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Session: VA PTSD Residential Rehabilitation Treatment Programs (PRRTPs): Lessons for Improving PRRTP Services for Iraq and Afghanistan Veterans with Severe PTSD

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Molly: And without further ado, we are at the top of the hour, so I would like to introduce our speaker today. Joining us we have Dr. Eric Slade. He is a research health scientist at VA VISN 5, Mental Illness Research, Education, and Clinical Center, known as MIRECC, and an associate professor and director in the Division of Psychiatric Services Research in the Department of Psychiatry. And I think I accidentally clipped off an additional part (laughing), so Eric if I missed anything, I’ll let you add to that. And I’m going to give you the screen share now, so you’ve got that popup.

Dr. Eric Slade: Thanks Molly. Can you hear me okay?

Molly: Yep, you’re coming through. Thank you.

Dr. Eric Slade: So welcome everyone, and thank you Molly and HSR&D for this opportunity to present some of our research from an HSR&D funded project that ended a couple years ago. The work that I’m going to be presenting today is all from a qualitative portion of the study in which we conducted interviews on several aspects of PTSD Residential Rehab Treatment Programs, or PRRTPs. And all the interviews focused specifically on the Iraq and Afghanistan Veterans, and I’ll just use, as a shorthand I’ll refer to these Veterans as Triple-O Veterans for the operations they were involved in.

And I also wanted to thank my collaborators on this project you can see on the screen, especially my collaborator Amanda Peebles who is a qualitative interview expert and research expert and worked closely with me on this. By training I’m an economist, so this was unfamiliar territory for me. And then just thinking ahead, I’ll be asking for comments at the end of the presentation, and I’m happy to receive any comments by e-mail or if you want to set up a phone call with me. Some of you are going to have, I’m sure, additional information for me based on this work that we did.

So I will move along, and you can see the disclaimer on the screen that the contents do not represent the views of the U.S. Department of Veterans Affairs or the U.S. government. It’s just my own study and my collaborators’ study. And also I just wanted to thank quickly the VA New England Performance and Evaluation Center for providing some of the background data for this talk.

So what I’ll be talking about today is I'll be describing these PTSD Residential Rehab Treatment Programs and their Triple-O Veteran clients. I'll be discussing the methods of our qualitative study and the themes that we looked at in those interviews. And then I'll briefly give you a summary of the major points that emerged from those qualitative interviews and some recommendations about what the VA might consider in terms of continuing to work on improvements in the quality of PTSD services for Veterans with severe PTSD. Okay.

Key features of these programs and the clients. First of all, I just wanted to ask a poll question, so I'll turn it over to you, Molly.

Molly: Thank you. So for attendees, as you can see up on your screen, you do have your first poll question, so go ahead and select your response there. You can just click right there on your screen next to your answer. So we’d like to know how familiar are you with VA PTSD Residential Rehabilitation Treatment Programs. The answer choices are very familiar, somewhat familiar, or unfamiliar. We’ve got a very responsive audience today; 80% have replied. Okay, it looks like I see a pretty clear trend, so let me go ahead and close out the poll now and share those results. As you can see on your screen, 25% responded very familiar, 45% somewhat familiar, and 30% unfamiliar. So thank you to those respondents.

Dr. Eric Slade: Great.

Molly: And I'll turn it back to you now, Eric.

Dr. Eric Slade: Thank you for that. I just wanted to get a sense of where people are starting from. Okay, so key features of these programs and clients, these are overnight programs. They have an average length of stay of approximately eight weeks. Sometimes they’re longer. The VA has been working hard to sort of uniformly have an eight-week length of stay in order to preserve access to the programs. There’s 42 of these PRRTP programs in the continental U.S. and Hawaii. The programs are advertised as providing residential care for posttraumatic stress disorder in “home-like environments,” and I'll come back to that point in a minute.

The programs are really designed for people who either haven’t done well or thought not to be able to do well in the standard specialty outpatient PTSD treatment in the VA. And below that you can see on these bullet points I tried to indicate the relative scale of service in these programs for Veterans. So the outpatient PTSD programs annually serve, I am estimating based on the numbers I had available, 12,000 to 13,000 Triple-O Veterans, and the PRRTPs approximately serve 1,000. Clients must be medically stable prior to entering the program, so that’s based on information provided by the referring VA provider. So there’s a screening process that occurs before people come into the programs, and medical stability is the main one. Some programs do screen, actually all programs screen at some point for substance use, but that’s usually not a criteria for entry into the program.

This just gives a couple of statistics about acuity and complexity of this group of Veterans compared to Veterans who are entering into the more standard specialty PTSD outpatient care, and you can see here that a greater percentage in the residential programs have a substance use disorder, had been prescribed an antipsychotic medication, had a VA emergency department visit, and had a VA mental health inpatient stay. For substance use disorder, I have here a percentage, 43% had a substance use disorder in the 90 days prior to entering a PRRTP. That’s probably a gross underestimate of the percentage who actually have problems with substance use. This is based just on recorded diagnoses that were recorded in VA administrative data. So in the residential programs, it’s a higher acuity group. It’s a group with a greater number of comorbid conditions. Many have serious medical co-conditions, although they may be stable, and you can see that 23% had a mental health inpatient stay in the past 90 days prior to entry into the program compared to just 1% of those entering PTSD outpatient care.

What do the programs provide? Generally they provide some type of individual and group therapy and counseling. Mostly these are group-based programs, although some individual therapy is also provided in most programs. There’s also, many programs have various types of rehabilitation goals focusing on functioning in the community, so some programs focus on budgeting, some focus on wellness, some focus on obtaining housing, and so there’s a real variety. And I think that’s probably one of the main points, sort of general points that I got out of the interviews with the residential program directors is that there’s a great variety in these programs both in terms of the content of what they provide and in terms of sort of their physical facilities and scale and sort of treatment focus.

Many programs, I'd say most programs have planned outings that are focusing again on integration, and so the types of outings that are offered tended to vary depending on the program’s location and sort of its history of what it tends to focus on. And so these bullet points are just some examples of the types of outings, and the idea is to have these outings in a sort of controlled setting to try to desensitize Veterans to their PTSD symptoms.

Most PRRTPs are located in stand-alone buildings, so a separate building that’s on the campus of a VA hospital so they would have access to medical care, urgent medical care, if it’s needed on the campus of the hospital. But some are located in off-site locations or off-campus locations that might be several miles away. And so in those cases, there’s always an issue around transportation to and from the facility and sort of whether the program is somewhat isolated from the rest of the campus. Some programs are actually located inside a hospital, and so they might be a unit that’s located within a psychiatric inpatient setting. Some programs have separate wings of the building for female Veterans, and they may have locked doors with passes that allow only female Veterans to enter the wing. Some have separate laundry facilities for female Veterans, and so there’s various arrangements in play there.

And many of the programs, I would say most of the programs draw clients from within their VISN, but there are some programs that are viewed more as national programs that would draw Veterans from all over the country. And this also raises a transportation issue because if you have Veterans who are seeking care from a particular program that draws more nationally, maybe that program offers exposure therapy, say, that isn’t offered locally. It does raise this issue of transportation cost and who is going to pay that. And so I think I have another poll question here, Molly.

Molly: Thank you.

Dr. Eric Slade: And this is just based off your own opinion.

Molly: All right. So for our attendees, as you can see, you’ve got the second poll question up there. So again, just based on your own opinion, who should pay the cost of Veterans’ transportation when they return home from VA RRTP? The answer options are the Veteran’s own VA healthcare facility, the RRTP’s VA healthcare facility, the Veteran, a VA Central Office transportation fund. So go ahead and take a few moments, give that some thought, and click right there on your reply. Looks like about two-thirds of our audience has responded, but the answers are still streaming in, so I'm going to give people a few more seconds. Okay, I'm going to go ahead and close this out and share those results. Looks like 20% of our respondents selected the Veteran’s own VA healthcare facility, 9% selected the RRTP’s VA healthcare facility, 9% selected the Veteran, and 63% selected a VA Central Office transportation fund. So thank you again to those respondents, and I'll turn it over to you one more time, Eric.

Dr. Eric Slade: Thanks Molly. So those results are really interesting. It’s pretty much what I expected to see in terms of the distribution across these answers. In fact, this is a debate that’s been ongoing in these programs. It’s somewhat unclear who actually does have responsibility for paying these transportation costs. I think based on the answers we received from program directors, I think generally what happens is that the Veteran’s own VA healthcare facility pays for transportation to the RRTP if it’s not local, and then the return trip is paid by the RRTP’s VA healthcare facility. And obviously that raises some logistical problems for those facilities that draw nationally because then they get a disproportionate share of the cost of transportation. I think most people would prefer if the VA Central Office set up some kind of fund to pay for these trips, but my understanding is that no such fund exists. Now my understanding may be outdated at this point, but at the time we did these surveys, there wasn’t any such fund.

Okay, so now I'm going to talk about our interview methods. So we sent out a request for interviews to all PRRTP program directors and to several directors of specialized outpatient PTSD programs which are, again, the kind of standard entry into care for Veterans with PTSD. We sent out the request and reminders. Most people responded. We ended up with 16 interviews completed during the fall of 2015 through the summer of 2016. Twelve of the interviews were with the PRRTP program directors and four were with directors of the PTSD outpatient programs. The interviews took approximately an hour, and they followed an interview guide, and we audio recorded them and transcribed them.

And then we had a process shown here to summarize the themes. Essentially we went through the transcripts. These were de-identified transcripts. And between myself and Amanda we discussed them and created a compilation document which grouped all of the responses by these domains of main points that we thought were emerging from the interviews and identified across these compilations some more general themes.

The following are the themes that we used in the interviews and that emerged from these interviews. First was what are the emotional and behavioral problems that are common among Triple-O Veterans with PTSD? The second theme was around care integration and coordinating PTSD care with other types of care that Veterans may need, especially Veterans with substance use problems and Veterans with special needs related to homelessness or related to medical problems, for example. Then we had themes related to how easy is it to access a Vet in a program and also issues around transitions into programs like what are issues that complicate transitions and/or how do programs deal with making transition easier for Veterans, and then transitions out of programs and how are those handled and sort of the handoffs to local facilities or home facilities.

Theme four was around staff training and program administration, so how can we sort of improve staff training. And you’ll see here a couple of points that we’re going to delve into more deeply and the results. Therapeutic approaches are the programs delivering evidence-based programs, or EDPs. How do they ensure that those EDPs are delivered with fidelity? There are two main EDPs in these programs, prolonged exposure therapy and cognitive processing therapy. Prolonged exposure, as most of you know, is around re-exposure to trauma in a controlled setting and trying to process the feelings that go along with that. And then cognitive processing therapy is a CBT-based, a cognitive behavioral therapy-based, approach focusing on PTSD. Both have very strong evidence of efficacy in multiple studies. As many of our respondents indicated, there are some limitations of both PE and CPT, so we’ll talk about that. And also we’ll talk about other programming that’s not evidence-based therapies. And then the sixth theme was just the facilities themselves, what were their amenities and what limitations do they have currently that could be addressed?

So we are going to dive into results. I don’t know if people can ask, Molly, should people ask any questions for clarification at this point?

Molly: None yet. We’ll go ahead and hold them until the end. Thank you.

Dr. Eric Slade: Okay. Okay, so emotional/behavioral problems. Pretty much all respondents mentioned these characteristics, a lot of anger, some aggression, a lot of impulsivity, and in relation to impulsivity, suicidal thinking. One thing to mention is, that several of our respondents emphasized, is that although these Veterans all had PTSD, it didn’t mean that all of them only had exposure to trauma in the military. In fact, probably most Veterans with severe PTSD had a history of trauma that extends prior to their military service and may extend into early childhood. And so the symptoms that are being expressed following military service could be sort of the expression of a compilation of years of trauma exposure and multiple trauma events and multiple types of trauma.

Obviously substance use is very common in this population, and it raised issues around sort of what are the rules of behavior in these programs and what are the contingencies for managing substance use in these programs? Obviously substance use was related to various behavior problems and aggressiveness among Veterans and some perhaps violent acts. And then also substance use itself posed a risk to other Veterans in the program, so there were lots of issues that came up around substance use as a complicating factor.

Also, this ambivalence about engaging with treatment came up often in our interviews. Although most of the Veterans were there because they understood they needed help with PTSD, there was a certain amount of ambivalence about whether treatment would be helpful, whether they expected to recover from PTSD, how much faith did they have in their providers. And this also was related in some ways to this issue of behavior problems in programs because some of the Veterans were expressing that maybe they didn’t want to be in the program, at least on the surface.

Okay, and I talked about this fourth point. Lots of Veterans obviously have problems reconnecting with their families. And in the context of these residential programs, it’s important to understand that Veterans are now being separated from their families when they come into these programs for at least eight weeks. And so part of the struggle in these programs is treating PTSD but also trying to lay the groundwork for reintegration with a family and sort of maintaining those ties with families when the Veteran is away for so long. Obviously many of the Veterans have responsibilities for caring for their own children. Most would if they have kids, and particularly for female Veterans, caregiving was a major issue because you have to leave your family for eight weeks. And so some of the program directors talked about childcare problems and how the VA might address those problems among clients.

And then the other major theme that came up around functioning was joblessness and what could the VA be doing to better connect Veterans in these programs to jobs. And just sort of jumping ahead to some of the other results, some of the program directors really strongly felt that connection to a job would be one of the most important things that could help a Veteran with severe PTSD recover, and so this came up a lot in connection with that.

Okay, so the next slide is around what did we find that’s really going well in these programs? All the respondents recognized that these programs serve a special population. These programs are unique to the VA. I’m not aware of any residential programs outside the VA that would provide these types of services in this type of environment. So these are really a treasure for the VA, and they deserve to be regularly evaluated and that opportunities for improving these programs need to be considered frequently. And they serve a very severely ill population, no doubt about it.

Generally the program directors felt that bed availability was really good nationally and in their own programs. Transportation is a barrier. Also, for some programs, a barrier was just the Veteran’s own situations and when could they afford to sort of take eight weeks and enter a program. So that was seen as probability one of the major barriers. It wasn’t so much that there was a lack of beds. Although in general access was good, it’s important to realize that there is a great variety in these programs. Some programs have really nice facilities, but others may need to be modernized. Some facilities lacked internet service, for example, and so you might have access to a program, but it might not be the program that you want to be going to.

Many but not all of these programs offer one of these two evidence-based programs. Most programs offered either prolonged exposure therapy or CPT, but several of our program directors made the point that they weren’t sure how commonly these evidence-based therapies were being provided at fidelity because they didn’t know of any sort of national standards around fidelity testing for the therapists who are providing these therapies in each of the programs. And so some program directors expressed skepticism as to whether really evidence-based prolonged exposure therapy or CPT were being provided. And some program directors made this point that their programs provide an evidence-based therapy and that this was a good thing because it discouraged Veterans who just want to come to a residential program and hang out with other Veterans or cycle through multiple programs because participating in the DBTs requires a lot of work. And, I don’t know, this is a point that several people made. Some programs did offer DBT, but I would say this was pretty unusual.

And all the program directors reported that their staffing levels were adequate, but at the same time there seemed to be certain gaps that were noted like, in particular, it was common for people to report a need for more training in evidence-based therapies. And there was this appeal made by several for more peer support specialists, and I think that’s probably happening.

Okay, so we’ll jump now to care integration. So in each of these programs you have to remember that each of the programs sits either on the campus of or nearby a VA hospital, which also is offering PTSD care and other services like substance abuse treatment. And then that facility also may be offering inpatient treatment and regular outpatient PTSD treatment as well as residential. And then there’s a further dimension of variability around what type of evidence-based practice is offered for PTSD and what types of services that facility offers for homelessness or for traumatic brain injury and other co-occurring conditions.

So this raised some problems around lack of integration, and these are a couple of examples that came up during interviews. So in one program they mentioned that while the residential program offers prolonged exposure therapy, the outpatient PTSD program at that same facility only offers cognitive processing therapy. And there was this disconnect between the programs where the outpatient program tended not to refer to the residential program, and the residential program wouldn’t refer to the outpatient program. And in part it was this difference in philosophy around evidence-based programs. And then someone else, another program director mentioned that many of her clients, after they leave the residential program, they go home to their home facility, and there have been many cases where they get started in the exact same evidence-based practice after they were discharged. So that didn’t make any sense because they had just completed and successfully completed the particular evidence-based practice offered at this residential program. And there was this disconnect that there was no communication around, well, what’s the next step for this Veteran?

And then an example of where things were better integrated, in one of the programs it was regular practice for all the PTSD clinicians at the facility, regardless of whether they were with the residential program or with the outpatient program, to review cases daily with the substance use clinicians, and so there was this greater integration of substance use treatment with the PTSD treatment.

Okay, so based on that first main point, our first recommendation would be to assign a single PTSD services director for all PTSD services staff at each facility and create a PTSD service line where everyone is part of the same team around PTSD. I think that this would be a more global approach to addressing the problems associated with Veterans with PTSD, the clinical problems I mean, and to have a much more integrated approach to addressing Veterans’ PTSD. The director of the PTSD program would be a specialist clinician, either PhD or an MD, who would not only be able to direct the various services and help integrate them but also have the authority to hire staff to fill needs as they arise instead of what is more common is that the residential program is only able to hire for its own program. And so there may be a need for a specialist, say, in cognitive processing therapy, but they can’t necessarily hire that person at their facility because they don’t have control of all the PTSD therapist positions.

There were some concerns expressed about trying to provide this type of integrated PTSD care because some program directors felt that the focus of their programs should be on PTSD only and that when you try to start doing all these different things like providing substance use treatment and so forth that you’re going to sort of dilute the focus on PTSD and it’s not going to work well for Veterans. And so although generally people thought integration was a good idea, some thought that that’s really going down a rabbit hole that’s going to raise more problems than it’s going to solve.

There was also, in terms of program access and transitions in and out of programs, a major theme was this tradeoff between access to programs on the one hand and program effectiveness on the other, so I'm just going to unpack that a bit. So certainly the national office for the residential programs has been under a lot of pressure from both external and internal forces to try to ensure that Veterans who need residential care have appropriate access and fast access to residential care. And so there is this great pressure in the VA to ensure that there aren’t very long wait times into the program. I think that goal is certainly understandable. At the same time, some of the program directors pushed back on this idea of access, and it was mainly because they were providing a cohort-based treatment model where a group of Veterans would come into the residential program at the same time and continue through treatment together, and usually these cohort-based programs were also evidence-based practice programs, and they practiced group-based cognitive processing therapy, or PE therapy. And it was felt by these program directors that having that cohort ensured both that they could provide these services at fidelity and also that it would encourage camaraderie and relationship building and cohesion among the clients entering the program and that it made for a better program and greater efficacy of the services.

However, having that cohort-based model as an alternative to a rolling admissions model probably results in longer wait times to entry into the program because you have to start the cohort at the same time. So there’s this tension between cohort-based treatment and its effect on delayed access to treatment versus rolling admissions, which would tend to keep bed occupancy high and reduce wait times. And that’s not something you can solve, but it was felt by some that there needed to be greater consideration of the advantages of the cohort model, and that’s what this last bullet point is about, that the national program goal of having an eight-week length of stay does increase access, but also it may create this tension with the effectiveness of the programs because it was felt that many Veterans, even after eight weeks, have unresolved problems that could take longer and that many of the programs felt they didn’t really have the flexibility to be able to increase length of stay as needed for some Veterans.

Now on the other side of that were the programs that were providing this cohort-based treatment model who felt that if you’re going to have an evidence-based program that addresses PTSD provided in eight weeks according to the model and then discharge people, and then if there are unresolved issues, those issues should be addressed after the program. And what they didn’t like was the idea that there could be sort of unlimited or not time limited access to these programs that would sort of drag on and on. And so again there was this tension between the cohort-based treatment programs and the rolling admissions programs on this issue of length of stay.

Okay, recommendation two around access and transition should be to conduct a survey of programs. As far as I'm aware, there’s no national data at this point around what are the models that are provided in each of these residential programs and how do the program directors feel about these tradeoffs that were discussed in access and length of stay versus this cohort-based treatment model. The existing evaluations and data that are collected at the New England Performance and Evaluation Center, which has responsibilities for conducting evaluations of these programs and collecting data, are not designed really to collect as detailed information about the model that’s being provided and what are its benefits and risks.

And I note here that although the cohort-based model does have, there is some experience with this model that suggests it might be beneficial. And I think there’s now evidence from other research literature supporting group-based CBT. We really don’t have any evidence that at the program level it’s better to provide this cohort-based treatment, and I think that evidence should exist, so that needs to be collected.

And then secondly that there should be some kind of national expert panel who makes recommendations to the VA around these issues of program models and extended stays, and I feel like this is really a central point of contention at the current time in these programs, and it would really help these programs if this could be resolved.

Okay, key issue three, punitive/authoritarian disciplinary practices. I should say punitive versus authoritarian disciplinary practices. I’m sorry, let me try that (laughing) one more time. Punitive/authoritarian versus authoritative disciplinary practices. So this issue is around behavior problems in residential care, and I've mentioned some of these behavior problems already. So several program directors made this point that the behavior problems are integrally and causally related to the underlying condition for which these Veterans are seeking treatment. And remember that these are all Veterans who either haven’t done well or thought not to be able to do well in sort of standard outpatient PTSD care. And so it’s expected that they’re going to come into these programs with some behavior problems that are impeding their progress in PTSD. So it shouldn’t come as any surprise that there are behavior problems among these Veterans. At the same time, the behavior problems can be disruptive to the entire program and to other Veterans in the program, and so it’s necessary that the program have some strategy for dealing with these behavior problems.

And there was a concern that was really troubling raised by several program directors that there’s sort of inconsistent training among staff and that there are examples of staff sort of responding punitively or in an authoritarian way to disciplinary problems. And these program directors were advocating for a more authoritative approach. I think I have a quote on this. So the quote was “what happens is that many of the staff get frustrated because they feel like we’re looking weak if we’re not just having these very hard and fast rules, and from the Veterans’ perspective, since we can’t explain about Veteran A’s issues, say, with substance use or other, some type of behavior problem to Veteran B, all they see is the result of our decision-making around whether Veteran A was punished or not. So there’s sometimes a perception of favoritism because the results are not always the same. We can’t defend what we did because that would be breaking one of the Veterans’ confidence, so we’re still really in the middle of sorting through all this. It’s messy at the moment.” That type of quote was made by most of the people that we talked to.

And then one program director added people cooperate for two reasons, out of fear or out of gratitude, and gratitude is the better approach. And so this respondent was advocating strongly for this authoritative approach where there’s sort of an expected consequence to specific rule breaking, and it’s applied relatively consistently across the programs and that it’s not punitive in nature. In other words, it shouldn’t always be the case that Veterans get kicked out or that their passes get taken away, the passes to leave the program temporarily get taken away as a result of breaking the rules around substance use, for example. The emphasis should be on consistent reinforcement of expected behaviors. And it did seem that there was a real need for some more uniform response on this issue that’s uniform across the VA in a uniform policy.

And so recommendation three was to develop uniform standards of practice around managing behavior problems in residential care and a training and implementation strategy to implement these standards.

One of the sort of troubling things was past restrictions being used as a punishment to Veterans who break the rules. And the reason why that’s so problematic is that the past restrictions are usually being used to go home and visit family for a couple of days. And obviously that’s very important for Veterans’ recovery and reintegration. And so if you want a recovery focus, you shouldn’t be using past restrictions in this way. That was reported by several of our program directors. Providing expectations of behavior and communicating them to Veterans is obviously important. And that Veterans should be involved in the design of practice standards so that there could be a Veteran representation on some panel around the program’s disciplinary practice. I think that would be feasible to set that up. You could create local panels similar to an ethics review board to which Veterans could report abuses and appeal punishments, and those panels could have Veterans as well as clinicians on them.

Okay, key issue four. The current evidence-based practices were felt to have limited benefits for Veterans. And so several of the program directors expressed the need to implement additional evidence-based practices beyond just PE and CPT and the types of problems that wouldn’t be necessarily addressed by those evidence-based practices are listed here. These are just examples. But the idea is that the evidence-based treatments are really geared towards the fear response and desensitizing Veterans to the fear response. And yet there’s lots of other things going on with Veterans that would prevent them or impede their recovery that should be addressed. And I think pretty much everyone recognizes that there’s this gap. It’s not going to be easy to implement other evidence-based practices, in part because there aren’t a great selection of options of evidence-based practices for, say, moral guilt. But several program directors felt that dialectical behavior therapy, or DBT, would be helpful. Vocational supports were thought to be helpful because having a job and retaining a job and retaining personal relationships were thought to be very helpful to Veterans with PTSD over the long term. So there was this expression by many of the respondents that PE and CPT are very good, especially for addressing the immediate problem of the fear response and the associated symptoms but really aren’t adequate for the range of problems that Veterans are experiencing that are impeding their recovery. It was also noted by several that there’s a shortage of providers who are trained in evidence-based practices other than prolonged exposure therapy and cognitive processing therapy.

Okay. This is just an additional point on this issue of evidence-based practices. Some of the program directors felt that the VA had really pushed the EBPs at the exclusion of provider-patient relationship building. And this also was a tension in the interviews in the sense that some program directors would agree with this and others did not. But I would say at least half raised this issue that the focus on the EBPs and providing only EBPs was harming their ability to address the other needs of Veterans who are in their programs, that this point again that the EBPs don’t address the range of problems and that the program directors felt they needed the flexibility to address the full range of problems.

On the other hand, other program directors were really opposed to this view. They felt that what the programs were there to provide was treatment for PTSD and that the evidence-based practices were able to do that and that they shouldn’t be going down this rabbit hole of trying to do all sorts of other things. They felt just provide the most effective treatment for PTSD that we know how to provide. So this again is a tension.

Okay, so one recommendation was for the VA to provide fidelity standards for EBPs and a process for certifying clinician competency. Also to establish quality standards for recovery-oriented, evidence-based programs and establish a rigorous process for verifying the programs meet these standards. Both of these, I think, are not in place at the present time uniformly across the VA, although they exist in some local facilities. And recommendation six, the VA should expand available PTSD clinician training to include other therapies beyond PE and CPT.

And that’s it.

Molly: Thank you. We do have lots of great questions that came in. We’ll get right to them. If any of our attendees are looking to submit a question or comment, you can do so using the GoToWebinar control panel on the right-hand side of your screen. The first question we have: I’m curious if anyone talked about having a peer support specialist in the director role.

Dr. Eric Slade: No, that never came up, and I don’t have an opinion about it.

Molly: Thank you. This one: I appreciate you mentioning prior life trauma certainly being a factor in Veteran PTSD and treatment choice. We should be evaluating ACEs before a person enters the military and then build addressing the resiliency or lack thereof into primary care comprehensive care plans before a crisis occurs. As a retired Army pediatrician and FP, I know we didn’t actively do this. Which programs do you know of, military or civilian, are including this important factor in therapy today?

Dr. Eric Slade: This isn’t a question about which I have much expertise. My understanding is that one of the surveys that everyone is required to take, required to complete at the time of entering the military service, does contain more information than it previously had about history, but I’m not sure of the exact contents. I would say that that’s probably very inconsistently done.

Molly: Thank you.

Dr. Eric Slade: I agree with the point, though.

Molly: Absolutely. During the, let’s see. This came in during the behavior management portion. Could you try using contingency management to control behavior?

Dr. Eric Slade: Yeah, and I think that’s actually done in some programs, so that would be one approach where you use contingencies. It could be, I suppose, some form of token economy to do that. I know that some programs did have contingency approaches, but we really didn’t get into the details of what those approaches are. And I think this is something where we could learn from the program’s experience with these approaches if we did an adequate job of collecting detailed information from each program.

Molly: Thank you. The next question. Shouldn’t the most effective PTSD treatment be individualized? Cohorts are fine but shouldn’t stop access. This seems like more of a business model rather than Veteran-centric model of evaluation and care [unintelligible 58:03].

Dr. Eric Slade: Right, yeah. And that point was echoed by several of the clinicians we spoke with. I think that all of the clinicians would recognize the need for individualization of treatment. Probably where people divide is do you provide as a base the evidence-based practice and then in addition provide individual therapy separate from that? Or do you just provide individual therapy that’s more supportive in nature or other types of psychotherapy other than the evidence-based practice and not provide the evidence-based practice?

Molly: Thank you. The issues of rule for relapses existed in substance abuse treatment programs long before PTSD programs existed. It seems the most stringent programs were good at maintaining sobriety in inpatient and outpatient programs but seemed less better at teaching Veterans to be sober outside the VA. Should Veterans with substance abuse problems, for instance, be allowed to go on pass to places where alcohol is available?

Dr. Eric Slade: Well, I mean from what I gained from these interviews, alcohol and drugs are available in these programs while people are in treatment, and that’s probably a complex topic as to why that’s the case. But there definitely seemed to be a general problem of trying to enforce the rules in these programs, and I think I probably don’t have the expertise to say how that can be solved, but I'm glad to hear that some programs have solved that.

Molly: Thank you. One person did write in: individual therapy can include evidence-based interventions, which is still evidence-based practice. Thank you for that.

This next question has an abbreviation which I'm not sure what it is, so maybe you can help me out with that. Is there any consensus as to whom pays home facility or treating RRTP facility or Vet if Vets are irregularly DC’d from the RRTP?

Dr. Eric Slade: Discharged. DC is discharged, meaning like they were discharged, say, for a rule violation or for some medical reason. I'm not aware that there’s any consensus on that. I think whatever the arrangement is at that program probably applies to those Veterans as well as to Veterans who are regularly discharged, but I know that in some cases at least it was mentioned that the Veteran had to pay their own way.

Molly: Thank you. We do still have three pending questions, but we are at the top of the hour. Are you able to stay on, Dr. Slade, so we can capture them in the recording?

Dr. Eric Slade: Sure.

Molly: Okay. If any of our attendees need to drop off, as you exit the session, please wait just a second while the feedback survey populates on your screen and take just a moment to fill out those few questions. We do consider your responses closely.

Do you have any data on how effective PRRTPs are in reducing symptom severity and improving quality of life?

Dr. Eric Slade: No, we really don’t know the answer to that because those outcomes are not collected in any sort of valid and uniform way, reliable way, that we could tell what the effects of the programs are on outcomes. I would say that if the programs are providing evidence-based therapy, there’s plenty of evidence that these therapies reduce symptoms of PTSD below, to the point of remission, so it would be effective in that sense. I think one of the problems with collecting the type of outcome data that would be needed is that it becomes an impediment to treatment in a sense because many of these Veterans would have to be really pushed to complete those types of surveys, and they may not be up to it. But it’s important, and I think this is an unsolved problem that needs to be addressed.

Molly: Thank you. One person writes: We are taking Vets with recalcitrant PTSD and anxiety on humanitarian clowning trips with Dr. Patch Adams and his Gesundheit Organization. We see impressive changes in baseline symptoms in as little as eight days after interactions in an interactional location. Have you heard our work, our residential programs using theater and/or clowning as a viable alternative group or individual therapy?

Dr. Eric Slade: I’m sorry. I've never heard of that before. It sounds really interesting. I’d like to hear more.

Molly: [Unintelligible 1:03:32] submitter. Go ahead.

Dr. Eric Slade: I'd appreciate more information because I just don’t know about that.

Molly: Yeah, I would encourage the person to reach out to you offline and have more interaction about that. That was the final question at this time. Would you like to give any concluding comments, Dr. Slade?

Dr. Eric Slade: Just that I was super impressed by the dedication of the staff in these programs. I think these providers are very well-meaning and very dedicated to our Veterans, and I really appreciated them participating in our survey.

Molly: Thank you. Well, we very much appreciate you coming on and lending your expertise to the field, and of course thank you to our attendees for joining us. As I mentioned, I am going to close out the session in just a moment, and a feedback survey will populate on your screen, so take just a moment to fill out those few questions. And with that, if there are any remaining questions, you can feel free to reach out to Dr. Slade individually. Thank you so much, Eric. Have a great rest of the day.

Dr. Eric Slade: Thanks Molly.

[ END OF AUDIO ]