Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Inpatient and Residential Programs For Female Veterans with Mental Health Conditions Related to Military Sexual Trauma

Report No. 12-03399-54

December 5, 2012

VA Office of Inspector General
Washington, DC 20420

Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Acronyms and Abbreviations Related to Mental Health

ACT	Acceptance and Commitment Therapy
BT	Behavioral Therapy
CBT	Cognitive Behavioral Therapy
CPT	Cognitive Processing Therapy
CT	Cognitive Therapy
CSTS	Center for Sexual Trauma Services (Bay Pines, FL)
CWT/TR	Compensated Work Therapy Transitional Residence
DBT	Dialectical Behavioral Therapy
EBP	Evidence Based Psychotherapy
EMDR	eye-movement-desensitization-reprocessing
IMHS	Integrated Mental Health Strategy
LGBT	lesbian, gay, bisexual, and transgender
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
MHS	Mental Health Services
MST	military sexual trauma
MHICM	Mental Health Intensive Case Management
NEPEC	Northeast Program Evaluation Center
PCT	PTSD Clinical Team
PE	Prolonged Exposure
PRRC	Psychosocial Rehabilitation and Recovery Center
PTSD	Post-Traumatic Stress Disorder
SA	Substance Abuse
SIPU	Specialized Inpatient PTSD Units
SS	Seeking Safety
WISER	Women's Inpatient Specialty Environment of Recovery (Houston, TX)
WITRP	Women's Integrated Treatment and Recovery Program (Brockton, MA)
WSDTT	Women's Stress Disorder Treatment Team
WTRP	Women's Trauma Recovery Program (Menlo Park, CA)
WTU	Women's Treatment Unit (Lyons, NJ)

Table of Contents

Executive Summary

At the request of the Senate Veterans Affairs Committee, the VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to review Veterans Health Administration (VHA) services available to women veterans who have experienced military sexual trauma (MST). We reviewed 14 inpatient and residential programs identified by VHA as resources for female veterans who have experienced MST. We reviewed the electronic health records of 166 female veterans with MST discharged from these programs between October 1, 2011, and March 31, 2012. We visited eight program sites representing a mix of geographic regions, facility sizes and complexities, and urban and rural locations. Inspection objectives were to describe the nature of services provided to these veterans, the characteristics of these veterans, the characteristics of providers, and geographic referral patterns and factors influencing access. We also assessed compliance with VHA requirements pertaining to MST care.

VHA estimates that approximately one in every five female veterans enrolled in VHA responded "yes" when screened for MST. MST is defined as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." MST is not a diagnosis in itself. It is an experience that is associated with some patterns of symptoms. VHA policy states that veterans and eligible individuals who report experiences of MST, but who are deemed ineligible for other VA health care benefits or enrollment, may be provided MST-related care only. VHA also requires that veterans and eligible individuals must have access to residential or inpatient programs able to provide specialized MST-related mental health (MH) care, when clinically needed, for conditions resulting from MST. VHA requires that all facilities screen veterans for MST. The MST Support Team in VHA's Mental Health Service tracks this screening data. We found that all of the veterans in our review had been screened.

Women veterans in our review ranged from 23-65 years with a median age of 44 years. Thirty-eight percent of the women served during the Post-Vietnam era, and approximately 27 percent each were from the Persian Gulf era and the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn era. Six percent were from the Vietnam era. Three women were on active duty and two were reservists who were eligible for MST related care, but were otherwise ineligible for VHA care. Nearly all of the women had more than one MH diagnosis. Ninety-six percent were diagnosed with Post-Traumatic Stress Disorder. Depressive disorders and substance use disorders were also common. Eight percent of the women in our review were employed and 16 percent were responsible for the care of minor children. Nearly one in five of the women in our review were homeless at the time of program admission. Seventy-one percent of

participants were service connected, 55 percent for a MH condition. Almost 90 percent of the women in our review were receiving outpatient MH services in the 3 months prior to the inpatient or residential admission under review. Nearly 30 percent of the women in our review had been in a VA MH Residential Rehabilitation Treatment Program (MH RRTP) in the 3-years prior to this admission.

We noted that women travel across the country to programs that consider themselves as "national resources." Some programs accept patients on a rolling basis (as space allows); others use cohort admissions where groups are admitted together at prescribed intervals and stay together for the duration of the program. During site visits, we found that many of the available beds were not occupied. This corresponds with data supplied by VHA's Northeast Program Evaluation Center, which indicates that most of these programs do not maintain a full census. We found diverse programming available in these specialized programs. Gender-specific care and same gender therapists were available. Treatments utilized varied by site, but all programs employed one or more evidence-based psychotherapies. Follow-up MH services were consistently arranged by the time of discharge. Thirteen percent of the patients in our review were readmitted to an inpatient or residential setting within 30-days of discharge. Twelve women went directly into another MH RRTP, and seven were admitted to acute psychiatry—two due to a suicide attempt or gesture.

Women were often admitted to programs outside their Veterans Integrated Service Network. Obtaining authorization for travel funding was frequently cited as a problem for patients and staff. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. This Directive is not aligned with the MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. Some programs cited challenges maintaining an adequate volume of appropriate referrals; others told us that managing women with eating disorders was a particular challenge. Many MST Coordinators we spoke with reported that they had insufficient time to fulfill their outreach responsibilities.

We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Purpose

At the request of the Senate Veterans Affairs Committee, the VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to review Veterans Health Administration (VHA) services available to women veterans who have experienced military sexual trauma (MST). Our review focused on selected inpatient and residential programs that were identified by VHA as potential resources for women veterans who have experienced MST. Inspection objectives were to:

- Describe the nature of services provided to women veterans admitted to inpatient or residential treatment programs that were identified as a resource for MST.
- Describe the women veterans who utilized these inpatient or residential programs during the first 6 months of fiscal year (FY) 2012.
- Describe geographic referral patterns to inpatient or residential treatment programs for MST and the factors that may influence access.
- Describe the staff that provides inpatient or residential MST treatment, specifically, the gender of individual and group therapy providers.
- Assess compliance with VHA policies pertaining to MST care.

Background

A. Women Veterans

Women veterans have been increasing steadily in numbers. As of September 2009, the estimated number of women veterans was over 1.8 million, representing over 8 percent of the veteran population.[1] Between 2000 and 2010, the number of women utilizing VHA for health care has nearly doubled, and dramatic increases in the enrollment of women into VHA health care is expected to continue. It is estimated that 14 percent of those deployed for Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) are women.[2] In recognition of this trend, VHA determined that future residential treatment programs must plan for women to comprise 15 percent of their census.[3]

[1] Women Veterans Health Care Report, August 20, 2011, http://www.womenshealth.va.gov/WOMENSHEALTH/publications.asp#research accessed August 28, 2012.
[2] http://www.va.gov/VETDATA/Demographics/Demographics.asp accessed August 28, 2012.
[3] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs)*, December 22, 2010.

Notably, 37 percent of all women veterans using VHA for outpatient care have had one or more encounters with a VA mental health (MH) provider.[4] One of the salient clinical issues for women veterans is whether or not they experienced sexual trauma during their military service.[5]

B. MST

The term "military sexual trauma" is defined as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."[6] VHA policy[7] states that "veterans and eligible individuals who report experiences of MST, but who are deemed ineligible for other VA health care benefits or enrollment, may be provided MST-related care only. This benefit extends to Reservists and members of the National Guard who were activated to full-time duty status in the Armed Forces. Veterans and eligible individuals who received an 'other than honorable' discharge may be able to receive free MST-related care with the Veterans Benefits Administration Regional Office approval". "Eligible individual" for the purposes of this directive means someone without veteran status who experienced sexual trauma while on active duty or active duty for training.

VHA mandates that all veterans and potentially eligible individuals seen in VA medical centers (VAMC) and associated Community Based Outpatient Clinics (CBOCs) must be screened for experiences of MST.[8] This is a onetime screen, completed as a "clinical reminder" in the electronic health record (EHR) which "follows" the veteran should he or she enroll at another VHA facility for care. If the screening question has not been completed, the record will reflect this as being due and providers will be prompted to complete the screening. If a patient declines to complete the screening questions when asked, this is documented as screening completed. In this case, the value is not recorded as positive or negative. VA reports that about one in every five female veterans enrolled in VHA respond "yes" when screened for MST.[9]

The clinical reminder screening consists of the following two questions: "While you were in the military:

[4] Women Veterans Health Care Report.
[5] MST is an experience common to both male and female Veterans. However, for purposes of this report, we focus on the experience and treatment of female Veterans.
[6] U.S. Code, Title 38, Section 1720D, 1992.
[7] VHA Directive 2010-033, *Military Sexual Trauma (MST) Programming*, July 14, 2010.
[8] VHA Directive 2010-033.
[9] http://www.womenshealth.va.gov/WOMENSHEALTH/facts.asp accessed June 8, 2012.

- Did you ever receive uninvited and unwanted sexual attention (i.e. touching, cornering, pressuring for sexual favors, or verbal remarks, etc…)?
- Did anyone ever use force or the threat of force to have sex with you against your will?"

An affirmative response to either question renders the screening as positive, and when making an entry into the EHR for an outpatient encounter, providers are prompted to check off whether or not treatment in any given episode of care is related to the MST. This encounter data is utilized by VHA to produce a variety of reports analyzing volume and utilization patterns. VHA is able to stratify the data by gender, location of care, and other variables. This encounter data is specific to outpatient encounters. Inpatient or residential care related to MST is not captured by encounter data. If a veteran has a history of MST but did not respond affirmatively to the screening questions, he or she would not be included within this data set.

The VHA goal is to complete MST screenings for 90 percent of all enrolled veterans (male and female). For FY 2011, VHA reports that MST screenings were completed on 98.4 percent of veterans seen for outpatient care.[10] Since the screenings are only done once, the rates are cumulative and represent all veterans who used VHA outpatient care during the respective year and had ever been screened, not just those screened during that FY.

VHA told us that they are in the process of adding a third question to the MST Screening. This additional question will ask the veteran if he or she would like to speak to someone further about the MST event. We were told that this would enable tracking of those veterans desirous of follow up related to MST.

MST is not a diagnosis in itself. MST is an experience, and is associated with some patterns of symptoms. MST research has found that female veterans with a history of MST have different, and more severe, residual MH symptoms than other (civilian) females who have been sexually assaulted.[11] MST is a predictor of psychological distress, and is correlated with several MH diagnoses, most frequently Post-Traumatic Stress Disorder (PTSD). PTSD is an anxiety disorder characterized by re-experiencing a traumatic event. Symptoms may also include guilt, avoidance, and hyperarousal (such as difficulty sleeping, irritability and hypervigilance). Research on the effects of trauma has found that the experience of rape can be equal to or greater than other stressors, including

[10] https://vaww.portal.va.gov/sites/mst_community/file_storage/monitoring_docs/MST_Screening_FY11.pdf accessed June 8, 2012.
[11] Suris et al, *Mental health, quality of life, and health functioning in women veterans,* Journal of Interpersonal Violence, 2007; 22:179-197.

combat exposure, in the risk of developing PTSD.[12] Experiencing MST has also been linked to an increased likelihood of diagnoses of "anxiety disorders, depression, dissociative disorders, eating disorders, bipolar disorder, substance use disorders, and personality disorders."[13] Since the experience of MST may result in a wide range of symptoms, it is expected that treatment related to MST may occur in a wide range of settings and acuity levels depending on the individual's needs. While there are known correlations between experiencing MST and some physical and MH diagnoses, it must be emphasized that not everyone experiencing MST will have the same response. Some individuals who have been victims of traumatic experiences including MST do not develop any symptoms. Others develop serious and complex chronic physical and MH issues.

C. MST Support Team

VA Mental Health Services (MHS) directs policy related to MST treatment on a national level. In 2006, MHS established an MST Support Team to "conduct monitoring of MST screening and treatment; to expand MST-related education, training, and outreach resources and outreach efforts; and to increase VA's capacity to provide MST-related care. The team also provides MST-related policy recommendations for consideration by MHS."[14] Staff are based in Boston, MA, and Palo Alto, CA. The MST Support Team disseminates training materials to VA providers on evidence based practices, conducts monthly training calls, shares best practices, and offers technical assistance and consultative services to VHA providers. They utilize data garnered from MST screenings to track utilization patterns and trends. The MST Support Team maintains an intranet site with numerous training resources, references, how-to guides, and monitoring reports.

In October 2009, officials from the Department of Defense (DoD) and the VA convened the "first-ever joint summit to make recommendations for how the two Departments can more effectively work together to meet the MH needs of America's military personnel, veterans, and their families."[15] This work culminated in the DoD/VA Integrated Mental Health Strategy, finalized in October 2010. This strategic plan outlines 28 target areas. Strategic Action 28 is "Gender Differences," with the objective "to support MH services and research for female service members and veterans, and for those who have experienced military sexual trauma."[16] In order to accomplish the milestones for this strategic action, VHA has undertaken several steps. In July 2012, MHS distributed a 30-

[12] Kimerling et al., *The veterans health administration and military sexual trauma*, American Journal of Public Health, 2007; 97:2160-2166.
[13] Valdez et al., *Veterans health administration mental health treatment settings of patients who report military sexual trauma*, Journal of Trauma and Dissociation, 2011; 12:232-243.
[14] https://vaww.portal.va.gov/sites/mst_community/section_pages/People-Finder/MST-Support-Team.aspx accessed August 29, 2012.
[15] Statement of Antoinette Zeiss, Ph.D., Acting Deputy Chief Officer, VHA Office of Mental Health Services, before the Committee on Veterans Affairs, United States Senate, May 25, 2011.
[16] DoD/VA Integrated Mental Health Strategy (IMHS), Consolidated Implementation Plans, pages 147-153.

page survey to all VHA facilities to collect data on what is currently available for women's MH and MST services at medical centers and CBOCs. Analysis of survey data is currently underway and a summary report, with recommendations on how to improve service gaps, will be forthcoming in FY13. Staff from the MST Support Team are heavily involved in this project.

D. MST Related Care

A key component of the VHA system of care for veterans with MST is the availability of MST Coordinators. VHA requires that every medical center have one or more staff in this role. The MST coordinator is responsible for monitoring and ensuring that national and VISN-level policies related to MST screening and treatment are implemented. The MST Coordinator is also tasked with monitoring and helping to ensure that education, training, outreach, and administrative tasks related to MST are completed, with the goal to ensure that veterans with MST are able to access the services they need.[17] Many MST Coordinators are also clinicians who work directly with this population.

VHA mandates that every medical center and CBOC make outpatient services available for veterans who have experienced MST. Since MST is not a diagnosis, but an experience, medical centers must make a variety of services available to meet the needs of veterans with MST who may have symptoms manifested in different ways. For example, PTSD Clinical Teams (PCTs) provide PTSD treatment in the outpatient clinic setting. Women's Stress Disorder Treatment Teams (WSDTTs) are available at several medical centers in the country, providing essentially a women's only PCT team. Some female veterans may be followed by a MH provider embedded into the Women's Health Clinic or team. Because of the spectrum and diversity of clinical presentation, there is no inherent, single venue at which these veterans receive care, and the deciding factor for treatment locale is often patient-driven. In one study, VHA researchers found that veterans with MST obtain MH services in a wide range of settings and clinics, including MH Intensive Case Management (MHICM) and Psychosocial Recovery and Rehabilitation Centers (PRRCs).[18,19]

VHA requires that veterans and eligible individuals must have access to residential or inpatient programs able to provide specialized MST-related MH care, when clinically needed, for conditions resulting from MST.[20] Residential programs (also known as MH Residential Rehabilitation Treatment Programs, or MH RRTPs) generally offer more

[17] VHA Directive 2010-033.
[18] Valdez et al.
[19] MHICM provides intensive case management, close monitoring, and frequent home visits to those with serious mental illness (SMI) who are at risk of psychiatric hospitalization. PRRC provides outpatient programming to those with SMI to decrease social isolation and promote community reintegration and recovery principles.
[20] VHA Directive 2010-033.

intensive treatment than typical outpatient MH programs.[21] Participants in these programs reside in a designated area, usually located on a VAMC campus. Treatment is available daily with 24/7 clinical support and length of stay varies by program. Inpatient programs for MST related treatment are called Specialized Inpatient PTSD Units (SIPUs). SIPU treatment programming may be similar to what is offered in an MH RRTP program. SIPUs are inpatient units, which may operate as locked psychiatric units. There is no one prescribed model or philosophy of care for these patients; clinicians, teams and programs may have different treatment approaches. For example, among the residential and inpatient programs we reviewed, there were differences in the philosophical stance towards same-gender treatment versus mixed-gender treatment. Proponents of women's only treatment argue the benefits of the psychological safety inherent in an all female environment as women veterans explore traumatic experiences. However, some clinicians favor mixed-gender treatment. In this model, female veterans learn to increase their comfort level with men, in order to prepare them to be able to function in real world settings, such as the workplace. Some program staff we spoke to were in favor of a blended approach. For example, a female veteran may start MST-related PTSD treatment in an all–female environment, but as progress continues, the team may incorporate male staff or add a mixed-gender group to the treatment plan so that the patient can try out new challenges and increase exposure to stimuli that may be typically avoided.

We also noted differences in program philosophy in deciding whether to admit patients as part of a treatment cohort or on a rolling basis. Cohort admissions involve admitting a group together and keeping the group intact through program completion in order to promote group cohesion. Cohort based programs are thought to facilitate a more consistent therapeutic milieu and attempt to foster cohesion similar to the military unit structure that patients were familiar with during their service. Additionally, a cohort structure better enables programs to organize and deliver treatment targeted at a group of patients with a similar set of challenges. Rolling admissions involve admitting patients as space allows, with program participants together at different stages of treatment. This allows patients who have been there longer to serve as role models for incoming patients. In this report, we take no stance toward a particular model, but recognize that there is ample room for variability in the treatment approach.

E. Evidence-Based Therapies

VHA also requires that evidence based therapies are available to this population.[22] Federal law[23] requires that VA "establish education, training, certification, and staffing

[21] Some MH RRTPs have a specific treatment focus such as PTSD or Substance Abuse, and may be referred to as PTSD RRTPs, SARRTPs, or other similar acronyms.
[22] VHA Directive 2010-033.
[23] 38 U.S.C. 1720D, 2009.

standards for VA health-care facilities for full-time employees who are trained to provide treatment and care to veterans for sexual trauma." Progress on these goals is reported annually to Congress by the Secretary of the VA.

Evidence-based psychotherapies (EBPs) are those therapies for MH conditions "that have consistently been shown in controlled research to be effective for a particular condition or conditions."[24] Cognitive Behavioral Therapy (CBT) is a blend of Cognitive Therapy (CT) and Behavioral Therapy (BT). CT focuses on a person's thoughts and beliefs, and how they influence their mood and actions, and aims to change a person's thinking to be more adaptive and healthy. BT focuses on a person's actions with a goal to modify unhealthy behavior patterns. In CBT, a MH clinician helps the patient learn to identify distorted or unhelpful thinking patterns and recognize and change inaccurate beliefs in order to relate to others in more positive ways and change behaviors accordingly.[25]

Two types of CBT widely used with the MST population include Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). Both of these therapies have been found to have a positive effect on the reduction of the symptoms of PTSD and anxiety,[26] are recommended in the VA/DoD Clinical Practice Guidelines for PTSD,[27] and have been confirmed by the Institute of Medicine to be efficacious treatments for PTSD.[28] CPT begins with the trauma memories and focuses on feelings, beliefs, and thoughts emanating from the traumatic event. The clinician helps patients examine whether the trauma appeared to disrupt or confirm beliefs held prior to this experience, and determine how much the clients have over-generalized (over-accommodated) from the event to their beliefs about themselves and the world. Patients are taught to challenge their own self-statements using therapy, leading them to understand their reasoning processes and beliefs, and to modify their extreme beliefs to bring them into balance.[29]

Prolonged Exposure (PE) is another type of EBP for PTSD. It involves four primary components: education about reactions to trauma and PTSD; breathing retraining for relaxation; exposure to real world, trauma-related situations that are objectively safe but

[24] Department of Veterans Affairs, Office of Patient Care Services, Office of Mental Health Services Fact Sheet: *Evidence-based psychotherapies for post-traumatic stress disorder and other mental health conditions*, September 2010.
[25] www.nimh.nih.gov, accessed July 5, 2012.
[26] Resick et al, *Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors*, Journal of Counseling and Clinical Psychology, 2012; 80:201-210.
[27] Department of Veterans Affairs and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress, Version 2.0*, 2010.
[28] The National Academies Press – Institute of Medicine, *Treatment for Post Traumatic Stress Disorder in Military and Veteran Populations: Initial Assessment*, 2012.
[29] https://vaww.portal.va.gov/sites/cpt_community/Lists/About%20CPT/AllItems.aspx, accessed July 5, 2012.

avoided due to trauma related distress (in vivo exposure); and exposure to the trauma memory through, repeated recounting of the traumatic event (imaginal exposure).[30]

CPT and PE are two of the more broadly utilized treatments in the residential setting. Other EBPs utilized may include:

- Acceptance and Commitment Therapy (ACT) – a type of CBT with emphasis on mindfulness and psychological flexibility[31]
- Dialectical Behavior Therapy (DBT) – a type of CBT focusing on skills building, behavioral change, problem solving, and emotional regulation[32]
- Seeking Safety (SS) – a therapy often used in the treatment of PTSD and substance abuse, promotes safety as the overall goal with emphasis on the four content areas of cognitive, behavioral, interpersonal, and case management[33]
- CBT for Depression – focuses on identifying and changing negative and extreme thoughts that contribute to depression, and promotes engagement in personally meaningful activities.

It is expected that patients in treatment for MST in a residential setting would be offered one or more of the above referenced EBPs, depending on their diagnosis and clinical presentation.

F. VHA Tracking of Other Relevant Data

As noted, the MST Support Team currently provides reports on outpatient care only. Some data pertaining to veterans with MST in inpatient and/or residential settings is available from the Northeast Program Evaluation Center (NEPEC). NEPEC performs program evaluation for MH RRTPs as well as some other PTSD specialty programs. All PTSD RRTP programs[34] collect outcome data at 4-month intervals after discharge, and transmit this to NEPEC for analysis.

While facilities are given data on their performance relative to other VA programs, the data is aggregated among multiple populations served and data is not provided to

[30] http://vaww.infoshare.va.gov/sites/pe/Lists/What%20is%20PE/AllItems.aspx accessed July 5, 2012.
[31] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=191 accessed August 31, 2012.
[32] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36 accessed August 31, 2012.
[33] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=139 accessed August 31, 2012.
[34] VHA has separate bed section codes for PTSD-RRTP programs and PTSD-Domiciliary programs. These program types may vary in organizational structure but do not differ in clinical programming. Therefore, for ease to the reader, we use the term PTSD-RRTP to refer to both types of these programs.

facilities on veterans with MST specifically.[35] NEPEC also reports a variety of other metrics regarding MH RRTP operations, such as bed capacity and average census.

G. Previous OIG and GAO Findings

With the increase in the enrollment of female veterans and the high prevalence of MST, there has been a corresponding focus and interest in MST among external reviewers. In March 2010, the United States Government Accountability Office (GAO) published a review of VHA health care for women veterans, including treatment related to MST. GAO reported that VA had "not defined what is the appropriate training needed for [providers] treating victims of MST."[36] In their report, GAO cited numerous anecdotal examples of staff who related that they did not feel they had adequate training to address MST. VHA has since implemented mandatory training for all primary care providers and MH providers on MST.

In December 2010, OIG reviewed the health care utilization patterns and disability claims of female veterans with PTSD related to combat and/or MST. This study found that women veterans were generally more likely to utilize VHA for health care at military discharge than their male counterparts. The study also found that women veterans were generally less likely to be receiving disability benefits related to PTSD than their male counterparts, but more likely to be receiving service-connected disability compensation for other MH conditions.[37]

Scope and Methodology

We reviewed information and self-assessment responses from 14 program sites. We reviewed the EHRs of 166 female veterans with MST. We conducted site visits to eight program sites between July 18 and August 10, 2012. We spoke with subject matter experts from MHS, including staff from the National Center for PTSD, MST Support Team, MH RRTP leadership, and NEPEC. During site visits, we spoke with facility MH leadership, MST Coordinators, MH clinicians, MH RRTP Admissions Coordinators, and clinical staff involved in these programs. We reviewed relevant VHA Directives and Handbooks, Public Law, Congressional testimony, reports and data supplied by the MST Support Team and NEPEC, and peer-reviewed literature pertaining to this population.

[35] A few RRTP programs serve only those with sexual trauma, so they would be able to obtain data for this population specifically. Other programs with multiple PTSD programs/tracks/cohorts would have data aggregated and they would not be able to pull out data just for those with MST.
[36] United States Government Accountability Office (GAO) Report to Congressional Addressees. *VA HEALTH CARE: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes* (Report No GAO-10-287), March 2010.
[37] OIG, *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits* (Report No. 10-01640-45), December 16, 2010.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

The MST Support Team compiles a list of "Military Sexual Trauma/Sexual Trauma Inpatient and Residential Treatment Resources" and makes this available as a reference on their intranet site.[38] It must be emphasized that programs on this list are not strictly MST programs; several programs do emphasize the treatment of sexual trauma but most focus on the treatment of PTSD, substance abuse, or other conditions which may be related to MST or may be related to other factors. Specifically, the MST Support Team denoted that this is a "list of programs identifying themselves as having expertise with MST and/or sexual trauma more generally and the ability to provide treatment targeting these issues in a residential or inpatient setting."

We contacted all of the 17 facilities on this list that were identified as offering a program for women only or mixed-gender (available to women but male veterans will also be accepted as participants). Programs identified as for men only were excluded from the inspection. Programs from this list which offered MST services to veterans at an outpatient clinic were included as long as the programs offered a residential or housing component to support this purpose. Two programs we contacted (Augusta, GA, and West Los Angeles, CA) were excluded from further review when they reported that they do not actually offer inpatient or residential services as described on the MST resource list. One program (North Chicago, IL) was also excluded from further review as the program only admits patients with combat-related PTSD. The remaining 14 programs we reviewed are summarized below (Table 1).

Program	Location	Gender Specific	Type
Women Veterans' Residential Program	Batavia, NY	Women only	Residential
Center for Sexual Trauma Services	Bay Pines, FL	Women only	Residential
Women's Integrated Treatment and Recovery Program (WITRP)	Boston, MA – Brockton	Women only	Residential
Women Veterans' Therapeutic Transitional Residential Program (TRUST House)	Boston, MA – Jamaica Plains	Women only	Residential
Women's Residential PTSD Program	Cincinnati, OH	Women only	Residential
Women's Treatment Unit (WTU)	Lyons, NJ	Women only	Residential
Women's Trauma Recovery Program (WTRP)	Menlo Park, CA	Women only	Residential
Residential PTSD Program for Women	Sheridan, WY	Women only	Residential

[38] https://vaww.portal.va.gov/sites/mst_community/default.aspx First accessed June 8, 2012.

Trauma Recovery Treatment Center	Temple, TX	Women only	Residential
Dual Diagnosis PTSD/Substance Abuse PRRTP	Baltimore, MD	Mixed Gender	Residential
Women's Inpatient Specialty Environment of Recovery Program (WISER)	Houston, TX	Women only	Inpatient
Specialized Inpatient PTSD Treatment Program for Women Veterans	Salem, VA	Women only	Inpatient
Stress Disorder Treatment Program	Topeka, KS	Mixed-gender	Inpatient
RENEW: Women's Trauma Recovery Program	Long Beach, CA	Women only	Outpatient intensive MST program with supportive housing offsite

Table 1. Residential/inpatient program resources identified by the MST support team.

Each of the 14 facilities provided responses to a self-assessment survey as well as provided a patient list, staff list, and other documents related to program operations, such as admission criteria and outcomes data. We asked facilities to provide us with the names of women who met the following criteria:

- Clinical history positive for an experience of MST
- Received treatment in one of the programs identified on the reference list
- The treatment episode was related to MST
- Discharged from the program between October 1, 2011, and March 31, 2012

We received the names of 210 women. For our purposes, patients were included if a history of MST was found upon review of the EHR, even if the MST clinical reminder screening was negative. Patients were included if they met the eligibility criteria for MST related care as defined by VHA Directive 2010-033, *MST Programming*. As a result, we included five women who were not veterans; three women were active duty military and two had served in the Reserves but were otherwise ineligible for VHA care. We excluded 30 women from review as there was no clinical history of MST. We excluded 14 women from review as they were discharged outside of the target timeframe. After exclusions, we reviewed the EHRs of the remaining 166 female veterans. Though fully inclusive of the set of MST patients in the 14 programs reviewed, the data is not a representative sample of the entire population of female veterans with a history of MST and results are not projectable to the broader population of female veterans who have experienced MST. Figure 1 illustrates the distribution of patients reviewed by facility.

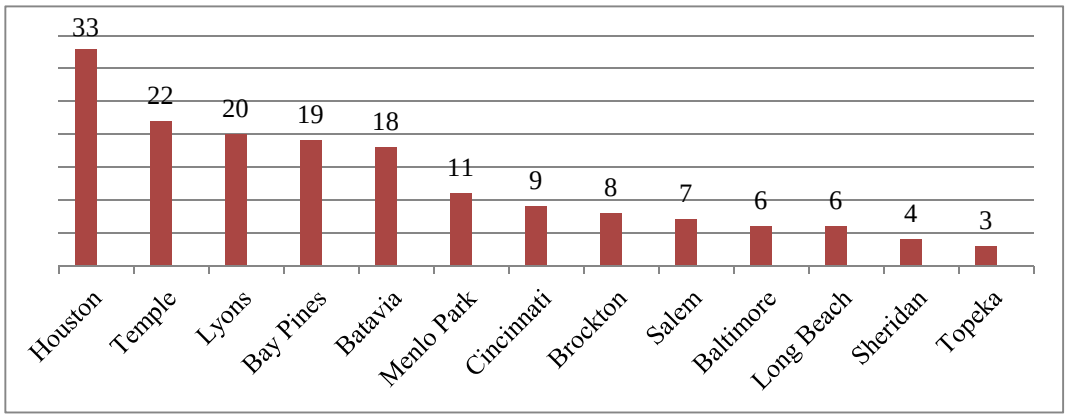

Figure 1. Number of female veterans with MST related treatment discharged during FY12 Quarters 1 & 2 from residential/inpatient programs included within our review. Boston-Jamaica Plain TRUST House had no women with MST discharged during that timeframe.

From these programs, we selected eight for site visits. We purposefully selected these sites as a convenience sample to obtain a mix of geographic regions, facility size and complexity, and urban/rural locations. Locations for site visits included: Baltimore, MD; Bay Pines, FL; Boston, MA (both programs); Houston, TX; Menlo Park, CA; Salem, VA and Sheridan, WY. Site visits were conducted to obtain more information about the availability and accessibility of services, gather information on the women veterans with MST served by these programs, and discuss barriers and challenges in service delivery encountered by these programs. Physical inspections and environment of care rounds were not within the scope of this inspection.[39]

[39] Environment of Care of MH RRTP programs is currently a review topic for Combined Assessment Program reviews during FY12. Reviews to date have shown very high compliance with applicable standards.

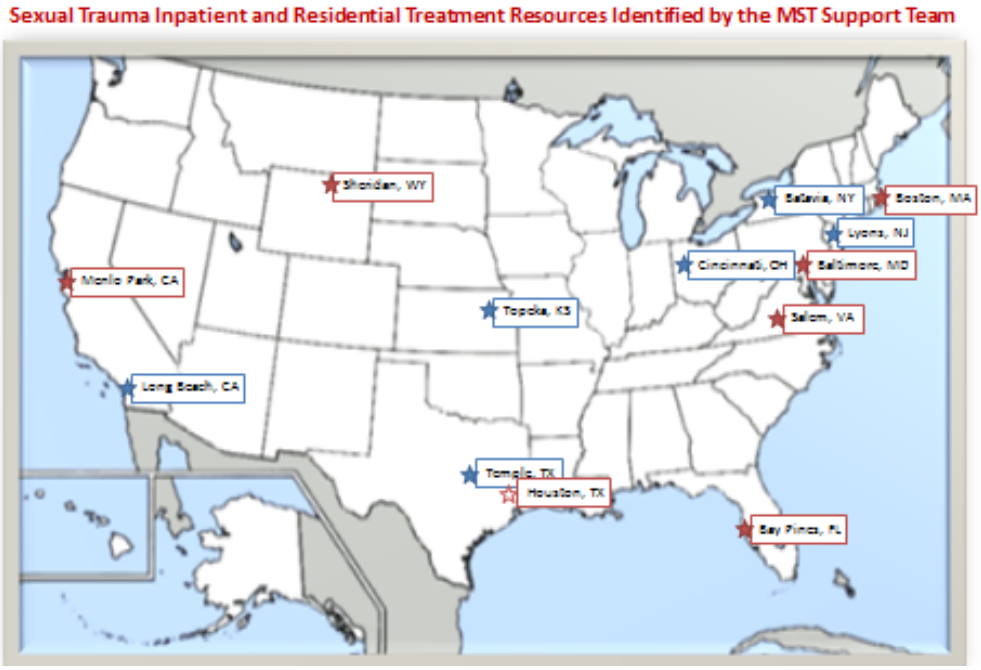

Figure 2. Locations of programs within our review. Site visits were made to those locations in red.

Results and Conclusions

Patient Characteristics

A. Age Distribution

Figure 3 depicts the age breakdown for the patients discharged from these programs. Participant ages ranged from 23-65 years. The average age was 44 years. The most common age range was 46 to 50 years. Six (3.5 percent) of participants were 25 years old or younger and 7 (4 percent) were between 61 and 65 years old.

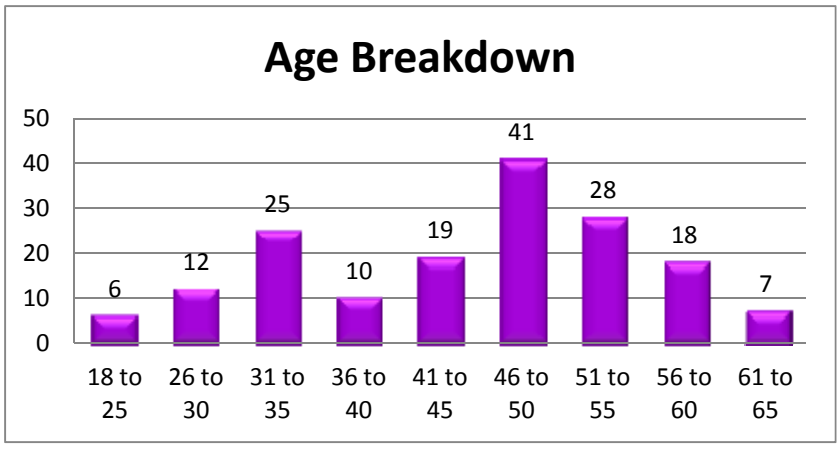

Figure 3. Age breakdown of female MST patients discharged from the residential/inpatient programs reviewed.

B. Service Era

Figure 4 depicts the service era of program participants. Thirty-eight percent of patients served in the Post-Vietnam era, 27 percent in the Persian Gulf War era, 27 percent in the OEF/OIF/OND service era, and 6 percent during the Vietnam era. The "other" category included three active duty service members and two former Reservists.

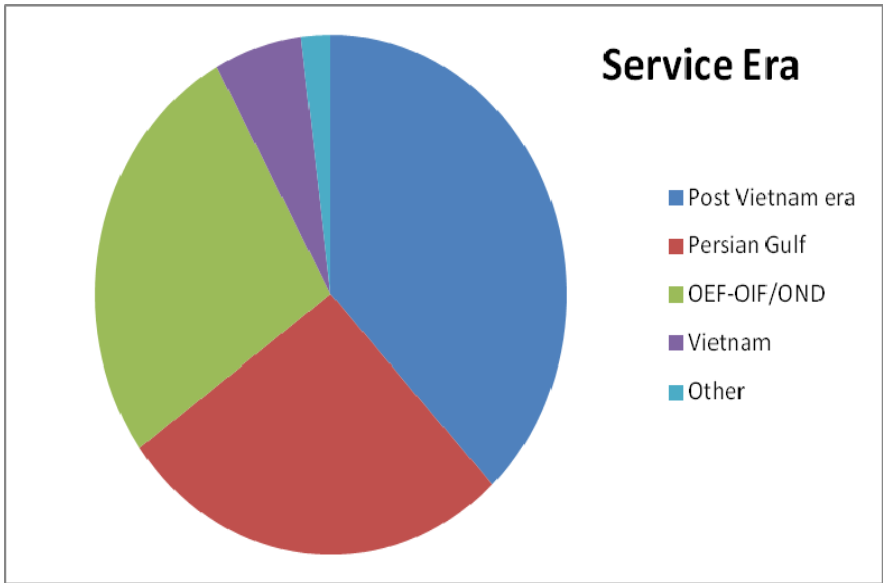

Figure 4. Service era of female MST patients discharged from residential/inpatient programs reviewed.

Among the 44 OEF/OIF/OND era patients, ages ranged from 23 to 51 years with an average age of 34. These patients represent veterans who served in the military during the OEF/OIF/OND era whether or not they were deployed. A few had also served in prior eras but for purposes of the review, patients were categorized by their most recent era of service.

C. MH Diagnoses

MST is a stressor rather than a MH diagnosis. Although not all patients who report a history of MST will need or want treatment, MST like other stressors has been shown to lead to the development of PTSD and other MH conditions including depression, anxiety, and substance use disorders. [40]

Figure 5 displays Axis I and II[41] diagnoses of patients in the programs reviewed. For the sake of consistency, any presumptive ("rule out") diagnoses were included in the categorization. PTSD, depression, and alcohol/substance abuse or dependence were the

[40] Valdez et al.

[41] In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) multi-axial classification scheme, mental health diagnoses (depression, schizophrenia, etc) are listed on Axis I. Axis II is used to denote personality disorders, intellectual deficits (mental retardation) or developmental disorders.

most common diagnoses. Ninety-six percent of patients had a diagnosis of PTSD, 63 percent had been diagnosed with a depressive disorder, and 70 percent had an alcohol or substance use disorder. Approximately 27 percent of patients also had an Axis II diagnosis of borderline personality disorder, further adding to the complexity of clinical presentation.

Not unexpectedly, most patients had more than one comorbid[42] MH diagnosis. Only seven women (4 percent) had a single MH diagnosis. The remaining 96 percent had two or more MH conditions. All of the women with an alcohol and/or substance use disorder were dually diagnosed with one or more MH conditions. Of the 160 women with PTSD, only four had this as a sole diagnosis; the remaining 98 percent had psychiatric comorbidities.

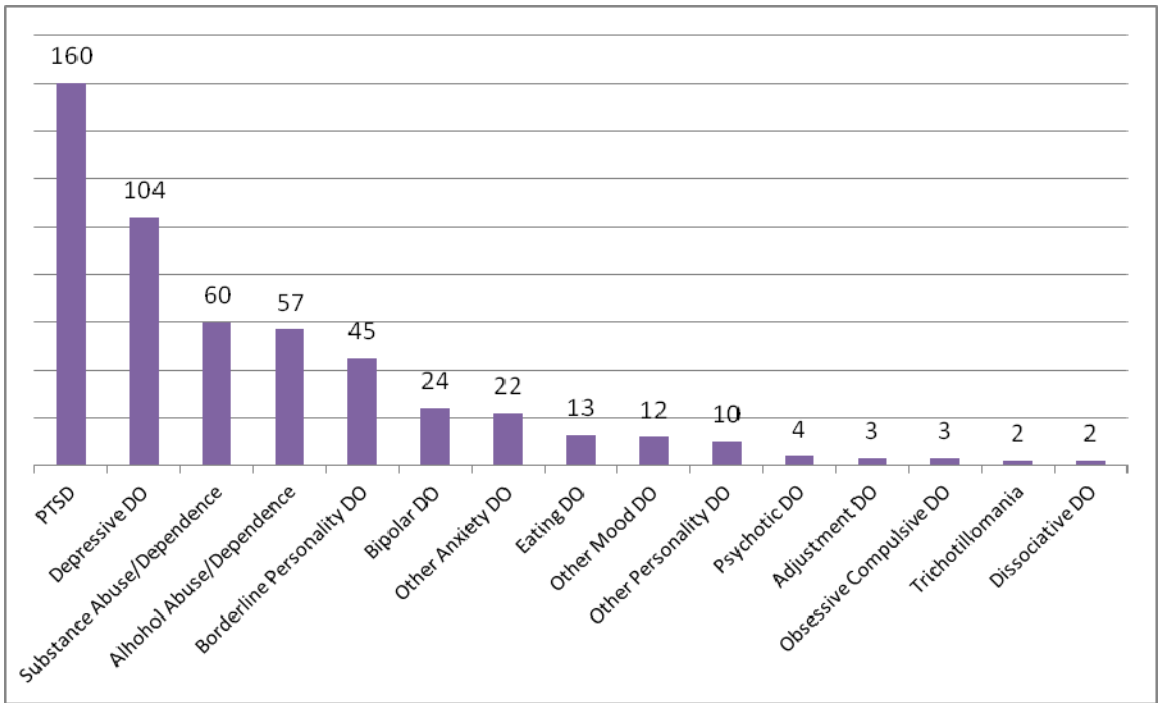

Figure 5. DSM-IV Axis I and II MH Diagnoses for female MST patients discharged from the residential/inpatient programs reviewed. DO=disorder. Other anxiety DO includes panic disorder, generalized anxiety disorder, social anxiety disorder, and anxiety disorder not otherwise specified. Other Mood DO includes Mood DO due to a general medical condition, substance-induced Mood DO and Mood DO not otherwise specified. Trichotillomania is an impulse-control DO characterized by the pulling out of one's hair.

Of note, 13 patients were diagnosed with some form of eating disorder. On self-assessment responses and during site visits, several programs responded that they did not feel equipped to manage patients with significant eating disorders (those with the potential to affect physical health status). Staff reported that the needs of these patients

[42] Comorbid refers to a disease, dysfunction or condition that occurs simultaneously with another.

are more appropriately addressed in an acute inpatient setting or in a program specialized in the treatment of significant eating disorders.

MST has been associated with a lifetime history of interpersonal trauma, including childhood sexual abuse, and sexual assault prior to, and subsequent to military service. Additionally, some studies have indicated high rates of pre-military, military, and post-military interpersonal trauma exposure among veterans.[43] We did not quantify patients' history of other traumas during EHR review. However, during site visits, clinical staff reported that program participants often had a history of multiple life traumas, including childhood sexual abuse, childhood physical abuse, domestic violence, adult civilian rape, or combat exposure.

D. Parental, Employment, and Housing Status

Because parental responsibility and job commitments could be factors affecting participation in a treatment program lasting several weeks or months, we examined the percentage of patients with responsibility for minor children and/or who were employed at the time of admission. Twenty-six (16 percent) of the 166 patients were responsible for the care of minor children. There were five patients for whom this could not be determined. Thirteen (8 percent) of program participants were employed.

Homelessness was not identified as a barrier for program admission at any of the programs. Thirty-one (19 percent) patients were homeless at the time of the admission under review. For homeless patients, an inherent advantage of residential programs over outpatient treatment is the ability to address housing needs during residential treatment. This is an important need as the rate of MST identified in homeless women veterans is higher than the rate of MST in the women veteran population overall. In FY10, among women who used VHA for health care, 23 percent of all women veterans had screened positive for MST, but over 39 percent of homeless women veterans had a positive MST screen. [44]

E. Service Connection

Figures 6 and 7 depict the percentage of patients in our review who were service connected for any condition or for a MH condition. Seventy-one percent of participants were service connected. Fifty-five percent of participants were service connected for a MH condition.

---

[43] Luterek et al., *Posttraumatic sequelae associated with military sexual trauma in female veterans enrolled in VA outpatient mental health clinics*, Journal of Trauma & Dissociation, 2011; 12:3, 261-274.

[44] Rachel Kimerling, PhD and Julie Karpenko, MSW, *Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma – Presentation to the National Association of State Women's Veterans Coordinators,* May 16, 2012.

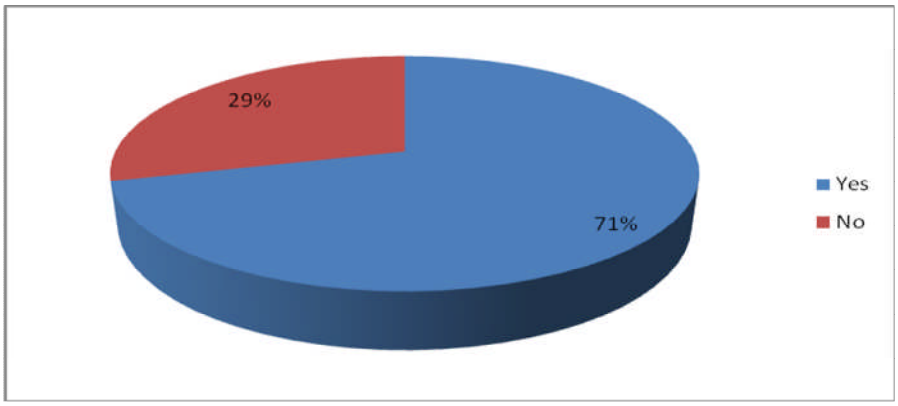

Figure 6. Service connection for any condition among female MST patients discharged from the residential/inpatient programs reviewed.

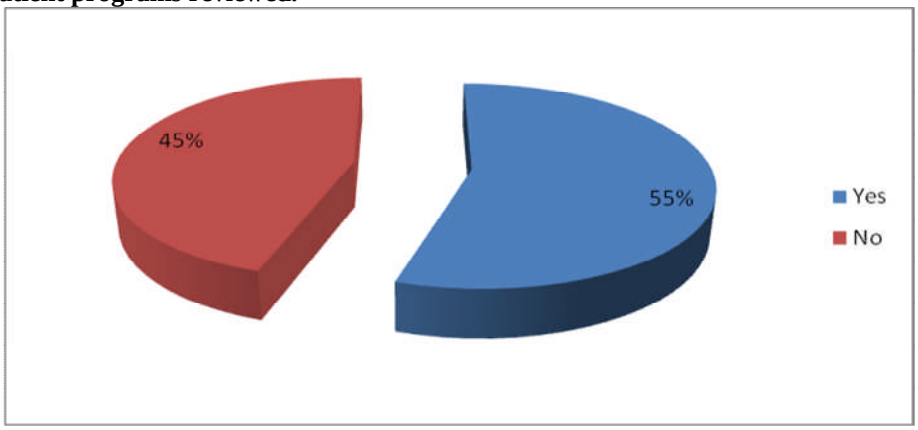

Figure 7. SC for any MH condition among female MST patients discharged from the residential/inpatient programs reviewed.

MST Screenings

Patients who screen positive for MST may or may not need or desire treatment for MST related issues or conditions. Some patients may not be in need of or pursue treatment at one point in time but may seek treatment at a later point in time. Most patients who screen positive for MST and seek MH care receive treatment in an outpatient setting. The programs highlighted in this inspection represent a higher level or intensity of care provision.

Of the 166 patients reviewed, five did not have veteran status and were therefore not screened for MST in VA. Table 2 depicts MST Screening results found:

MST Screening Results Positive	154 (95.7 percent)
MST Screening Results Negative	7 (4.3 percent)
MST Screening Not Completed	0 (0 percent)

Table 2. Distribution of MST Screening Results.

Of the 161 women eligible to be screened, 131 patients had a positive MST screening at some point in time prior to referral to the program in our review. Twenty-three patients had a positive screening documented after referral to residential treatment. Seven patients had their MST screening documented as negative. For these seven patients, any outpatient care received related to MST would not be captured by MST monitoring data.

MH Treatment Proximate to Admission

A. Outpatient Treatment

We reviewed aspects of patients' MH care immediately prior to the index residential or inpatient treatment. We found that 147 of 166 (89 percent) received outpatient VA MH treatment in the 3-month period prior to admission to the residential or inpatient program.

Figure 8 illustrates the type of facility(ies) at which the 147 patients with outpatient treatment in the 3-months prior to admission received care.

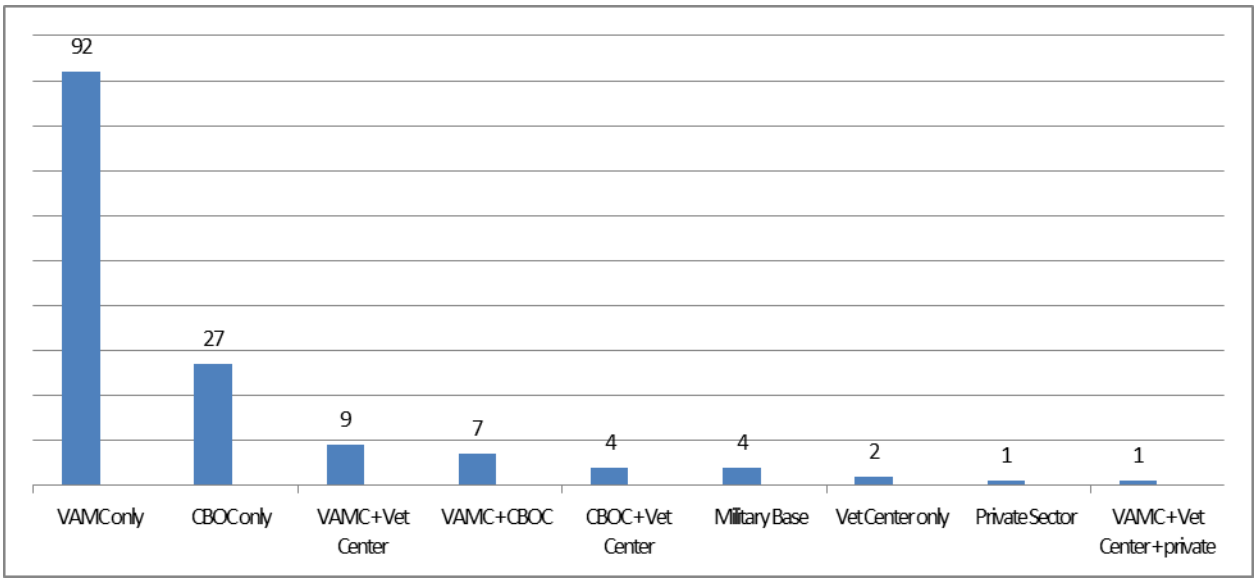

Figure 8. Location of outpatient MH care in the 3-month period preceding participation in the residential/inpatient programs reviewed.

Nineteen patients in our review did not receive outpatient care prior to admission, however, of these, 10 went directly from one residential program to another, and 3 went from an inpatient to a residential program.

B. Type(s) of MH Services Received Proximate to Program Admission

For those who received outpatient MH care prior to admission, Figure 9 displays the types of treatment received. Most women received more than one type of treatment:

- 32 (22 percent) were involved in one type of treatment
- 77 (52 percent) were involved in two types of treatment
- 34 (23 percent) were involved in three types of treatment
- 4 (3 percent) were involved in four types of treatment

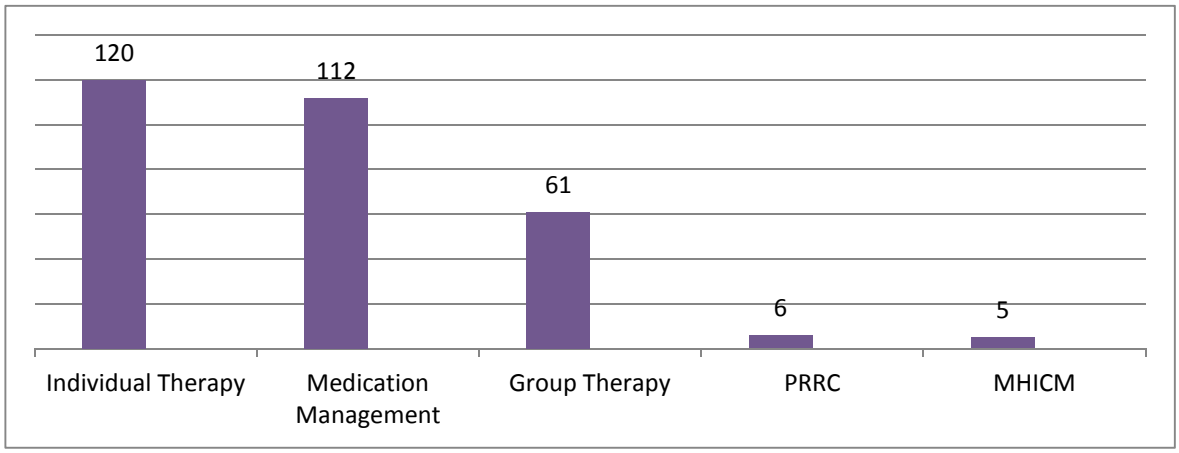

Figure 9. Type of outpatient MH treatment received by those female patients seen for outpatient MH during the 3-month period prior to participation in the residential/inpatient programs reviewed.

Five patients were being treated in MH Intensive Case Management (MHICM) programs; additionally, six patients were receiving treatment in a Psychosocial Rehabilitation and Recovery Center (PRRC) program. While patients in these programs typically receive individual and group therapy as well as medication management, we did not count these towards the totals above unless it was clear from the EHR that these were received outside of PRRC or MHICM.

C. Prior Residential/Inpatient MH Treatment within 3 Years of Program Admission

We determined whether program participants had been treated in a MH RRTP program within a 3-year period prior to the admission under review. Approximately 29 percent (48 of 166) of the patients within our review had previously received treatment in one or more MH RRTPs. Previous MH RRTP treatment was not always MST related; some women were in residential treatment for substance abuse or homelessness. MST was one of the issues involved in prior residential treatment for nearly half (23 of 48) of those who had been in an MH RRTP within the prior 3 years.

D. Gender of Outpatient Providers

Figure 10 shows the gender of the MH provider seen prior to admission. We used the gender of the primary therapist (provider who performed individual therapy). If there was no therapist, we used the gender of the psychiatrist who saw the patient for medication management. Five patients had both male and female therapists. For four

patients, the provider's gender was unclear from EHR review. Most female patients (83 percent) received outpatient MH treatment from a female therapist or clinician.

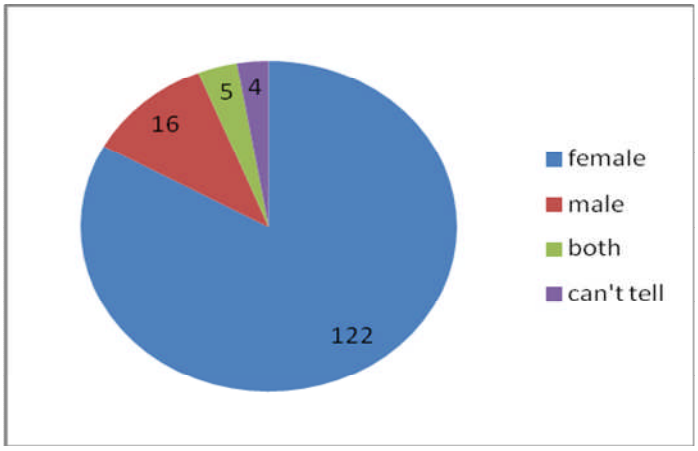

Figure 10. Gender of primary therapist for patients in our review who received outpatient MH treatment within 3-months prior to admission to inpatient/residential treatment.

Of the 147 patients who received outpatient MH care in the 3-months prior to admission, 138 were seen for primary care by a provider at the same facility. Of these patients, 103 (75 percent) were seen by a female primary care provider and 11 (8 percent) by a male primary care provider. Primary care provider gender was unclear from EHR review for 24 patients (17 percent).

Referral Patterns and Issues

A. Referral from another Facility

In order to evaluate whether the programs reviewed served mainly as local resources or national resources for female veterans with MST, we ascertained whether female MST patients in a residential/inpatient program had been referred from the same facility as the residential/inpatient program or from another VA facility. Figure 11 illustrates that 67 percent of the program participants had been referred by a different facility than the one providing this residential admission.

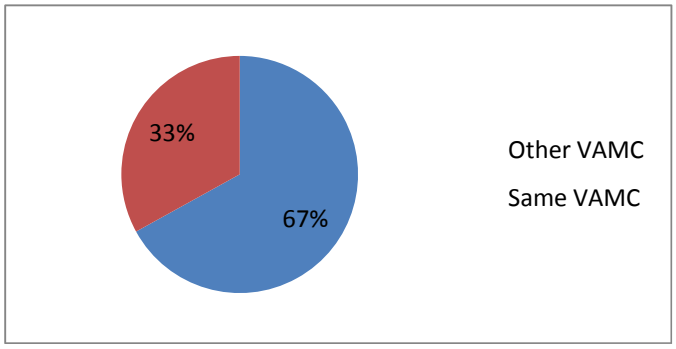

Figure 11. Percentage of female program participants with MST referred from VA facilities other than the VAMC of the residential/inpatient program reviewed.

B. Referral from Outside the VISN

On self-report, all but one program indicated that they accept patients from other Veterans Integrated Service Networks (VISNs). This one program reported that it is mainly a referral source for its own VISN, but will accept patients outside of the VISN on a case-by-case basis.

Figure 12 indicates the percentage of participants who had been referred from a facility within the same VISN or from a VA facility outside the VISN. Ninety-three women (58 percent) had been referred from within the VISN while 68 women (42 percent) were referred from another VISN. Of the 93 patients who had been referred from within the VISN, 54 were referred from the same facility as the residential/inpatient program, while 39 had been referred from other VAMCs.

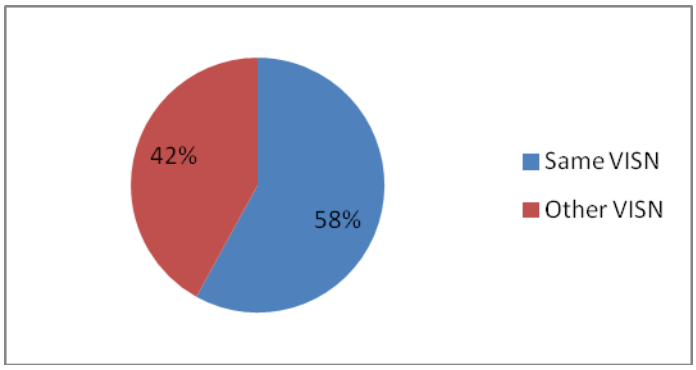

Figure 12. Percentage of participants referred from VA facilities in the same VISN or a different VISN from the residential/inpatient program reviewed.

Program staff at all sites reviewed reported accepting referrals directly from Vet Centers.[45] During EHR review, we noted that 6 of the 166 patients had been directly referred by Vet Center staff. A few programs required patients to be engaged in outpatient MH treatment or a less restrictive treatment alternative at the time of referral. Other programs preferred but did not require that referred patients were engaged in outpatient MH care.

C. Geographic Distribution of Female Program Participants

Table 3 illustrates the breadth of locations from which program participants were referred for each of the residential/inpatient programs reviewed. Most programs function as a national referral resource and draw patients from both within and outside of the program site's VISN. As an example, in this review, we found that Bay Pines, FL, accepted women from California, Oklahoma, Wisconsin, Texas, Mississippi, Iowa, Alabama, and Washington, DC, in addition to those participants from their own VISN.

[45] Vet Centers are community based MH clinics, separate from VAMCs, managed by VHA Readjustment Counseling Service.

Facility	VISN	Percent of Participants From Outside of VISN
Boston – Brockton	1	88
Baltimore	5	83
Lyons	3	78
Batavia	2	72
Bay Pines	8	47
Menlo Park	21	45
Temple	17	41
Cincinnati	10	40
Topeka	15	33
Long Beach	22	33
Salem	6	14
Houston	16	0
Sheridan	19	0

Table 3. The percentage of participants in our review admitted to a program outside their VISNs.

D. Transportation

Some of the most frequently cited concerns we heard from program staff at both the facility and VHA level pertained to patient travel. According to the VHA Handbook on Beneficiary Travel, [46] only certain veterans are eligible for travel pay. Those eligible for travel pay include veterans who:

- Travel for treatment related to a service-connected (SC) condition
- Are SC at a rate of 30 percent or more, for treatment of any condition
- Travel for Compensation and Pension examinations
- Receive non service-connected (NSC) pension
- Are low income, defined by income not in excess of the VA pension rate

Travel policy dictates that travel pay will only be given for transport to the closest VA facility "where the care or services could be provided."[47] The admission patterns we found in our review demonstrated that women were routinely referred to programs in facilities outside of their VISN and geographic region as they needed the services provided at some programs that were considered "national resources."

[46] VHA Handbook 1601B.05, *Beneficiary Travel*, July 23, 2010.
[47] VHA Handbook 1601B.05.

During site visits, clinical staff at several program sites reported that negotiating patient travel was "always a problem." From EHR review, we noted one veteran whose start date was postponed to the next cohort as the referring facility and treating facility were debating responsibility for transportation costs. We also noted that veterans are not eligible for travel pay after an irregular discharge, causing logistical difficulties for treating programs when this arises, especially given that the women they serve may need to traverse the country in order to return home. In a recent report, GAO identified logistical challenges such as travel and transportation as a key barrier faced by some veterans seeking MH treatment.[48]

One program with a wide national patient distribution indicated "travel having to be paid for by our facility both ways" as a challenge; but putting patients first, had decided to provide bi-directional transportation. Another program, which primarily serves patients within their VISN, reported that they also decided to provide the bi-directional transportation funding for all patients participating in the program who come from an outside facility. However, at other sites, clinicians reported that sorting out travel funding arrangements continues to be challenging for patients and staff.

VHA mandates that "veterans and eligible individuals must have access to residential or inpatient programs able to provide specialized MST-related MH care, when clinically needed."[49] The MST Directive also states that "at a national level, there is a need to consider developing a number of these programs as national resources and to arrange processes for referral, discharge, and follow-up."[50] The same directive requires that "all health care for treatment of mental and physical health conditions related to MST, including medications, is provided free of charge" and that fee basis should be available when indicated. The directive supports the development of national resource programs and suggests that national resources should be utilized to facilitate patient participation in these programs. Because eligibility requirements for care are waived in the case of MST, veterans may expect any transportation costs to be covered.

E. Time Interval from Referral to Program Start

Program duration, cohort versus a non-cohort treatment structure, and frequency of cohorts are among the factors that impact the time between when a patient is referred to a program and when they begin treatment in the program. For example, if a program uses a cohort-based structure, and there is an ongoing cohort at the time of referral, the patient would typically start the program at the beginning of the next cohort.

[48] GAO, *VA Mental Health – Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access,* October 2011.
[49] VHA Directive 2010-033.
[50] VHA Directive 2010-033.

Patient preference, such as deferring program start until the end of the school year, also impacts the referral to start interval. In addition, as previously mentioned, resolving issues related to travel reimbursement may affect program start for some patients. The combination and variability of these factors from patient to patient and site to site make it difficult to meaningfully compare average days from referral to start (referral to start interval) from program to program. However, significant changes (positive or negative) in an individual program's referral to start interval over time might lead the program's leadership to explore reasons for the change.

Structure, Programming, and Treatment Characteristics

During the course of the inspection, we found a diversity of structure and programming emphasis through which these programs treated patients with complex histories and clinical presentations. From surveys, interviews and site visits, we elicited information about the programs' missions, capacities, strengths, and challenges. From EHR review, we corroborated self-reported data and verified the availability of specific services and gender specific care.

A. Program Structure

As noted previously, programs differed in structure and programming emphasis, but we found they did not differ appreciably in core services offered. Types of programs within our review included residential (MH RRTP), inpatient (SIPU), or outpatient services with a corresponding supportive housing component. One of these programs was classified as a Compensated Work Therapy program with a Therapeutic Residence (CWT/TR). Residential and inpatient programs are available for patients who require a more structured, intensive experience than can be obtained through typical outpatient MH treatment programs.

All of the programs classified as MH RRTPs require that participants be self-care. According to VHA policy, one distinction between PTSD RRTPs and SIPUs is that PTSD RRTPs are more suited for those "veterans who have better self care and self control capabilities than those who require inpatient care."[51] MHS staff told us that there are very few SIPUs left. We found that the treatment provided in the PTSD RRTP programs and the SIPU programs we reviewed was very similar.

We heard consistently that the most important factor in the screening for admission process is whether the veteran is motivated and able to engage in the type of treatment offered. Participation requires the ability to tolerate the group environment. Most programs have admission criteria related to psychiatric stability, and will not admit patients who are actively suicidal, actively psychotic, or manic, or a danger to themselves

[51] VHA Handbook 1160.03, *Programs for Veterans with Post-Trauma Stress Disorder (PTSD),* March 12, 2010.

or others. However, Houston's WISER program accepts patients who are less psychiatrically stable. WISER staff reported that 44 percent of the women in their program had a psychiatric hospitalization within 1-month prior to admission and 27 percent had a suicide attempt within 1-year of admission to their program.

Four programs we reviewed (Bay Pines, Long Beach, Lyons, and Temple) focus specifically on working with survivors of sexual trauma. The programs in Baltimore and Brockton both emphasize dual PTSD-substance abuse treatment. Other programs in our review emphasize and often require a diagnosis of PTSD for admission. It should be noted that even if programs were not specifically substance abuse treatment programs (SATPs), they accepted and worked with patients with a history of comorbid alcohol and/or other substance abuse.

The Jamaica Plains CWT/TR program (the TRUST House) in Boston emphasized vocational and community reintegration. No particular diagnosis was required for this program, but women would need to benefit from a long-term program to address employment and other individualized psychosocial issues and must be able to work at least part-time. Women in the TRUST House receive MH care through the outpatient Women's Stress Disorder Treatment Team (WSDTT), which specializes in the treatment of trauma-related disorders, but the TRUST House staff and WSDTT work closely together to provide coordinated care. TRUST House patients receive other health care services through the Women's Health Clinic.

The Long Beach RENEW program combines outpatient MH care with supportive housing. The Long Beach RENEW program markets their program to those who live locally and would benefit from outpatient care, and those who live remotely or need housing and can benefit from the supportive housing program at US VETS while they participate in the RENEW program. US VETS is a Grant Per Diem (GPD) program, meaning that housing and supportive services have been contracted out but VA has oversight for services provided. The Long Beach US VETS program offers beds for 10 women, not all of whom have experienced MST. We found several women were in the US VETS program while going through RENEW; others were provided housing through hoptel[52] for the program's 12-week duration. The RENEW/US VETS program was the only program we reviewed which was able to house women and their children.

[52] Hoptel is a program providing temporary lodging, typically at VA facilities, or otherwise at a nearby motel or hotel and funded by the VA.

B. Program Duration, Capacity, and Census

Program lengths varied, partly as a function of the type of program structure. Those defined as inpatient (SIPUs) tended to have a shorter program duration, while the one CWT/TR program in our review (Boston-Jamaica Plain) routinely had participants stay in the TRUST House for 9 months or more. Average, self-reported program length (in days) is depicted in Figure 13 below.

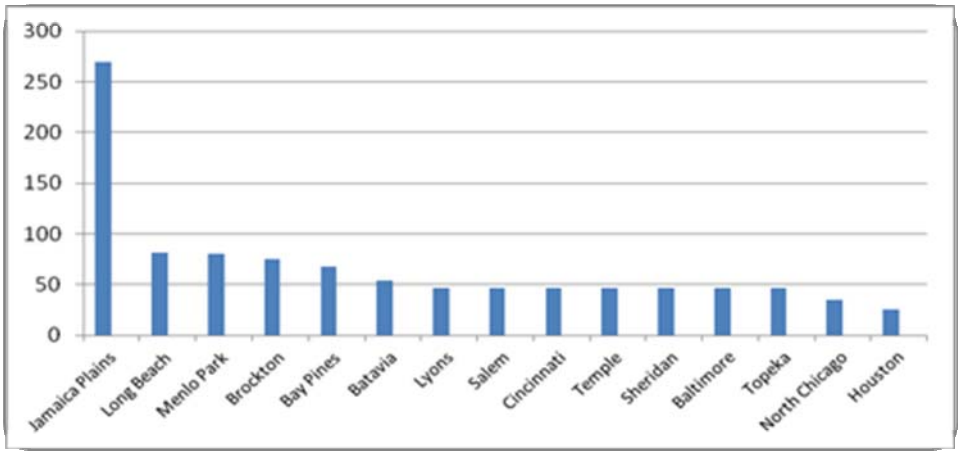

Figure 13. Self-reported approximate program length (in days) for programs reviewed.

Since FY05, the proportion of female veterans served in MH RRTP programs has nearly doubled. In FY11, women represented 6 percent of veterans served in any MH RRTP program and 9 percent of veterans served specifically in a PTSD-RRTP program.[53] Most of the programs we reviewed are not exclusive to women with MST. For most programs, bed capacity includes other types of patients – for example, programs like Menlo Park and Houston work with women veterans with PTSD regardless of the stressor; many of their patients have PTSD due to combat experiences or the combination of combat with other stressors such as childhood sexual abuse, or other traumatic experiences. The housing available for RENEW participants through the Long Beach VAMC is part of a larger GPD program for homeless women in general; therefore, it is not expected that all of these beds would be available for RENEW participants.

Another factor in determining capacity is whether programs use cohort based or a rolling admissions schedule. Cohort admission means that a group of participants starts and finishes the program together, at defined intervals. The Houston WISER program is a 25-day program; therefore, a new cohort of women starts every 4 weeks. Capacity is impacted by the frequency that women's cohorts are scheduled. Some programs (Salem and Sheridan) have women's only cohorts scheduled only twice per year. Cincinnati had been offering women's only cohorts twice per year, but will increase to 6-7 cohorts per year now that facility construction has been completed.

[53] http://vaww.nepec.mentalhealth.va.gov/RRT/PRR/prrtp.htm NEPEC FY11 RRTP Workload Data Tables, accessed August 28, 2012.

Rolling admissions means that participants are admitted as space allows. As veterans' discharge dates are determined, new admissions can be planned accordingly. Rolling admissions offer the ability to "fill a bed" in a timely manner if there are no-shows or unexpected, premature discharges from the program. It also allows new participants to benefit from the role modeling of participants who are further along in their treatment. Similar to the issue of same-gender or mixed-gender treatment, we do not take a stance on whether one model of admissions is advantageous over the other; there are known benefits and limitations of each.

Program capacity is more difficult to determine with rolling admissions. To illustrate, we estimated that the bed capacity for the Women's PTSD-RRTP program at Menlo Park was 45 participants per year. The program length is 60 to 90 days, depending on the patient's needs and treatment plan. We were told that the average bed turns over every 80 days, or approximately 4.5 times per year. With 10 beds dedicated to women, this offers an estimated annual capacity of 45. Table 4 lists our estimated capacity for the women only programs reviewed. Our estimate is based on the number of beds in the program, multiplied by the approximated program cycles completed per year (based on the program duration as reported by facilities).

Program	# of Female Beds	Approximated Program Cycles per Year	Estimated Annual Capacity
Batavia	6	6	36
Bay Pines	8	5	40
Boston-JP	8	1 – 2	12
Boston-Brockton	8	4 - 5	36
Cincinnati	12	6 -7	78
Houston	10	12	120
Long Beach[54]	10	4	40
Lyons	10	7	70
Menlo Park	10	4 - 5	45
Salem	14	2	28
Sheridan	10	2	20
Temple	8	7	56

Table 4. Estimated annual capacity for the programs reviewed with a women's only track. Baltimore and Topeka are mixed gender programs and do not have a specified number of beds for women participants; therefore, they were not included. Bay Pines CSTS program has 16 beds between the men's and women's programs and census has historically been about 50 percent female.

A review of NEPEC data on bed utilization of MH RRTP programs shows that most of the programs within our review do not maintain a full census.[55] This represents overall capacity, not just the availability for women or any sub-population. Staff at several sites told us that they do not typically maintain a full census and could increase their number of women served. Table 5 illustrates the most recent available NEPEC data on bed

[54] There are 10 beds in US VETS program; if filled then Hoptel may be utilized for those veterans who travel for this program and need lodging.

[55] http://vaww.nepec.mentalhealth.va.gov/RRT/PRR/prrtp.htm NEPEC RRTP Quarterly Bed Report, accessed August 28, 2012.

utilization for the MH RRTP programs in our review. Houston, Salem, Long Beach, and Topeka are not included in the table as these programs are not MH RRTPs. Except for those programs which specialize specifically in sexual trauma (Bay Pines, Lyons, and Temple) programs listed below include the overall capacity for the bed section, not just capacity for patients with MST.

MH RRTP Programs Reviewed	FY12 Q2 Average Program Occupancy Rates, per NEPEC (in percents)
Lyons	81.1
Bay Pines	80.4
Sheridan	79.5
Batavia	73.2
Baltimore	69.6[56]
Temple	59.3
Menlo Park	59.0
Boston-Jamaica Plan – TRUST House	58.6
Cincinnati	49.7[57]
Boston-Brockton	41.9

Table 5. Average daily census versus capacity, per NEPEC for the MH RRTP programs in our review.

C. Therapies/Programming/Services Offered

Staff from MHS and the MST Support Team indicated that there is "no uniform model" of care for MST patients, and further stated "nor should there be." Because symptoms emanating from MST can be manifested in many different clinical presentations and patients present with a variety of complex treatment issues, it was expressed that there should be a variety of treatment approaches available for this population.

All programs we reviewed offered one or more types of EBP. Every program had multiple staff that had completed VA CPT training. Some programs offered more than one approach and worked with women to help them decide which treatment option to pursue. Most sites offered CPT as the dominant approach for trauma processing but incorporated other EBPs into the curriculum. For example, Houston's WISER program offered a daily CPT group, but also offered DBT and Seeking Safety groups, as well as other recovery-oriented options, throughout the week. Lyons offers PE and CPT on an individual basis, but incorporates other EBPs such as DBT into group sessions.

Some programs adopted a particular approach that was used program wide with all participants. For example, Salem utilized ACT as their primary treatment approach. Long Beach's RENEW program uses Holographic Reprocessing, a "cognitive-experiential psychotherapy," in addition to other EBPs such as CPT and PE. Several sites reported the additional use of Eye-Movement-Desensitization-Reprocessing (EMDR)

[56] Baltimore SATP-RRTP had a temporary decrease in beds during the timeframe due to building repairs.
[57] A significant number of beds for the Cincinnati PTSD-RRTP were unavailable due to renovations and construction.

therapy. We also found a wide diversity of offerings related to treating insomnia, nightmares, and other sleep disturbances.

All programs utilized recreational therapy as a component to promote leisure skills development and self-expression, whether the emphasis was on art therapy, music therapy, yoga, or self-defense. Sheridan, a rural locale, was able to offer equine therapy where program participants help care for the horses. Menlo Park patients had the opportunity to work with community partners to help train service dogs.

Two programs mentioned their intention to expand programming for the lesbian, gay, bisexual, and transsexual population (LGBT). Menlo Park is starting a treatment group specific to these veterans, and the Salem program is collecting data to determine if there is adequate demand for a cohort specific to this sub-population.

We did not find a treatment plan documented in the EHR for only 2 of the 166 patients we reviewed. Both of these patients left the program after only 3 days, prior to completion of a treatment plan. Of the 164 women with a treatment plan, 98 received individual psychotherapy and 66 did not. Women in programs at Houston, Topeka, Menlo Park, Brockton, and Salem did not routinely receive individual psychotherapy sessions. Most of these programs offered individual sessions weekly for case management, homework review, medication management, or discharge planning; however, individual psychotherapy was not conducted during these sessions. In programs where individual therapy was provided, we consistently found that the clinician providing the treatment was female.

At some sites, clinicians told us that they saw the group milieu[58] as central to the treatment process and the decision to emphasize group treatment over individual treatment was purposeful based on that approach. Salem program clinicians told us that overcoming feelings of guilt, shame, and secret-keeping, as well as leaning how to communicate and confront, are central dynamics in the recovery from sexual trauma. For this reason, all therapeutic activities are conducted as a group.

The 164 treatment plans we reviewed all included group therapy. We found that 100 percent of the 164 women participated in one or more types of group therapy. Both male and female clinicians facilitated groups, although the vast majority of clinical programming was provided by female staff. We found that groups involving trauma processing were usually led by female clinicians. At several programs, male clinicians, when involved, led groups on topics such as maintaining sobriety, anger management, or self-defense. Male clinicians might also lead other recreational groups and psycho-educational groups and classes. If women patients requested to work with a therapist of a specific gender, this request was honored.

[58] Milieu is defined as a healing environment and therapeutic community.

D. MH Clinicians and other Staff of the Programs Reviewed

MHS and program staff told us that there was no prescribed criteria for being a "MST provider." Typically, the expectation was that the clinician would be a licensed professional of a MH discipline and that the individual had experience working with trauma victims. All VHA MH providers are required to complete a VA MST training module. The Bay Pines program offers annual MST training for other VHA staff and was cited by other sites as a resource.

We found that individual and group therapy sessions were led by licensed MH providers, usually psychologists or licensed clinical social workers. Occasionally, groups were facilitated by addiction therapists or vocational rehabilitation counselors. Frequently, documentation indicated that groups were co-led, meaning there was more than one facilitator present.

Every program had at least one psychiatrist. Typically, the psychiatrist was involved in weekly medication monitoring and other rounds or team meetings, but in some programs, such as the WISER program in Houston, the psychiatrist was also involved in providing psychotherapy. Most of the programs identified a designated mid-level provider (physician's assistant or nurse practitioner) to perform history and physical examinations at admission and address medical needs as they arose. Medical issues of a more serious nature, or those occurring during off-tour hours, were addressed in the nearest VHA or community emergency department.

To the extent that it was documented in the EHR, we found varying degrees of chaplaincy support involved in the programs. Cincinnati had a female chaplain who was engaged with the treatment team and offered spirituality groups as well as individual pastoral care for those who wanted it.

In recent years, VHA has increased emphasis on the use of peer support in the recovery process. A peer is defined as "a consumer who has had similar life experiences in terms of illnesses, life events, and treatments for mental illness and/or substance use disorder as the persons being served."[59] According to MHS, the use of peer support staff, either paid or as volunteers, is increasing in PTSD and MH RRTP programs. We found peer support technician documentation in the EHR (typically as a co-facilitator of a weekly recovery group) at several programs we reviewed. We noted that the peer support technician at one program was female, and helped orient women to the program and remained available for the duration of the program.

[59] VHA Handbook 1163.05, *Psychosocial Rehabilitation and Recovery Services – Peer Support*, July 1, 2011.

Aftercare

A. Aftercare Location and MH Outpatient Treatment Arrangements

Our EHR reviews showed that aftercare (follow-up MH services after program discharge) was almost always arranged before women left the inpatient or MH RRTP program. Generally, aftercare was provided by the referring facility where the veteran had been receiving outpatient MH services prior to admission to the program. This was true whether the referring facility was a medical center, CBOC, Vet Center, or any combination of the above.

We usually did not find that treating program staff remained engaged with the veteran after she returned home unless she received her outpatient care at the same facility as the program. Ten women received aftercare from program therapists on an outpatient basis after they relocated to the area where the program was located. Some women who completed the 12-week Long Beach RENEW program opted to stay for the 12-week follow-up program offered there as well. Clinical staff for the TRUST house in Jamaica Plains also reported that some patients previously treated in their program had relocated to the area and were receiving MH care in the Boston VA's WSDTT program.

Five women received aftercare at a facility that was neither the referring or the treating facility. Three of these women were admitted to another MH RRTP program at discharge.

Only six women (less than four percent) did not have aftercare arranged before leaving the program. Of these six, four ultimately had aftercare arranged within a few days. The two women who did not have any aftercare arranged both told staff they were going to move to another geographic region where they were not previously established with VA care and would enroll with the local VA medical center once they were moved.

Some patients required admission to an acute psychiatry unit prior to or at the time of discharge from the MH RRTP program. In these cases, the acute psychiatry unit staff made the aftercare arrangements at the time of discharge from that unit.

B. Admission to another MH RRTP or Acute Inpatient Unit Post-Discharge

Twenty-two of 166 (13 percent) patients were readmitted to an inpatient unit or residential setting within 30 days of program discharge. Three of the 22 women were admitted to medical units. Seven of the 22 were admitted to an acute psychiatry unit at discharge from the MH RRTP or within 7 days of discharge. Two of the seven women were admitted due to a suicide attempt or gesture.

Twelve women (7 percent) went directly to another MH RRTP program at discharge. Five women went to MH RRTPs with an emphasis on homelessness. Two women went

to a different PTSD-RRTP program upon discharge. Two other women went into a SARRTP program. Three women returned to the MH RRTP where they had been before this admission.

Program Barriers and Challenges

Capacity. A challenge commonly cited by facility staff related to maintaining an adequate volume of women veterans in these residential and inpatient programs. When asked about challenges in working with this population, Topeka staff reported their challenge as "maintaining enough female veterans in programs to focus on their issues." Some staff at Sheridan also expressed that they would like to see a greater number of women in each cohort and more cohorts scheduled. Houston cited challenges in "maintaining a consistent flow of referrals" and "getting the word out about their program." Assistance with program marketing was also cited as a need by staff at both Lyons and Temple.

Accuracy of Resource Information. The MST Support Team intranet site includes a list of inpatient/residential treatment resources for patients with MST. On initial review, we found that the reference list was not entirely up to date or accurate. Two programs on the list (Augusta, GA, and West Los Angeles, CA) indicated to us that they no longer provide the program listed.[60] During site visits, we asked program staff to compare the program description they provided us in their self-assessment to the program description on the MST Support Team list. Some of them noted discrepancies and/or outdated or incorrect information about their programs. The MST Support Team reported that they periodically survey programs to verify information posted is accurate, but otherwise relies on facilities to report program changes.

Some program staff reported an inordinate amount of time spent reviewing and eliminating referrals inconsistent with program focus. Other program staff reported having available beds but insufficient female veteran referrals. Clinical staff at one site reported that for the first few years their women's only program was functioning, they were at about 50 percent capacity; with aggressive intra-VA outreach and informal provider education, the program generated a sufficient and appropriate referral base.

NEPEC also posts information on their intranet site about MH RRTP programs that provide MST treatment; however, NEPEC staff told us this information is self-reported by facility without additional validation. Maintaining a current, accurate, coordinated resource list with comprehensive program descriptions might serve to facilitate outreach and increase the flow of appropriate referrals.

[60] When we subsequently accessed the list from the online intranet site in July 2012, Augusta had been removed from this list.

MST Coordinators. We met with MST Coordinators during our site visits and frequently heard that they had limited time (as little as 2 hours per week), for outreach activities and/or tracking of patients with positive MST screens, which is a key component of their function as outlined by VHA policy.[61] The proposed change to the MST screening clinical reminder to indicate if the veteran needs follow-up arranged could potentially further increase the duties and time demands of the MST Coordinator.

Eating Disorders. Research has found that women with PTSD (particularly those with a history of MST) have an elevated risk of being diagnosed with an eating disorder.[62] Thirteen women in our review were diagnosed with an eating disorder. Two sites we visited, and the MST Support Team, told us that working with women with active eating disorders was a particular challenge, as they may need a level of medical oversight that is not typically available in the MH RRTP setting.

Program Space. Some programs told us that even if they offer a women's only cohort or program, the women participants may be housed in the same building or share treatment space with men's or mixed gender programs. Depending on the program's philosophy and the expectations of the population served, this could be seen as a strength or a challenge. Some clinical staff perceived this as a challenge for some female veterans with MST. Other clinical staff expressed that an environment that includes men is normalizing, prepares women to be better able to integrate into the real world environment after program completion, and is a means to help women confront their fears while in a therapeutic environment.

Conclusions

We reviewed specialized services provided to female veterans with MST. The services were provided in selected inpatient and residential treatment programs identified by the MST Support Team as resources for female patients with MST. We found a diverse range of MH conditions among the women served. PTSD, depressive disorders, and alcohol/substance use disorders were the most common Axis I diagnoses. The patient population is clinically complex; nearly all patients had comorbid MH conditions and more than a quarter had been additionally diagnosed with a personality disorder. Clinical presentation was also complicated as far as the overall psychosocial composite; most patients were unemployed and many were also homeless. Program staff reported that patients often had histories of multiple traumas.

Patients highly utilized MH services in the 3-month period prior to treatment in the residential/inpatient programs reviewed. Most women were engaged in outpatient care

[61] VHA Directive 2010-033.

[62] Maguen et al., *Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with posttraumatic stress disorder,* Women's Health Issues Journal, 2012; 22:61-66.

prior to entering a residential program; some went directly from treatment in one residential program to another residential program. Patients' pre-program MH therapists were largely female.

We found diversity in the programming available in these specialized programs. Gender-specific care and same gender therapists were available. The MH RRTP and inpatient programs provide treatment to patients with a complex set of MST related MH conditions, non-MST related conditions, and psychosocial issues, for which there is not one "right" treatment approach but a handful of reasonable approaches. Across programs, we found a diversity of structures, program emphases, and treatment approaches through which programs address treatment of female veterans with MST related conditions. Treatments utilized varied by site, but generally included either formalized EBPs, mixed therapies comprised of underlying treatment principles from different EBPs, or both, in conjunction with supportive therapies and medication management.

Most programs drew patients from all areas of the country and appeared to serve as national resources. Three programs largely served only patients within their VISN. As we only examined those who were discharged from a program during a specific period of time, we cannot fully speak to the barriers that may inhibit access for those who did not seek or receive treatment in these programs. Program participants tended to be middle-aged and most did not have minor children in their custody.

From our review of EHRs or interviews with staff, we noted the following concerns: Difficulties obtaining authorization for patient travel funding was a consistent theme we heard from both facility and MHS staff. A review of the current policy for MST and the current policy for Beneficiary Travel reveals that the two do not align. VHA policy states that any veteran with MST needs to be able to access clinically appropriate care regardless of the location. We found that women were often referred outside their parent facility or VISN to one of these programs. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. While there are many MH RRTP programs within VHA, not all have been identified by VHA as a specialized resource for MST. If these two policies were better aligned, barriers to access could potentially be reduced.

Another issue we heard frequently from staff concerned program outreach within VHA. Some programs reviewed indicated a need to "get the word out" in order to attract an appropriate and consistent stream of referrals. In the same vein, we heard that MST Coordinators did not have adequate time to fulfill duties as outlined in the MST Directive, particularly as related to outreach.

VHA should review existing travel funding policy for this population; establish a centrally coordinated, comprehensive, and descriptive MST program resource list; and

ensure that MST Coordinators have adequate time to fulfill their outreach role. These efforts may promote fuller utilization by those women veterans who have experienced MST and whose individual clinical course indicates the need for a more intensive level of care than is available on an outpatient basis.

Recommendation

We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: November 9, 2012

From: Under Secretary for Health (10)

Subject: **Veterans Health Administration: Review of Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the Office of Inspector General (OIG) draft report, and I concur with the report's recommendations and findings. The Veterans Health Administration (VHA) is committed to ensuring that Veterans who experience military sexual trauma (MST) have access to the services they need to assist them in their recoveries. For a Veteran who needs intense treatment and support, specialized MST-related residential and inpatient programming can be a crucial component of the treatment process.

2. VHA appreciates OIG's thorough review of VHA's specialized MST-related residential and inpatient treatment programs, particularly OIG efforts to highlight the complexity of the treatment needs of Veterans who experienced MST and thus the benefits offered by the range of treatment approaches offered in these programs.

3. VHA has worked diligently to ensure access to residential rehabilitation and treatment for female Veterans with significant focus on ensuring safe and secure treatment environments and access to gender-specific care, and this will continue.

4. Thank you for the opportunity to review the draft report. An action plan to implement the report recommendation is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10AR) at (202-461-7014).

Robert A. Petzel, M.D.

Under Secretary for Health Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

Recommendation. We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

Concur

The Veterans Health Administration (VHA) agrees with the recommendation to review existing VHA policy pertaining to authorization of travel for veterans seeking Military Sexual Trauma (MST)-related treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

VHA will establish a workgroup to review issues and provide recommendations to the Under Secretary for Health NLT April 30, 2013.

In Process **To be completed: April 30, 2013**

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Carol Torczon, ACNP, Project Leader Karen McGoff-Yost, LCSW, Team Leader Michael Shepherd, MD Christa Sisterhen, MCD Darlene Conde-Nadeau, ARNP David Griffith, RN William Eli Lawson, Program Support Assistant

Appendix C

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
Office of General Counsel

Non-VA Distribution

Senate Committee on Veterans' Affairs
House Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Health, House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

This report is available at http://www.va.gov/oig/publications/default.asp