for other veterans, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to prioritize those recommendations needed to improve PTSD services and to expedite VA's time frames for fully implementing those recommendations.

Do Not Concur – The Department of Veterans Affairs does not concur with either GAO's report or the recommendation. VA does not believe GAO's findings and conclusions accurately portray the actual provision of post-traumatic stress disorder (PTSD) services to veterans by VA over the past 20 years nor VA's ability to provide future services to veterans. To the average reader, this report will leave the impression that VA services to veterans with PTSD is woefully inadequate, which is completely wrong.

VA believes it is imperative to make the following significant observations on GAO's draft report.

- On page three, GAO states, "VA's delay in fully implementing the recommendations raises questions about VA's capacity to identify and treat veterans returning from military combat who may be at risk for developing PTSD, while maintaining PTSD services for veterans currently receiving them." This is an egregious misrepresentation of VA's ability to provide care to returning Operation Iraqi/Operation Enduring Freedom (OIF/OEF) servicemembers, and is not supported by GAO's findings. In fact, VA provided PTSD services to approximately 6,400 OIF/OEF veterans to date. This is a small percentage of the total of more than 244,000 veterans treated for PTSD in the VA health care system, and indicates that VA does indeed have sufficient capacity to provide care to veterans with PTSD.

Enclosure 1

THE DEPARTMENT OF VETERANS AFFAIRS (VA) COMMENTS
TO GOVERNMENT ACCOUNTABILITY OFFICE (GAO)
FINAL REPORT

***VA HEALTH CARE: VA Should Expedite the Implementation of
Recommendations Needed to Improve
Post-Traumatic Stress Disorder Services
(GAO-05-287)***

- GAO acknowledges VA as a world leader in the treatment of PTSD. The co-chairs of the Under Secretary for Health's Special Committee on PTSD reviewed VA's draft mental health strategic plan and concurred that the Special Committee's recommendations were fully addressed in the comprehensive strategic plan. The co-chairs also concurred that the implementation time frames outlined in the mental health strategic plan were appropriate.
- GAO failed to include in its report the Secretary's letter to members of Congress, dated October 18, 2004, which explained the Department's response to the recommendations of the Special Committee. These responses are crucial to understanding the Department's constructive actions toward the Special Committee and to its recommendations. Enclosure 2 is a copy of the Secretary's letter and extracts from its enclosure to Ranking Democratic Member Evans so that it may be included as part of the Department's published response to this draft report.
- GAO's report gives the impression that VA is ignoring the provision of PTSD services.
- GAO's report discounts the progress made on each of the Special Committee recommendations and ignores the relevant information provided by Dr. Mark Shelhorse, Acting Chief Consultant, Mental Health Strategic Healthcare Group. Other VA experts also share documentation that represents progress towards meeting recommendations of the Special Committee. VA recommends that GAO reexamine its findings in the light of the support provided to VA efforts by the co-chairs of the Special Committee in letters dated February 3, 2005. The co-chairs are firm in their belief that the report "portrays an unfair and one-sided image of the agency...." (Enclosure 3 provides copies of the co-chair letters to be included as part of the Department's published response to GAO's draft report.)



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

February 3, 2005

In Reply Refer To:

Cynthia A. Bascetta
Director, Health Care -
Veterans' Health & Benefits Issues
United States Government Accountability Office
Washington, DC 20548

Dear Ms. Bascetta:

We would like to express our discomfort with the negative tone of the Government Accountability Office report on Post Traumatic Stress Disorder (PTSD) as presented in the exit conference on January 28, 2005, and in the draft report. Recognizing, treating, and assisting veterans with PTSD is one of Veterans Health Administration's (VHA) highest priorities. The Under Secretary for Health and the agency are invested and engaged in implementing the *President's New Freedom Commission on Mental Health Recommendations*, and have developed a National Mental Health Strategic Plan (MHSP) to lead us to those goals. This plan includes PTSD. We have cross-walked our recommendations with the MHSP with the help of the Mental Health Strategic Healthcare Group (MHSHG) and all recommendations are addressed within the body of that plan. We have also agreed with the Under Secretary for Health that 7 of the 24 recommendations are complete. We do not understand why the report continues to portray those 7 as incomplete.

The report fails to address the many efforts undertaken by the agency and the members of the PTSD Advisory Group to improve the care delivered to Veterans with PTSD. This includes:

- A clinical practice Guideline for PTSD
- The Research efforts of the National Center for PTSD
- The development of an Iraqi War guide for Clinicians
- A national Clinical Reminder to prompt Clinicians to assess OIF/OEF Veterans for PTSD, Depression, and Substance abuse
- A National system of 144 Specialized PTSD Programs in all states
- A National System of 207 Community Readjustment Counseling Centers (RCS)
- The Treatment in 2003 of over 200,000 Veterans with PTSD
- Establishing a Mental Illness Research and Education Center in 2004 in Durham, NC directed to evaluate post deployment veterans
- The development of 17 individual educational initiatives for staff, patients, and families

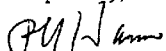
Enclosure 3

- The 2005 planning for a joint VHA/DoD PTSD 101 Course for providers and programs focusing on PTSD in special groups (women veterans, older adults, medically ill, etc.)
- The March Planning for a joint VHA/DoD conference centered on improving care to the returning war veteran
- VHA placing Social Workers in Military Treatment Facilities to assist soldiers in the transition to VHA
- The addition of 50 Global War on Terrorism (GWOT) counselors to Readjustment Counseling Service to assist with counseling
- The current expansion of VHAs four Traumatic Brain Injury Centers to Polytrauma Centers including Services for Mental Health
- VHAs ongoing efforts with DoD through Seamless Transition Task Force to improve the care we deliver to this population.

We are concerned that anyone reading your report will not be aware of these actions taken by the agency, many of which were contributed to by the members of the PTSD Advisory Committee. To not include these efforts not only portrays an unfair and one-sided image of the agency but discounts the work of the dedicated employees and members of the Advisory Committee.

VHA is the World Leader in the treatment of PTSD and we will continue to work with the system to assure that that status is maintained and improved.

Respectfully,



Philip Hamme, MSW.

Co-Chair, PTSD Advisory Committee

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Marcia A. Mann (202) 512-9526

Acknowledgments

In addition to the contact named above, key contributors to this report were Mary Ann Curran, Linda Diggs, Martha Fisher, Lori Fritz, Alice L. London, Janet Overton, and Marion Slachta.

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