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Report to Congressional Requesters

June 2019

VA MENTAL HEALTH

VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight

Accessible Version

GAO-19-465

GAO Highlights

Highlights of GAO-19-465, a report to congressional requesters

June 2019

VA MENTAL HEALTH

VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight

Why GAO Did This Study

In fiscal year 2018, of the roughly 6 million veterans who received services from VHA, approximately 2 million had a diagnosis for at least one mental health condition. Treatments for such mental health conditions can include psychotropic medications or non-pharmacologic therapies, which can be prescribed or offered by VA providers in outpatient settings including primary and specialty care.

GAO was asked to review how mental health treatment decisions are made by providers in VAMCs and monitored by VHA. This report examines, among other things, (1) factors that contribute to providers' treatment decisions for veterans with mental health conditions, (2) VHA's guidance for documenting mental health treatment plans, (3) VHA's monitoring of whether providers document their consideration of different treatment options, and (4) VHA's efforts to improve the treatment of veterans prescribed psychotropic medications. GAO reviewed VHA documents and a nongeneralizable sample of veterans' medical records from five VAMCs (selected for variety in facility complexity and location); analyzed data on psychotropic medication prescribing; and interviewed VHA and VAMC officials.

What GAO Recommends

VHA should (1) disseminate guidance reflecting its expectation that providers document mental health treatment plans in an easily identifiable way, and (2) implement an approach for monitoring whether these treatment plans include consideration of treatment options. VHA agreed with GAO's recommendations.

View GAO-19-465. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

Officials from the five selected Department of Veterans Affairs (VA) medical centers (VAMC) GAO spoke with reported various factors that contribute to providers' mental health treatment decisions, including decisions regarding the prescribing of psychotropic medications and the offering of non-pharmacologic therapy. Examples of reported factors include: VAMC resources, such as the availability of appointments with mental health providers in specialty care, and the complexity of veterans' mental health conditions, such as the veterans' diagnoses and treatment history.

Officials with VA's Veterans Health Administration (VHA) told GAO that specialty mental health care providers are expected to document mental health treatment plans in an easily identifiable way in veterans' medical records, but VHA has not developed guidance explicitly addressing this expectation. For example, VHA's mental health services handbook requires that treatment plans include certain components, but does not specify where to document the plan within a veteran's medical record. As a result, there is a risk that a provider may be unable to readily access information about a veteran's mental health treatment, including the use of medication or therapy, during changes in a veteran's care.

VHA has not monitored whether mental health providers in specialty care document the required consideration of different treatment options—such as psychotropic medications or non-pharmacologic therapy—within mental health treatment plans. VHA officials told GAO that VHA relies on the Joint Commission (an independent, not-for-profit organization that accredits and certifies health care organizations) to assess specialty mental health treatment plans as part of the organization's accreditation process for each VAMC. However, the Joint Commission's standards do not specifically assess whether providers consider different treatment options. As a result, VHA cannot ensure that providers are considering all available treatment options and providing the most appropriate treatments to each veteran.

VHA has taken steps to improve veterans' mental health treatment through the Psychotropic Drug Safety Initiative (PDSI)—an initiative focused on the safe and effective prescribing of certain psychotropic medications. For example, the first phase included a performance metric aimed at decreasing the percentage of veterans with post-traumatic stress disorder receiving one or more outpatient prescriptions for a benzodiazepine (a medication used to treat anxiety) because of risks associated with the medication. VHA reported a nationwide 5.4 percentage point decrease in the prescribing of this medication for these patients, as well as improvements in the majority of the initiative's other performance metrics.

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Abbreviations

CPG	clinical practice guideline
GAD	generalized anxiety disorder
MDD	major depressive disorder
PC-MHI	primary care-mental health integration
PCP	primary care provider
PDSI	Psychotropic Drug Safety Initiative
PTSD	post-traumatic stress disorder
REACH VET	Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

June 17, 2019

The Honorable Jack Bergman
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable Ann McLane Kuster
House of Representatives

In fiscal year 2018, about 2 million veterans who received health care from the Department of Veterans Affairs (VA) had at least one diagnosed mental health condition. Certain mental health conditions, such as major depressive disorder (MDD) and post-traumatic stress disorder (PTSD), are highly prevalent among veterans. Methods of treatment vary; for some veterans, psychotropic medications may be the safest and most effective method of treatment, while specific forms of non-pharmacologic therapy in lieu of, or in addition to, these medications may work better for others.[1] If conditions are left untreated or if treatment is unsuccessful, some veterans may experience serious consequences; for example, unresolved PTSD may lead to substance abuse, depression, or suicide. These serious consequences underscore the importance of providers' mental health treatment decisions for veterans.

Veterans may be treated in outpatient settings at VA medical centers (VAMC), including in primary and specialty care. In recent years, the Veterans Health Administration (VHA) has aimed to increase the role of primary care and mental health providers in the primary care setting in making mental health treatment decisions, so that treatment can begin as early as possible. These providers may decide to prescribe psychotropic medications or offer non-pharmacologic therapy, among other things. The primary care setting is also advantageous, as veterans assessed there are concurrently screened for risk for suicide, a persistent and growing public health problem for the United States and its veterans, particularly those with mental health conditions. According to VHA, an average of 20

[1]Psychotropic medications are those that affect mood, thought, or behavior. Non-pharmacologic therapy, or psychotherapy, involves treating mental illnesses using psychological rather than medical means.

veterans die by suicide each day, and approximately 75 percent of those veterans each had at least one mental health condition recorded in their medical records in the 5 years prior to their deaths.[2]

You asked us to review how treatment decisions are being made by VAMC providers across outpatient settings and how those decisions are monitored by VHA. In this report, we examine:

1. the factors that have contributed to providers' treatment decisions for veterans with mental health conditions;
2. the extent to which VHA has developed guidance for the documentation of mental health treatment plans in veterans' medical records;
3. the extent to which VHA has monitored providers' documentation of treatment option considerations for veterans with mental health conditions;
4. the extent to which VHA has taken steps to improve the treatment of veterans with mental health conditions who are prescribed psychotropic medications; and
5. the extent to which VHA has included the treatment of mental health conditions with psychotropic medications in its efforts to examine suicide risk among veterans.

To examine the first three objectives, we interviewed officials involved in veterans' mental health treatment from five VAMCs and their four associated Veterans Integrated Service Networks (VISN), VHA's regional networks of care, and we reviewed a random, nongeneralizable sample of veterans' medical records.[3] Specifically, we interviewed providers who work in outpatient care settings, including primary care providers (PCP), mental health providers in specialty care (e.g., psychiatrists), and clinical

[2]See Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028* (Washington, D.C.: June 29, 2018); see also Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* (Washington, D.C.: June 2013).

[3]When we refer to "mental health treatment" in this report, we are referring to treatment provided in outpatient care settings (meaning they involved office visits with no overnight stays), rather than inpatient settings (such as hospitals or residential environments that generally provide longer-term care for patients).

pharmacy specialists.[4] We selected the five VAMCs for variation in (1) the percentage of veterans who were seen by any provider at the VAMC for a mental health diagnosis and received at least one psychotropic medication prescription in fiscal year 2017 (the most recent year for which data were available), (2) facility complexity level, and (3) geographic location.[5] See table 1 for a list of the five VAMCs we selected and their four associated VISNs. Perspectives obtained from these VAMCs and VISNs cannot be generalized.

Table 1: Selected Department of Veterans Affairs Medical Centers (VAMC) and Associated Veterans Integrated Service Networks (VISN) Included in Review

VAMC	VISN
Hunter Holmes McGuire VA Medical Center (Richmond, Virginia)	6
James A. Haley Veterans' Hospital (Tampa, Florida)	8
West Palm Beach VA Medical Center (West Palm Beach, Florida)	8
West Texas VA Health Care System (Big Spring, Texas)	17
Cheyenne VA Medical Center (Cheyenne, Wyoming)	19

Source: GAO analysis of Veterans Health Administration information. | GAO-19-465

We reviewed a random, nongeneralizable sample of medical records for 150 veterans with MDD, PTSD, or generalized anxiety disorder (GAD) (the three most prevalent mental health conditions among veterans) who received outpatient mental health care services in fiscal year 2017 from the five VAMCs within our review. The sample included two groups of randomly selected medical records: (1) 75 veterans, each of whom had a primary care visit, and were prescribed a new psychotropic medication, and (2) 75 veterans, each of whom had a mental health visit in an outpatient setting and who may or may not have been offered non-pharmacologic therapy. Across these two groups of veterans, 80 had a visit with a mental health provider in specialty care and were prescribed a

[4]In this report, "mental health providers in specialty care" refer to providers (such as psychiatrists) who work in mental health clinics and other outpatient specialty care settings; it excludes mental health providers (such as social workers) who are integrated in primary care settings.

[5]VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient populations served, clinical services offered, educational and research missions, and administrative complexity. We ranked VAMCs by the percentage of veterans who were seen for a mental health diagnosis and received at least one psychotropic medication in fiscal year 2017 and split the VAMCs into three equal groups. We then selected one VAMC from the lower third group, three from the middle third, and one from the upper third.

psychotropic medication; we reviewed their medical records to examine how mental health providers document treatment decisions. Examples provided from our review of veterans' medical records cannot be generalized to the five selected VAMCs.

We took additional steps to specifically address each objective. For the first objective, to describe the factors that contributed to providers' treatment decisions for veterans with mental health conditions, we interviewed officials at the five selected VAMCs and reviewed documentation VAMC providers may use when making treatment decisions. In our interviews with officials, we asked about factors that contributed to PCPs' decisions to prescribe psychotropic medications to veterans before or without referring veterans to mental health providers in specialty care. We also asked about factors that contributed to providers' decisions to offer non-pharmacologic therapy to veterans in lieu of, or in addition to, prescribing psychotropic medications. We then identified factors that were reported by officials at multiple VAMCs. During our interviews, 52 PCPs and mental health providers in specialty care completed questionnaires so we could obtain their perspectives on how frequently certain treatment decisions were made by providers within their VAMCs. We also reviewed documents developed by VHA and VAMC officials, such as guidance for providers to consider when treating veterans with mental health conditions. For context, we obtained data from VHA related to the pharmacologic and non-pharmacologic treatment of veterans with mental health conditions for fiscal year 2018. We analyzed these data to determine the specific outpatient care settings in which veterans with different numbers and types of mental health conditions were seen, as well as the types of treatment that were provided to these veterans.

For the second objective, to examine the extent to which VHA has developed guidance for the documentation of mental health treatment plans in veterans' medical records, we reviewed VHA documentation, such as VHA's *Health Information Management and Health Records* handbook.[6] We also interviewed VHA officials from the Office of Mental Health and Suicide Prevention and the Office of Health Informatics, as well as officials at our five selected VAMCs, regarding the documentation of veterans' mental health treatment plans. Additionally, we interviewed

[6]Veterans Health Administration Handbook 1907.01, *Health Information Management and Health Records* (March 19, 2015).

officials from the Joint Commission, the organization responsible for accrediting and certifying VAMCs and other health care facilities. We then compared VHA's issued guidance with federal internal control standards related to control activities, risk assessment, and information and communication.[7]

For the third objective, to examine the extent to which VHA has monitored providers' documentation of treatment option considerations for veterans with mental health conditions, we reviewed VHA documentation, such as VHA's *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook.[8] We interviewed VHA officials from the Office of Mental Health and Suicide Prevention, as well officials at our five selected VAMCs, regarding documentation of these considerations. We also interviewed officials from the Joint Commission about its standards related to such documentation. We then compared VHA's monitoring efforts for mental health treatment planning with federal internal control standards related to monitoring.[9]

For the fourth objective, to describe the extent to which VHA has taken steps to improve the treatment of veterans with mental health conditions who are prescribed psychotropic medications, we reviewed VHA documentation, such as VHA program manuals related to initiatives to improve the prescribing of psychotropic medications and evaluation reports documenting the outcomes of relevant VHA programs. We also interviewed VHA officials, including those from the Office of Mental Health and Suicide Prevention and Pharmacy Benefits Management Services, as well as officials at the four VISNs associated with our five selected VAMCs, regarding national and local roles and responsibilities related to improving the safety and effectiveness of prescribing psychotropic medications. We also obtained data from VHA on national prescribing rates for certain psychotropic medications.

[7]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[8]Veterans Health Administration Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008). VHA officials told us that this handbook is currently being revised into a directive, but until then they expect the handbook and its requirements to be followed as written.

[9]GAO-14-704G.

For the fifth objective, to describe the extent to which VHA has included the treatment of mental health conditions with psychotropic medications in its efforts to examine suicide risk among veterans, we reviewed relevant VHA documentation, including reports and presentations (such as public webinars) from relevant VHA programs, as well as publications and other documents (such as draft manuscripts) related to ongoing and completed research studies. We interviewed officials from VHA's Office of Research and Development and Office of Mental Health and Suicide Prevention about relevant efforts, as well as VHA officials from the following VHA research centers: (1) the Serious Mental Illness Treatment Research and Evaluation Center; (2) the VISN 2 Center of Excellence for Suicide Prevention; and (3) the Rocky Mountain Mental Illness Research, Education, and Clinical Center for Veteran Suicide Prevention. In our discussions with VHA officials, we also obtained information related to advantages and challenges that may impact VHA's ability to include the use of psychotropic medications as a factor when examining suicide risk.

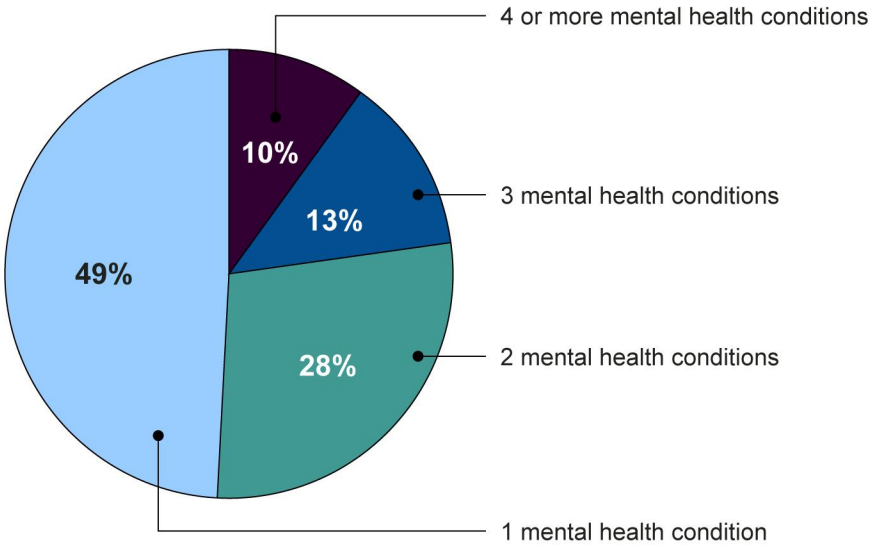
We conducted this performance audit from November 2017 to June 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Veterans with Mental Health Conditions

About 2 million of the more than 6 million veterans who received VHA services in fiscal year 2018 had at least one diagnosed mental health condition, with MDD being the most prevalent diagnosis. About half of these approximate 2 million veterans had a single mental health condition while the remaining half had multiple mental health conditions (see fig. 1).

Figure 1: Percentage of Veterans with At Least One Diagnosed Mental Health Condition, by Number of Conditions, in Fiscal Year 2018



Source: GAO analysis based on Veterans Health Administration (VHA) data. | GAO-19-465

Note: In fiscal year 2018, there were 2,006,246 veterans who had at least one mental health condition diagnosis and who used any VHA services.

In fiscal year 2018, the three most prevalent mental health conditions among veterans using VHA services were MDD (15 percent), PTSD (12 percent), and GAD (3 percent):[10]

- **MDD.** This condition is the most prevalent and disabling form of depression. In addition to the immediate depression symptoms (such as persistently feeling sad or anxious, loss of interest in activities, and difficulty sleeping or oversleeping), MDD can result in poor quality of life overall and decreased productivity, and increased risk of suicide.

[10]There is widespread variation in published estimates on the prevalence of mental health conditions in the veteran population. Such variation may be caused by differences in methods and criteria used for each analysis, among other factors. See, for example, National Academies of Sciences, Engineering, and Medicine, *Evaluation of Department of Veterans Affairs Mental Health Services* (Washington D.C.: The National Academies Press, 2018), 51. We obtained data from VHA on the prevalence of mental health conditions among veterans using VHA services. To determine the three most prevalent mental health conditions for the purposes of our report, we excluded certain mental health conditions from these data, such as those that were composites of different conditions. For example, we excluded prevalence data for “any substance use disorder,” since veterans diagnosed with alcohol use disorder were combined with veterans diagnosed with drug use disorder.

- **PTSD.** Those with PTSD have experienced symptoms that have persisted for more than 1 month after exposure to a traumatic event, although the onset of symptoms may be delayed for much longer, and cause significant distress or impairment in social, occupational, or other important areas of functioning.[11] Symptoms may include recurrent, involuntary memories of the traumatic event and flashbacks in which the veteran feels or acts as if the traumatic event were recurring. PTSD is strongly associated with reduced quality of life and adverse physical health outcomes.
- **GAD.** Those with GAD feel continually worried or anxious about a range of events or activities in their daily lives and have difficulty controlling or stopping this worry. Along with feeling worried, those with GAD experience symptoms of tension such as restlessness, feeling on edge, being easily tired, difficulty concentrating, and sleep difficulties.

Outpatient Mental Health Treatment

Veterans with mental health conditions may be offered a variety of treatment options. Of the approximate 2 million veterans with at least one diagnosed mental health condition in fiscal year 2018, 45 percent received non-pharmacologic therapy, 27 percent received a combination of non-pharmacologic therapy and psychotropic medication, and 10 percent received psychotropic medication only.[12]

- **Non-pharmacologic therapy.** Non-pharmacologic therapy, or psychotherapy, involves treating mental health conditions using psychological rather than medical means. There are many different types of therapy options, although not all may be available at every

[11]A traumatic event means exposure to actual or threatened death, serious injury, or sexual violence, including directly experiencing the traumatic event or witnessing the event as it occurred to others.

[12]The remaining 18 percent of the approximate 2 million veterans who had a diagnosed mental health condition and used VHA services did not receive psychotropic medication or non-pharmacologic therapy from a VAMC that year. This may have been due to any one of numerous reasons (e.g., veterans receiving treatment outside of the VHA system, veterans declining treatment, or veterans receiving other VHA services to help manage their mental health conditions).

VAMC.[13] Examples of non-pharmacologic therapies include cognitive behavioral therapy and prolonged exposure therapy.[14] Some therapy options may be provided to individual veterans, while others are offered to groups of veterans.

- **Psychotropic medications.** Psychotropic medications are used to affect one's mood, thought, or behaviors. Veterans can be prescribed one or more psychotropic medications, from one or more classes, to treat their diagnosed mental health conditions.[15] For example, sertraline—a psychotropic medication commonly known by its brand name Zoloft®—is used by VHA providers to treat both depression and anxiety.
- **Combining treatment.** Providers may decide to offer both psychotropic medications and non-pharmacologic therapy, rather than prescribing or offering either option alone.

Decisions to offer any of these treatment options are made by providers in various VAMC outpatient care settings.

- **Primary care setting.** In addition to addressing other health care needs, PCPs may order non-pharmacologic treatment, prescribe psychotropic medications, or combine both treatment options to address a veteran's mental health conditions. Through the primary care-mental health integration (PC-MHI) model, which VAMCs began implementing in 2007, PCPs may also collaborate with mental health providers (e.g., psychologists, social workers, nurses) who are collocated within the primary care clinic before making treatment

[13]According to VHA's mental health services handbook, veterans are to be offered non-pharmacologic therapy by staff at their local VA clinics or by telemedicine if indicated. If an indicated service is not provided by a VAMC or telemedicine, the service must be made available to veterans through referral to other accessible VA facilities or non-VA providers in the community to the extent that veterans are eligible.

[14]Cognitive behavioral therapy involves helping individuals solve their problems by, for example, recognizing and changing inaccurate beliefs or relating to others in more positive ways and changing behaviors accordingly. Prolonged exposure therapy involves exposing individuals to images, situations, or cues that evoke traumatic memories in order to reduce fearful associations with them and replace them with a sense of safety and control over emotional reactions.

[15]A medication may be classified by the chemical type of the active ingredient or by the way it is used to treat a particular condition. Psychotropic medication classes include, among others, (1) antidepressants, (2) antipsychotics, (3) anxiolytics, and (4) mood stabilizers.

decisions.[16] These collocated mental health providers can also offer non-pharmacologic therapy to veterans without requiring a separate visit outside of primary care.

- **Specialty care setting.** Mental health providers in a specialty care setting, such as psychiatrists, decide whether to provide any type of treatment for veterans who have been referred to them by providers in primary care for services specific to their mental health conditions. Veterans may also seek services from a mental health provider in specialty care without first obtaining a referral from primary care.

Mental Health Treatment Planning Requirements

VHA has established certain requirements for providers' documentation of specialty mental health care treatment plans, and the Joint Commission periodically reviews the documentation of such plans to ensure that they align with the Commission's standards.

- **VHA.** To ensure that providers develop appropriate approaches to treating veterans with mental health conditions and reevaluate such treatment approaches over time, VHA has established certain policies to govern the documentation of mental health treatment decisions by mental health providers in specialty care. For example, in 2008, VHA issued its mental health services handbook to define minimum clinical requirements for mental health services at VAMCs, requiring that providers in specialty care document mental health treatment plans in veterans' electronic medical records.[17] The mental health services handbook specifies that plans should include certain components such as documentation that different evidence-based treatment

[16]VHA requires that PC-MHI providers must be available at all VAMCs and at community-based outpatient clinics considered "very large" (those clinics that serve more than 10,000 veterans each year). The PC-MHI model aligns with the American Psychiatric Association's recognition that a model of integrated care in the primary care setting is, among other things, the most effective approach for achieving positive outcomes for different mental health diagnoses. See American Psychiatric Association, *Position Statement on Integrated Care* (Washington, D.C.: July 2016). According to VHA, the model also helps reduce the stigma of seeking care for mental health conditions.

[17]According to VHA officials, the mental health services handbook's mental health treatment planning requirements do not apply to mental health providers who create treatment plans in a primary care setting through PC-MHI.

options were considered by mental health providers and that approaches to monitor the outcomes of care were developed.[18]

- **The Joint Commission.** The Joint Commission is an independent, not-for-profit organization responsible for accrediting and certifying health care organizations and programs in the United States (including VAMCs) at least once every 3 years, and it has developed standards to use as the basis of its evaluative process.[19] These standards focus on specific patient and organization functions that are essential to providing safe and high-quality care, including plans for treatment provided in mental health care settings.

VAMC Resources and the Complexity of Veterans' Mental Health Conditions Are among Factors That Contribute to Providers' Treatment Decisions

VAMC officials we interviewed reported various factors as contributing to providers' decisions to prescribe psychotropic medications and offer non-pharmacologic therapy to veterans. Specifically, officials from multiple VAMCs cited each of the following factors as contributing to treatment decisions: VAMC resources, complexity of veterans' mental health conditions, comfort level of providers with treating conditions or prescribing medications, veterans' preferences, and logistics of receiving mental health treatment. See table 2 for the factors and supporting examples offered by VAMC officials during our site visits.

[18]Evidence-based treatments are those that have been scientifically studied and proven to be effective for the treatment of a mental health condition. The mental health services handbook includes additional mental health treatment plan requirements that elaborate on this component, such as that mental health treatment plans must consider treatment options intended to reduce symptoms, improve functioning, prevent relapses or recurrences of episodes of illness, and be attentive to the veteran's values and preferences.

[19]To earn and maintain the Joint Commission's accreditation, VAMCs must undergo an on-site survey by a Joint Commission survey team at least once every 3 years. As part of this process, surveyors select a random sample of veterans and review their medical records to evaluate compliance with the Joint Commission's standards.

Table 2: Examples of Factors That Contribute to Providers' Decisions to Prescribe Psychotropic Medications or Offer Non-Pharmacologic Therapy, per Selected Veterans Affairs Medical Centers (VAMC), May through September 2018

Examples of factors that make particular prescribing practices more likely:

Factor	Primary care provider (PCP) prescribes psychotropic medications before or without referring veterans to mental health providers in specialty care	PCP or other type of provider offers non-pharmacologic therapy to veterans in lieu of, or in addition to, prescribing psychotropic medications
VAMC resources	• An insufficient number of mental health providers in specialty care • A lack of appointments available with mental health providers in specialty care	• A sufficient number of mental health providers who can provide therapy • Available appointments for therapy
Complexity of veterans' mental health conditions	• Veterans with less complex diagnoses, such as uncomplicated depression who may not need to see a mental health provider in specialty care • Veterans who have not previously experienced unsuccessful treatment for mental health conditions	• Veterans who do not need medication to help with immediate functioning • Veterans with post-traumatic stress disorder (PTSD) who are able to begin therapy after medication successfully addresses needs for immediate functioning
Comfort level of the provider with treatments for conditions	• PCPs who are more comfortable prescribing medications due to past experience • PCPs who are less comfortable seeking consultation from other providers	• Providers who are well educated on non-pharmacologic therapies • Providers who are not comfortable prescribing certain medications, such as benzodiazepines for veterans who are at risk for suicide[a]
Veterans' preferences of treatment	• Veterans who prefer to be treated by a PCP because of the stigma associated with receiving mental health services in specialty care • Veterans who prefer seeing one provider rather than multiple providers may prefer receiving medication from a PCP	• Veterans who are open to therapy despite the greater time commitment in comparison to medication • Veterans who are uncomfortable with the idea of taking a medication
Logistics of receiving mental health treatment	• Veterans who cannot attend appointments with mental health providers in specialty care due to their work schedules • Veterans who have difficulty traveling to the VAMC for separate mental health appointments if they live far away[b]	• Veterans who have the flexibility to attend multiple therapy sessions a week • Veterans who do not live in rural areas and do not have to drive long distances to attend therapy sessions

Source: GAO analysis of interviews with officials at selected VAMCs. | GAO-19-465

Note: Each factor cited in table was mentioned by officials from at least two VAMCs within our review.

[a]The *VA/DOD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* recommends that providers use caution when prescribing benzodiazepines to patients at risk for suicide as the medication can cause disinhibition which can lead to suicide. See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* (Washington, D.C.: June 2013).

[b]VA officials stated that they generally try to make telehealth appointments for mental health available to veterans who have difficulty traveling to appointments. VA's telehealth services include health informatics, disease management, and telehealth technologies to target care and case management to improve access to care.

In our review of documentation VAMC providers may use when making treatment decisions, we identified some additional factors. For example, providers' use of clinical practice guidelines (CPG) established by VA and the Department of Defense may contribute to providers' treatment decisions. Specifically, the CPG for mental health conditions that are highly prevalent among veterans, including MDD and PTSD, are a resource that all VAMC providers may use when making treatment decisions.[20] For example, the CPG for the management of MDD recommends that providers offer either psychotropic medications or non-pharmacologic therapies (such as behavioral therapy) for the primary treatment of uncomplicated MDD.[21] In contrast, the CPG for the management of PTSD recommends initial treatment for this condition to be a specific type of non-pharmacologic therapy (individual trauma-focused therapy), and when this therapy is not readily available or preferred, then treatments include prescribing psychotropic medications or offering another form of non-pharmacologic therapy.[22] Though it is not mandatory for providers to follow the recommendations of the CPGs, which are based on the strength of evidence and also the potential benefits and harms of treatment options, every provider is responsible for evaluating the appropriateness of applying CPG recommendations in any particular clinical situation.

Another factor we identified in our review of documentation was service agreements that VAMCs have in place to help coordinate mental health services across outpatient settings. All five of the VAMCs in our review have formal agreements to help coordinate mental health services across outpatient settings to help manage VAMC resources. These agreements indicate that, for example, providers in primary care can provide treatment for certain mental health conditions, such as uncomplicated depression, without referring veterans to mental health providers in specialty care (see text box).

[20]VA developed these CPGs jointly with the Department of Defense for veterans and military servicemembers.

[21]See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for the Management of Major Depressive Disorder* (Washington, D.C.: April 2016). The CPG for MDD notes that the evidence does not support recommending a specific evidence-based psychotropic medication or non-pharmacologic therapy over another.

[22]See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (Washington, D.C.: June 2017).

Service Agreements between Primary and Specialty Care for the Treatment of Mental Health Conditions in Selected VA Medical Centers (VAMC)

All five of the VAMCs in our review have formal service agreements to help coordinate treatment across primary and specialty care settings for certain mental health conditions, such as uncomplicated depression:

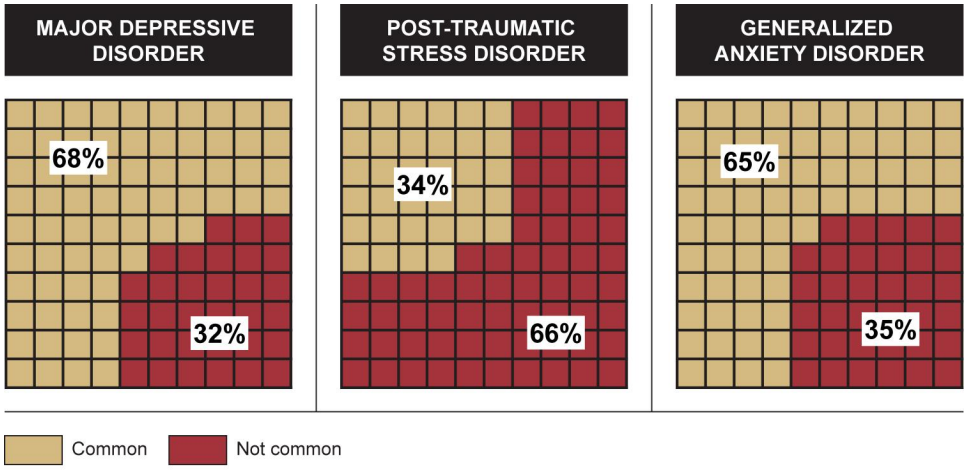
- All service agreements from the VAMCs in our review indicated that providers in primary care can treat uncomplicated depression without referring veterans to a mental health provider in a specialty care setting.
- All service agreements indicated at what point mental health providers in specialty care should be involved to help treat veterans with uncomplicated depression—for example, if veterans failed to respond to treatment after trying two different psychotropic medications, or if symptoms worsen over time.

In addition to uncomplicated depression, other mental health conditions (including anxiety, PTSD, schizophrenia, and bipolar disorder) were addressed in four of the five service agreements we reviewed. For example, the four service agreements indicated that veterans with bipolar disorder should be treated by mental health providers in specialty care.

Source: GAO analysis of a selection of VAMC service agreements. | GAO-19-465

In light of these factors, providers we interviewed reported on the extent to which each of the most prevalent mental health conditions resulted in PCPs prescribing medication to veterans prior to or without being referred to specialty care. Specifically, more providers reported that psychotropic medications are commonly prescribed to veterans with MDD, PTSD, or GAD prior to referring them to specialty care compared to providers who reported that it is common to prescribe without referring veterans to specialty care at all. See figure 2 for the percentages of providers reporting that psychotropic medications are commonly prescribed to veterans with these three conditions prior to referring them to specialty care.

Figure 2: Providers Reporting It Is Common to Prescribe Psychotropic Medications to Veterans with the Three Most Prevalent Mental Health Conditions Prior to Mental Health Specialty Care Referral, May through September 2018

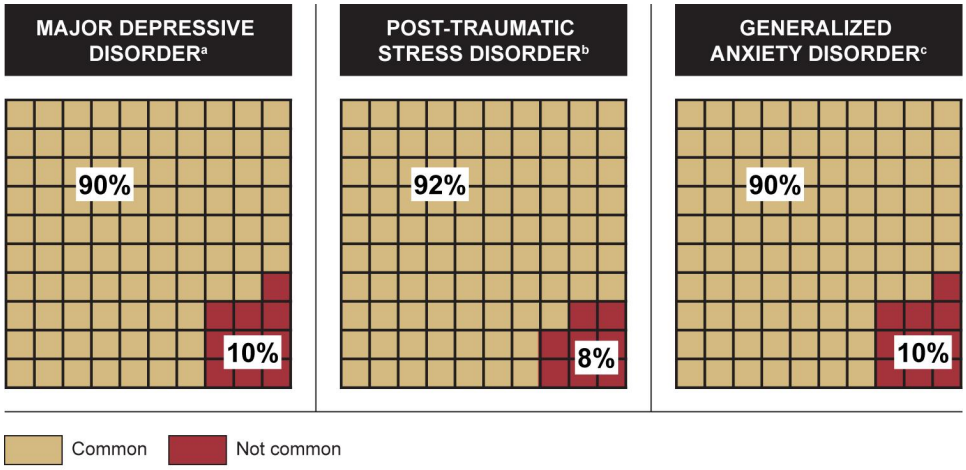


Source: GAO analysis of completed Veterans Affairs medical center (VAMC) provider questionnaires. | GAO-19-465

Note: The 52 providers who completed the questionnaire were employed across five VAMCs and represented a mix of primary care and mental health providers (e.g., psychologists, psychiatrists). Each provider was asked to indicate whether it was common for primary care providers to prescribe psychotropic medications to veterans with the three most prevalent mental health conditions found in veterans in fiscal year 2018 prior to referring them to mental health providers in specialty care. We excluded responses from providers who did not select one of the given answers. Consequently, the result for each condition includes the perspectives of 50 or 51 providers and totals 100 percent.

Providers also reported on the extent to which it was common for any provider to offer non-pharmacologic therapy to veterans with these three conditions in lieu of, or in addition to, prescribing psychotropic medications. More providers reported that non-pharmacologic therapy is commonly offered in addition to psychotropic medications compared to providers who reported that it is common to offer therapy instead of medication. See figure 3 for the percentages of providers reporting that non-pharmacologic therapy is commonly offered in addition to psychotropic medications.

Figure 3: Providers Reporting It Is Common to Offer Non-Pharmacologic Therapy in Addition to Prescribing Psychotropic Medications to Veterans with the Three Most Prevalent Mental Health Conditions, May through September 2018



Source: GAO analysis of completed Veterans Affairs medical center (VAMC) provider questionnaires. | GAO-19-465

Note: The 52 providers who completed the questionnaire were employed across five VAMCs and represented a mix of primary care and mental health providers (e.g., psychologists, psychiatrists). Each provider was asked to indicate whether it was common to offer non-pharmacologic therapy to veterans with the three most prevalent mental health conditions diagnosed in veterans in fiscal year 2018 in addition to prescribing them psychotropic medications. The result for each condition includes the perspectives of all 52 providers and totals 100 percent.

[a]The Departments of Veterans Affairs and Defense jointly developed a clinical practice guideline (CPG) for major depressive disorder. The CPG recommends for the management of uncomplicated mild to moderate cases of major depressive disorder both evidence-based psychotropic medications (e.g., selective serotonin reuptake inhibitor) and non-pharmacologic therapy (e.g., cognitive behavioral therapy) as first-line treatments for veterans. For veterans at high risk for relapse, the CPG recommends a course of non-pharmacologic therapy even after remission is achieved to reduce the risk of relapse or recurrence.

[b]The Departments of Veterans Affairs and Defense jointly developed a CPG for the management of post-traumatic stress disorder, which recommends certain individual trauma-focused non-pharmacologic therapy over other non-pharmacologic therapies and psychotropic medications. When individual trauma-focused psychotherapy is not readily available or not preferred, psychotropic medications or individual non-trauma-focused psychotherapy (e.g., stress inoculation training) are recommended—the evidence does not support recommending one of these secondary options over another.

[c]As of March 2019, the Departments of Veterans Affairs and Defense have not developed a clinical practice guideline for generalized anxiety disorder.

See appendix I for additional information about mental health treatment practices, including the prescribing of psychotropic medications and offering non-pharmacologic therapy to veterans in a random, nongeneralizable selection of medical records from the VAMCs in our review. See appendix II for information on the use of psychotropic medications or non-pharmacologic therapy by VHA providers to treat veterans with certain mental health conditions, nationally, in fiscal year 2018.

VHA Has Not Developed Guidance that Communicates Its Expectation That Mental Health Treatment Plans Be Easily Identifiable

VHA has not developed and disseminated guidance that specifies its expectation that mental health providers in specialty care document treatment plans in an easily identifiable way within veterans' medical records. According to VHA officials responsible for overseeing mental health services, mental health providers should be documenting treatment plans in notes that are easily identifiable and separate from other health information, rather than embedding the plans in progress notes where they may combined with other information related to veterans' medical histories and current health conditions. In our nongeneralizable review of 80 medical records for veterans who were seen by providers in specialty care and prescribed a psychotropic medication, we found that a majority (50) had a mental health treatment plan recorded in a progress note. We viewed several examples where the treatment plan was not the only information recorded within the progress note, making it difficult to readily identify the mental health treatment plan itself.

A VHA official responsible for overseeing mental health services told us it is important for a mental health provider in specialty care to document each veteran's treatment plan in such a manner so that the provider, or any other providers who may become involved in the veteran's treatment, can readily refer to the plan as they evaluate progress. This may be particularly important during transitions between inpatient and outpatient care settings, or when adding providers to a veteran's care team. Providers need to be able to readily access veterans' mental health treatment plans to ensure that treatment is being provided as ordered, understand why certain treatments were decided against, and assess whether treatment changes are needed. The same VHA official told us

that he encourages this practice to support VAMC compliance with the Joint Commission's standards for mental health treatment plans.[23]

However, relevant VHA guidance documents for mental health providers do not specify this expectation:

- **VHA mental health services handbook.** The VHA mental health services handbook, published in 2008, requires that mental health providers in specialty care document treatment plans that include certain components. However, it does not specify where providers should document such plans within veterans' medical records.
- **VHA memo.** A 2012 VHA memo promotes the use of a software program by mental health providers in specialty care that, according to VHA officials, facilitates the documentation of treatment plans in notes that are easily identifiable and separate from other information. However, the memo did not specifically state that documenting treatment plans in easily identifiable and separate locations from other information is the goal of using the software program, nor does the memo require providers to use the software.
- **VHA health records handbook.** This handbook, published in 2015, provides basic health information procedures for managing veterans' health records and specifies that all outpatient providers must include treatment plans in progress notes.[24] It does not explicitly reflect VHA's expectation for mental health providers in specialty care to document mental health treatment plans in an easily identifiable way. Further, the health records handbook specifies that progress notes must also include other types of information, including the history of the veteran's medical problem, the provider's assessment of the problem, any tests or consults ordered, and instructions given to the veteran.

VHA officials did not provide a rationale as to why they have not developed guidance that clearly directs mental health providers in

[23]According to a VHA official, if a specialty mental health treatment plan is not documented in an easily identifiable manner, the Joint Commission surveyors may not be able to readily locate the plan within a veteran's medical record to determine whether it includes all of the components required to satisfy the Joint Commission's standards for mental health treatment plans. This official told us that, as a result, VAMCs may receive citations for non-compliance with these standards.

[24]Veteran's Health Administration Handbook 1907.01, *Health Information Management and Health Records*. When asked, VHA officials responsible for the health records handbook confirmed that outpatient providers include mental health providers in specialty care.

specialty care to document treatment plans in an easily identifiable way within veterans' medical records. They noted that VHA has relied upon the VAMCs to develop local processes for documenting specialty mental health treatment plans in an easily identifiable way when providers decide not to use the software program that VHA promoted in its 2012 memo. According to VHA officials, VHA is developing a new memo to communicate its expectation that mental health providers in specialty care document treatment plans in an easily identifiable way within veterans' medical records. However, as of March 2019, VHA officials had not finalized this memo or indicated when the memo will be disseminated. Standards for internal control in the federal government require that agencies document responsibilities through policies and define objectives in terms that are understood at all levels. These standards also require that agencies communicate necessary information throughout all agency reporting lines to achieve the agencies' objectives.[25] Absent VHA guidance that clearly identifies its expectation for documenting specialty mental health treatment plans, providers may incorrectly record treatment plans in veteran's electronic medical records such that they are not easily identifiable. As a result, there is a risk that a provider may be unable to readily access important information about a veteran's mental health treatment, including the use of psychotropic medication or non-pharmacologic therapy, during changes in a veteran's care.

VHA may learn of the extent of this risk through efforts to collect information resulting from the Joint Commission's accreditation survey process. Specifically, VHA uses various conference calls to discuss the Joint Commission accreditation survey process and results:

- According to a VHA official, VHA has weekly and quarterly conference calls with VISNs to, in part, help them prepare their VAMCs for future surveys and, as a result, VHA may learn about different types of citations that apply to multiple VAMCs. This, in turn, may allow VHA to identify concerns that may need to be addressed system-wide, including those related to mental health treatment planning.
- The Joint Commission provides VHA with an annual summary of data on common citations issued to VAMCs. According to the Joint Commission officials, the Commission provides VHA with this information through a conference call, which may also include a discussion of the underlying causes for any trends in system-wide

[25]GAO-14-704G.

citations. VHA officials may be able to use this information to address any systemic problems related to the documentation of specialty mental health treatment plans in an easily identifiable way within veterans' medical records.

According to a VHA official, VHA has not identified the documentation of specialty mental health treatment plans as an area for improvement across VAMCs. This issue was not included in the November and December 2018 conference calls with the VISNs, nor was it included in the 2018 annual summary of data that the Joint Commission provided to VHA.

VHA Has Not Monitored Providers' Documentation of Required Treatment Option Considerations in Mental Health Treatment Plans

VHA has not developed or implemented an approach for monitoring whether mental health providers in specialty care are documenting their consideration of different evidence-based treatment options in mental health treatment plans as required by VHA's mental health services handbook.[26] In our review of a nongeneralizable sample of 80 medical records for veterans who were seen by such providers and prescribed a psychotropic medication, we found that none of the veterans had treatment plans that documented consideration of different evidence-based treatment options for the veterans' mental health conditions.

VHA relies on the Joint Commission to assess mental health treatment plans as part of the organization's accreditation process for each VAMC, according to VHA officials. However, VHA does not obtain information resulting from the Joint Commission's accreditation process that specifically relates to whether mental health providers are documenting consideration of different treatment options in their mental health treatment plans as required. The Joint Commission's accreditation

[26]VHA officials told us that VHA surveyed VAMCs from 2010 to 2015 to assess implementation of the mental health services handbook; however, this survey did not include questions specific to implementation of this handbook required mental health treatment plan component and, according to VHA officials, this survey has been discontinued.

standards related to mental health treatment plans align with some, but not all, of VHA's mental health services handbook's required treatment plan components. For example, the standards align with VHA's requirement that mental health providers in specialty care must document how they plan to track outcomes and re-evaluate treatment when needed. However, they do not call for the Joint Commission's accreditation survey to assess whether specialty mental health treatment plans include providers' consideration of different treatment options, and, according to organization officials, this is not something they look for when conducting their reviews.

VHA's mental health services handbook calls for monitoring through the use of metrics to ensure implementation of the handbook's requirements, including those related to the documentation of the mental health treatment plan components by mental health providers in specialty care. Additionally, standards for internal control in the federal government require that agencies establish appropriate performance measures for defined objectives, perform ongoing monitoring activities, and remediate identified deficiencies on a timely basis.[27]

VHA's lack of monitoring may contribute to inadequate documentation of the treatment options considered by mental health providers in specialty care in accordance with the mental health services handbook's requirements. As a result, VHA cannot ensure that mental health providers in specialty care are appropriately considering all available evidence-based treatment options to provide the best care for veterans. This monitoring may be accomplished, for example, by establishing metrics and monitoring performance against such metrics, as called for by VHA's mental health services handbook. Without metrics or other approaches to monitoring, VHA officials may not be identifying and addressing any systemic problems related to consideration of different evidence-based treatment options.

[27]GAO-14-704G

VHA Has Taken Steps to Improve Veterans' Treatment through the Psychotropic Drug Safety Initiative

VHA has reported improvement in the safe and effective prescribing of certain psychotropic medications used to treat veterans with mental health conditions since the 2013 start of its Psychotropic Drug Safety Initiative (PDSI). To date, PDSI has consisted of three phases, with each phase focusing on different classes or types of psychotropic medications, age groups, or mental health conditions and substance use disorders. PDSI is currently in phase 3 and VHA is in the process of planning for a new phase 4, scheduled to begin in July 2019.[28] For each phase, VHA developed a set of performance metrics from which each VAMC was required to select a designated number as a focus for implementing prescribing-related quality improvement efforts (referred to as the VAMC's priority metrics).[29] See table 3.

[28]PDSI phase 4 is expected to begin in July 2019 and focus on reducing benzodiazepine use among high-risk veteran populations—including veterans 65 years or older; with PTSD; with an alcohol, opioid or sedative-hypnotic use disorder; or with a concurrent prescription for an opioid—to reduce adverse events and side effects associated with the drug (such as over sedation and cognitive impairment). VHA has noted that reducing benzodiazepine use among veterans also supports suicide prevention, since higher rates of the prescribing of benzodiazepines to veterans with PTSD have been associated with increased rates of death by suicide. Further, according to VHA, the co-prescribing of benzodiazepines and opioids is associated with an increased risk of overdose death, and is strongly recommended against by the CPG for opioid therapy. See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (Washington, D.C.: February 2017).

[29]For PDSI phase 4, VHA has developed four population metrics, from which VAMCs will have to choose one as a priority metric. VHA has also developed one safety metric that all VAMCs are required to focus on for the purposes of quality improvement.

Table 3: Past and Current Phases of the Veterans Health Administration's (VHA) Psychotropic Drug Safety Initiative (PDSI)

Phase (years active)	Focus for phase	Number of performance metrics required of Department of Veterans Affairs Medical Centers' (VAMC) as priority metrics[a]	Example of performance metrics
Phase 1 (2013–2015)	Reducing differences between VAMCs in their rates of prescribing certain classes of psychotropic medications, or more than one medication, to treat certain mental health conditions.	Any number of 20 VHA developed metrics for which the VAMC's baseline score was greater than two standard deviations from the national score.[b]	The percentage of veterans with post-traumatic stress disorder (PTSD) who received one or more outpatient prescriptions for a benzodiazepine, which is a type of antianxiety medication (goal is a decrease in this percentage).[c]
Phase 2 (2015–2017)	Improving the safety and effectiveness of prescribing psychotropic medications to older veterans in the outpatient care setting and Community Living Center setting.[d]	At least one of 14 VHA developed metrics.	The percentage of veterans age 75 or older who received an outpatient prescription for a benzodiazepine, among other medications (goal is a decrease in this percentage).
Phase 3 (2017–ongoing)[e]	Improving access to medication-assisted therapy for the treatment of opioid use disorder and alcohol use disorder.	At least one of two VHA developed metrics.	The percentages of veterans receiving pharmacologic treatment for an (1) opioid use disorder or (2) alcohol use disorder (goal is an increase in these percentages).

Source: GAO analysis of VHA documentation. | GAO-19-465

[a]For each PDSI phase, VHA developed a set of performance metrics from which each VAMC was required to select a designated number as a focus for implementing prescribing-related quality improvement efforts, referred to as the VAMC's priority metrics.

[b]According to a VHA official, VAMCs identified between one and 10 priority metrics with an average of three such metrics.

[c]The clinical practice guideline (CPG) for the management of PTSD strongly recommends against the use of benzodiazepines for the primary treatment of PTSD due to the lack of evidence for effectiveness and because the risks—including worse overall severity, aggression, depression, and tolerance and dependence—outweigh potential benefits. See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (Washington, D.C.: June 2017). Though it is not mandatory for providers to follow the recommendations of the CPGs, every provider is responsible for evaluating the appropriateness of applying CPG recommendations in any particular clinical situation.

[d]A VA Community Living Center provides veterans with short-term or life-time nursing home level care, including assistance with activities of daily living (e.g., bathing and getting dressed) as well as skilled nursing and medical care.

[e]A VHA official told us that, as of January 2019, they expect to complete PDSI phase 3 in June 2019. VHA is in the process of planning for a new phase 4, scheduled to begin in July 2019, according to a VHA official.

VHA reported improvements in the majority of the performance metrics from the past PDSI phases.[30] Specifically, VHA reported nationwide improvements in 16 of the 20 metrics that it developed for phase 1, and all 14 of the metrics that it developed for phase 2. For example, upon the

[30]VHA expects to complete their evaluation of PDSI phase 3 in late 2019.

completion of phase 1, VHA found that there was a nationwide 5.4 percentage point decrease (indicating improvement on this metric) in the percentage of veterans with PTSD who received one or more outpatient prescriptions for a benzodiazepine (a type of antianxiety medication).[31] VHA reported that the change in benzodiazepine prescribing, among other improvements in treating veterans with PTSD, was particularly noteworthy given that the number of veterans diagnosed with this mental health condition increased over the duration of phase 1. Further, upon the completion of phase 2, VHA found that there was a nationwide 1.7 percentage point decrease (indicating improvement on this metric) in the percentage of veterans 75 or older with an outpatient prescription for a benzodiazepine or sedative hypnotic medication.[32]

During each PDSI phase, VHA works with VISNs and VAMCs to support their quality improvement efforts related to their priority metrics.[33] For example, VHA

- provides feedback and technical assistance to VISNs and VAMCs for developing and implementing quality improvement strategies for their priority metrics, which must be updated and submitted to VHA semiannually;
- convenes a bi-monthly PDSI conference call for VISN and VAMC staff and providers involved in PDSI, which serves as a forum for providing training to participants, discussing best practices, and facilitating collaboration among VAMCs that may have chosen the same priority metrics;
- develops a semi-annual feedback report for each VISN that includes, among other content, the most recent quarterly score on the priority performance metrics for each VAMC within the network, according to a VHA official;[34] and

[31]VHA reported that there were significantly greater improvements at VAMCs that selected this measure as a priority metric (mean decrease of 6.8 percentage points).

[32]VHA reported that there were significantly greater improvements at VAMCs that selected this measure as a priority metric (mean decrease of 2.0 percentage points).

[33]In some locations, VAMC staff and providers develop and implement quality improvement strategies. In other locations, VISN staff develops and implements quality improvement strategies across multiple VAMCs within their networks.

[34]A VHA official told us that officials plan to continue to leverage these quality improvement strategies, conference calls, and feedback reports for PDSI phase 4.

- provides VISNs and VAMCs access to a PDSI clinical management dashboard to use to identify veterans who may benefit from changes to their psychotropic medication prescriptions. These lists can be filtered by the care setting in which the patient is seen, such as the primary or specialty care settings.

Although VISNs and VAMCs are not always required (but are encouraged) to continue quality improvement efforts related to VAMCs' priority metrics from past PDSI phases, VHA continues to monitor VAMC performance on all metrics from each PDSI phase. Specifically, a VHA official told us that VHA monitors performance by calculating quarterly VAMC scores on all performance metrics, which are published on the PDSI clinical management dashboard. VHA also disseminates these scores to the VISNs in the semiannual feedback reports. In these feedback reports, VHA highlights any metric—from the current or a past phase—for which a VAMC within that VISN has regressed. A VHA official stated that if a VAMC regresses significantly in any area, VHA would work with that medical center to determine the cause and take action to reverse the trend as needed.

See appendix III for information on PDSI's planned focus on reducing the co-prescribing of benzodiazepines and opioids as well as the initiative's collaboration with VHA's Academic Detailing program, which has developed its own campaign related to stimulant prescribing.

VHA Has Included Psychotropic Medications in Multiple Efforts to Examine Suicide Risk among Veterans

Since 2012, VHA has included psychotropic medications in multiple efforts to examine suicide risk among veterans, including two programs and three research studies.[35] These efforts include:

Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) Program. VHA includes psychotropic medications as part of its effort to examine veterans who may be at risk of suicide through its REACH VET program. Specifically, REACH VET uses prior research findings to conduct predictive modeling on data collected from VHA's electronic medical records to identify veterans who are within the top tier (0.1 percent) of predicted suicide risk. These veterans may also be at increased risk of other adverse outcomes, such as overdoses, violence, and mental health hospitalization. Of note, five of the 61 variables used in REACH VET's predictive model relate to the prescription of specific psychotropic medications (e.g., alprazolam), and three relate to the prescription of specific psychotropic classes (e.g., antidepressants).[36] Other variables used in the model include demographic characteristics, past suicide attempts, measures of VHA care utilization, and certain diagnoses such as substance use disorder, MDD, and chronic pain.[37]

[35]In a recent study that was not counted among these three research studies, VHA researchers began collaborating with researchers from Mount Sinai in January 2019 to study the use of ketamine for treating suicidal ideation among veterans. We did not include this study in our list of relevant VHA studies because VHA does not classify ketamine as a psychotropic medication; however, VHA notes the drug may have similar psychotropic effects on patients.

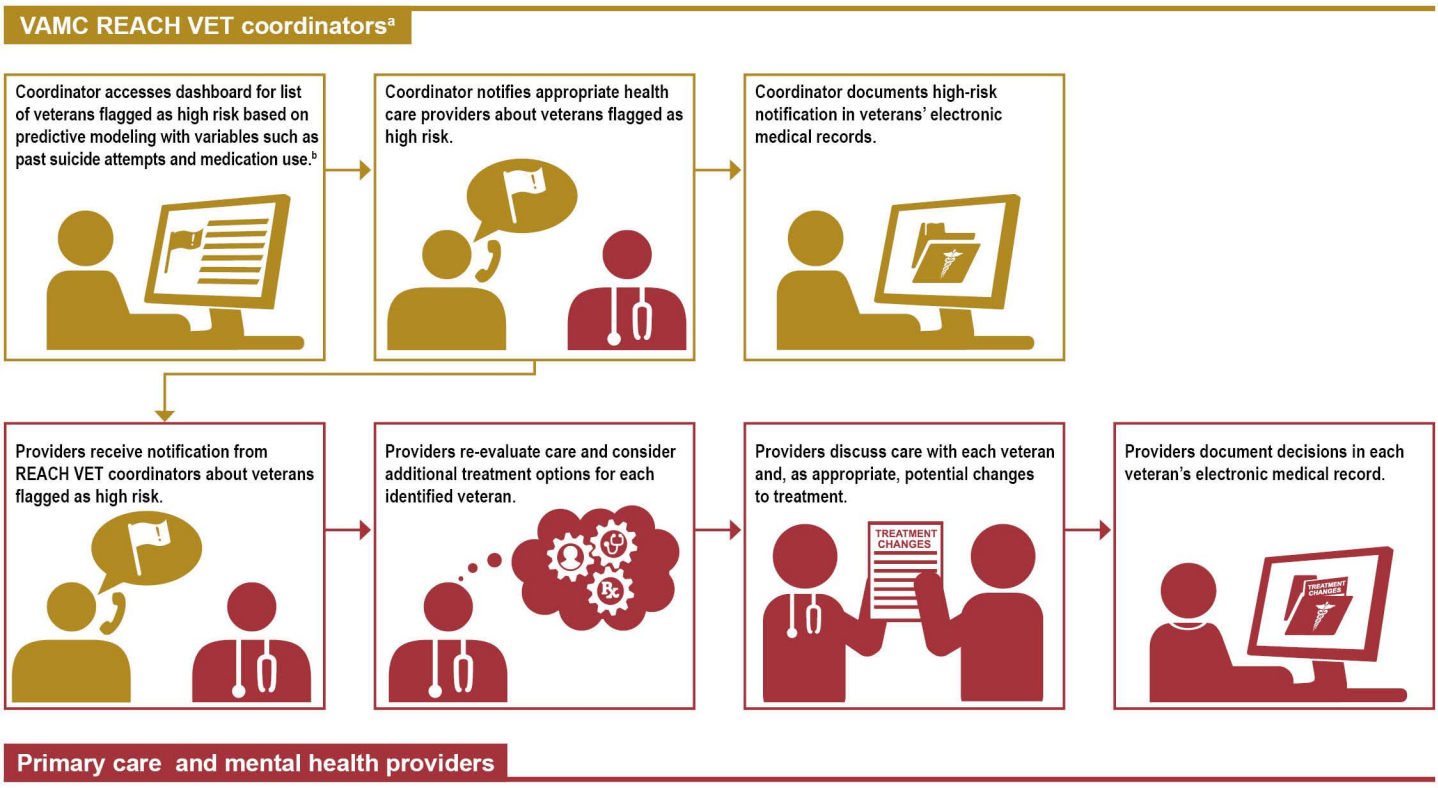
[36]The five psychotropic medications included are alprazolam, clonazepam, lorazepam, mirtazapine, and zolpidem. The three classes of psychotropic medications included are antidepressants, antipsychotics, and mood stabilizers.

[37]VHA researchers found that veterans identified as being in the top 0.1 percentile of suicide risk are 30 times more likely to attempt suicide within one year as compared to the overall VHA care-seeking veteran population. Furthermore, VHA researchers found that 79 percent of these veterans had not been previously identified in the medical record by a clinical provider as being at high suicide risk.

REACH VET coordinators staffed at VAMCs are responsible for notifying the appropriate mental health provider or PCP that a veteran has been identified as being at high risk for suicide, based on a high-risk list of veterans generated monthly by REACH VET's predictive model.[38] As shown in Figure 4, veterans identified as being at high risk for suicide may then receive targeted outreach from their mental health providers or PCPs if those providers conclude that outreach is warranted based on their review of the veterans' medical records, according to VHA officials. This outreach may result in changes to the veteran's treatment as agreed upon by the provider and veteran. VHA reported that within the first year of nationwide implementation, February 2017 through February 2018, the program identified close to 30,000 veterans at high risk for suicide.

[38]VHA officials told us that at each VAMC the role of REACH VET coordinator is a collateral duty fulfilled by a staff member in the mental health service line, typically the facility's suicide prevention coordinator, who is responsible for conducting suicide prevention activities at a VAMC. REACH VET's predictive model uses data from veterans' electronic medical records to populate its high-risk list of veterans at each VAMC who are within the top 0.1 percent tier of suicide risk as predicted by the model.

Figure 4: Roles of Coordinators and Providers in the Veterans Health Administration's Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) Program at VA Medical Centers (VAMC)



Source: GAO analysis of Veterans Health Administration documents. | GAO-19-465

[a]The role of the REACH VET coordinator is a collateral duty fulfilled by a staff member in the mental health service line at each VAMC, typically by the suicide prevention coordinator, who is responsible for conducting suicide prevention activities at each VAMC.

[b]The REACH VET program populates monthly a high-risk list of veterans—those veterans who are in the highest 0.1 percent tier of being predicted for risk of suicide—by applying a predictive modeling algorithm to data from veterans' electronic medical records. The model includes, among others, eight variables representing different psychotropic medications or classes.

Behavioral Health Autopsy Program. VHA also includes psychotropic medications in its Behavioral Health Autopsy Program. This program

examines information about veteran deaths by suicide that are reported to VAMC providers and suicide prevention coordinators.[39]

When informed that a veteran has died by suicide, suicide prevention coordinators are to electronically report, among other things, whether the veteran had (1) been prescribed psychotropic and other medications, for the treatment of a mental health condition within the previous year, and (2) adhered to the medications.[40] Other sources of information collected through the program may include coroners' and medical examiners' reports, death certificates, and information provided by family members and significant others. Data are reported to and analyzed by VHA's VISN 2 Center of Excellence for Suicide Prevention.[41] One recommendation in the program's 2017 annual report called for more efforts to study issues related to medication management, such as veterans' medication adherence, overmedication, and frequent and abrupt medication changes.[42] In the past, recommendations from the program have been used to inform VHA suicide prevention policies, programs, and educational efforts, according to VHA officials. For example, officials shared that the program informed the development of a tool kit for providers to use to help address veterans' sleep issues after analyses found that sleep patterns were often altered for veterans prior to their death by suicide.

Lithium for Suicidal Behaviors in Mood Disorders study. As of March 2019, VHA is in the process of conducting a randomized clinical trial that

[39]We have previously reported on VA's Behavioral Health Autopsy Program; see GAO, *VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data,* GAO-15-55 (Washington, D.C.: Nov. 12, 2014). In this report we recommended, among other things, that VA implement processes to review this program's data on veteran suicides submitted by VAMCs before submission to VA's Central Office, and that VA clarify guidance for suicide prevention coordinators on how to complete templates for this program. VA agreed with these recommendations and they were implemented in 2016.

[40]Suicide prevention coordinators report on the use of all psychiatric medications by veterans who died by suicide, which VA officials said includes psychotropic medications.

[41]The VISN 2 Center of Excellence for Suicide Prevention aims to integrate surveillance and research efforts to inform the implementation of effective veteran suicide prevention strategies.

[42]In addition to this recommendation, the report also recommended that VA (1) consider how to provide veterans' with coordinated care across a variety of VHA care settings, (2) incorporate suicide prevention efforts across care settings, and (3) standardize practices for helping individuals who are affected by a veteran suicide.

examines the effect of a specific psychotropic medication (lithium) on reducing suicide risk for veterans with MDD or bipolar disorder who either survived a recent suicide attempt or were hospitalized to prevent one. VHA plans to enroll 1,600 veterans in the study from 28 VAMCs and provide them with the appropriate treatment options as determined by their respective providers, as well as provide some additional care coordination.[43] Additionally, half of the participants will receive lithium, and half of the participants will receive a placebo. The study's investigators told us that, to their knowledge, this study is the first effort to test lithium's efficacy for reducing suicide risk in a randomized clinical trial setting. Investigators also told us that, because all participants will receive medications already proven safe and effective for the treatment of their conditions, it is not considered unethical to withhold lithium, a yet untested medication for treating suicide risk, from half of participants. VHA investigators told us they hope to use the results of this clinical trial to inform future treatment options for patients with MDD or bipolar disorder and who are at risk of suicide.

Drugs and Suicide Risk study. Between January 2017 and October 2018, VHA officials and collaborators at the University of Chicago and Columbia University analyzed 513 medications, which included psychotropic medications, prescribed between 2003 and 2014 for association with increased or decreased risk of suicidal events in VHA patients. According to the study's investigators, they expect to be able to identify specific psychotropic medications that are found to be associated with the largest increases and decreases in suicide risk. VHA officials told us that as of March 2019, the research manuscript was under review for publication in a peer-reviewed journal.

Using Big Data and Precision Medicine to Assess and Manage Suicide Risk in U.S. Veterans study. As of March 2019, VHA officials, in collaboration with the Department of Energy, were in the process of developing a new model to predict suicidal behavior among veterans by combining data on genetic and non-genetic risk factors, such as demographics, medical conditions, and stressful life events; psychotropic medications are also included as a risk factor, according to VHA

[43]As of March 2019, VHA said that this study had recruited approximately 500 veterans for participation of the originally planned 1,600 veterans and that a possible extension to the recruitment period is under review.

officials.[44] The researchers are expected to combine data from VHA electronic medical records with data from a VHA Office of Research and Development program that collects genetic information from veterans to develop the new algorithm.

VHA officials we interviewed noted some broad challenges not exclusive to VHA that may affect efforts for any researcher in examining suicide risk and the use of psychotropic medications:

- **Multiple risk factors.** All VHA officials that we spoke with discussed the need for efforts examining psychotropic medications and suicide risk to account for other suicide risk factors beyond the use of these types of medication. Such factors may include having a substance use disorder or other mental health diagnoses; homelessness; chronic (non-mental health) medical conditions; age; and psychosocial factors, such as recent loss of a significant other or a history of abuse or violence.
- **Methodological considerations.** Most VHA officials that we spoke with mentioned some methodological considerations that must be considered when designing a research study to examine this relationship. For example, an official told us that measuring veterans' medication adherence is important to track, but is difficult to do as VHA generally only has data on whether medications were dispensed to veterans, not whether medications were actually taken.
- **Ethics.** Some VHA officials that we spoke with noted that certain ethical considerations may limit the methodological options available to researchers, such as randomized clinical trials. For example, it would be unethical to withhold medications that have been proven as safe and effective from veterans who may clinically benefit from receiving such treatments, such as from veterans in a control group.

In the face of these challenges, VHA officials also noted some advantages VHA researchers, in particular, may experience in examining the use of psychotropic medications and suicide risk:

[44]In this study, researchers will develop an algorithm to predict the risk of suicide in patients by using data from several federal agencies (including VA) combined with expertise and computing technologies from the Department of Energy's National Laboratory System. This system contains 17 laboratories that, among other things, develop unique, often multidisciplinary, scientific and technical capabilities to benefit U.S. researchers.

- **a large patient population** with more than 2 million veterans who have at least one mental health condition, and a corresponding electronic medical records database, providing sufficient data and sample sizes needed to test hypotheses;
- **internal funding streams** dedicated to research activities examining issues related to suicide prevention, such as funds available through three of VA's Office of Research and Development's four central research services;[45] and
- **research centers** with researchers who have specific expertise about issues related to suicide prevention and the treatment of serious mental health conditions.[46]

Conclusions

Veterans diagnosed with mental health conditions rely on providers in VAMCs across the country to make treatment decisions that are safe and effective, including whether to treat highly prevalent and serious conditions such as MDD and PTSD with psychotropic medications, non-pharmacologic therapy, or a combination of both. In recent years, VHA has taken steps aimed at improving the safety and effectiveness of prescribing decisions for certain psychotropic medications and noted important improvements resulting from these efforts. However, VHA's oversight related to treatment planning needs improvement. VHA has yet to disseminate guidance that clearly reflects its expectation that mental health providers in specialty care document mental health treatment plans in a readily identifiable manner in veterans' medical records. Additionally, VHA does not monitor whether mental health providers are considering evidence-based treatment options in treatment plans, as VHA requires in its mental health services handbook. As a result, VHA cannot ensure that providers are considering and documenting all appropriate treatment options, adequately evaluating patient care, and making treatment modifications as necessary, among other issues. Furthermore, the lack of monitoring may impede VHA's ability to identify important factors that

[45]VA's Office of Research and Development's four research services focus on (1) biomedical laboratory research, (2) clinical science research, (3) health services research, and (4) rehabilitation research.

[46]Examples of VHA's research centers include (1) the Serious Mental Illness Treatment Research and Evaluation Center; (2) the VISN 2 Center of Excellence for Suicide Prevention; and (3) the Rocky Mountain Mental Illness Research, Education, and Clinical Center for Veteran Suicide Prevention.

contribute to providers' treatment decisions, which could in turn allow VHA to identify more systemic barriers to safe and effective treatment, such as needed training.

In addition, being able to readily identify how veterans are being treated for mental health conditions may allow VHA to enhance its research efforts related to suicide risk. VHA has noted several advantages it has in conducting research involving the role of psychotropic medications in suicide risk among veterans, including that VHA researchers have access to a large patient population with at least one mental health condition. Monitoring veterans' use of psychotropic medications and non-pharmacologic therapies and related outcomes may further enhance this capacity for research on suicide risk.

Recommendations for Executive Action

We are making the following two recommendations to VA:

The Veterans Health Administration should disseminate guidance for VISNs and VAMCs that more clearly reflects its expectation that mental health providers in specialty care should record mental health treatment plans within veterans' medical records in an easily identifiable way. (Recommendation 1)

The Veterans Health Administration should develop and implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure that such plans include documentation that different evidence-based treatment options were considered. (Recommendation 2)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, which are reproduced in Appendix IV, VA concurred with our recommendations. VA agreed that the recommendations would promote adherence to mental health treatment planning requirements. VA stated that it is developing guidance to help ensure that mental health providers in specialty care record mental health treatment plans in separate, easily identifiable documents within veterans' medical records. VA also stated that it will develop and implement a process for monitoring whether such plans include documentation that providers considered

different evidence-based treatment options. We will monitor VA's efforts to address our recommendations.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committee and the Secretary of Veterans Affairs. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at DraperD@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Debra A. Draper
Director,
Health Care

Appendix I: Mental Health Treatment Practices for Veterans in a Nongeneralizable Sample of Selected Medical Centers

We reviewed a nongeneralizable, randomly selected sample of 75 veterans' medical records from five Department of Veterans Affairs (VA) medical centers (VAMC)—25 for each of the three most prevalent conditions diagnosed among veterans—who had at least one primary care visit in fiscal year 2017 and were prescribed a new psychotropic medication. About half (37) of the 75 medical records we reviewed indicated the veteran was prescribed a new psychotropic medication prior to or without being referred to a mental health provider in specialty care. See table 4.

Table 4: Referral Status of a Sample of Veterans with Selected Mental Health Conditions Prescribed New Psychotropic Medications by Primary Care Providers, Fiscal Year 2017

Veterans prescribed a new psychotropic medication by a primary care provider. (n=75).

Mental health condition	Veterans diagnosed with condition	prior to being referred to a mental health provider in specialty care		without being referred to a mental health provider in specialty care		at the same time as being referred to a mental health provider in specialty care		after being referred to a mental health provider in specialty care	
Major depressive disorder	25	5	20%	8	32%	6	24%	6	24%
Post-traumatic stress disorder	25	6	24%	7	28%	2	8%	10	40%
Generalized anxiety disorder	25	4	16%	7	28%	3	12%	11	44%
Total	**75**	**15**	**—**	**22**	**—**	**11**	**—**	**27**	**—**

Source: GAO analysis of a sample of veterans' medical records. | GAO-19-465

Note: The nongeneralizable, randomly selected sample included medical records of 75 veterans (25 for each condition) who had at least one outpatient encounter for one of the conditions in fiscal year 2017 and was prescribed a new psychotropic medication by a Department of Veterans Affairs (VA) primary care provider employed at one of the five selected VA medical centers in that year. The

prescription was considered to be new if the veteran had not received a medication from that class of medication in the last 5 years. Psychotropic medications were limited to medications designated as recommended first line therapies for our three selected mental health conditions. To determine whether a veteran was referred to a mental health provider in specialty care, we examined consults and progress notes entered into veterans' medical records from six months prior to the date each veteran was prescribed a psychotropic medication through six months after that date. VA officials stated that primary care providers may verbally refer veterans to mental health providers in specialty care but not document the referral in veterans' medical records. We were not able to quantify how frequently such referrals occurred because they were not always documented.

We reviewed a separate, nongeneralizable, randomly selected sample of an additional 75 veterans' medical records from the five VAMCs—25 for each of the three most prevalent conditions diagnosed among veterans—who were newly diagnosed within that year. Over half (44) of the 75 medical records we reviewed indicated whether the veteran was offered non-pharmacologic therapy in lieu of or in addition to being prescribed a psychotropic medication. See table 5.

Table 5: Sample of Veterans Newly Diagnosed with Selected Mental Health Conditions, Occurrence of Documentation of Being Offered Non-Pharmacologic Therapy, Fiscal Year 2017

	Veterans newly diagnosed with a select mental health condition (n=75)						
Mental health condition	**Veterans diagnosed with condition**	**Offered non-pharmacologic therapy in lieu of being prescribed a psychotropic medication**		**Offered non-pharmacologic therapy in addition to being prescribed a psychotropic medication**		**No documentation of being offered non-pharmacologic therapy**	
Major depressive disorder (MDD)[a]	25	2	8%	8	32%	15	60%
Post-traumatic stress disorder (PTSD)[b]	25	5	20%	10	40%	10	40%
Generalized anxiety disorder (GAD)[c]	25	4	16%	15	60%	6	24%
Total	**75**	**11**	**—**	**33**	**—**	**31**	**—**

Source: GAO analysis of a sample of veterans' medical records. | GAO-19-465

Note: The nongeneralizable, randomly selected sample included medical records of 75 veterans (25 for each condition) who had at least one outpatient encounter for one of the conditions in fiscal year 2017 at one of the five selected VA medical centers (VAMC) in that year. The sample of veterans did not have an encounter for the condition between fiscal years 2012 and 2016—the five years prior to fiscal year 2017. According to VA officials, a condition is generally considered to be a new diagnosis if a veteran did not have an encounter for the condition in five years. To determine whether a veteran was offered non-pharmacologic therapy, we examined consults and progress notes entered into veterans' medical records from the date of each veteran's first visit for the condition through six months after that date. VA officials stated that providers may verbally offer non-pharmacologic therapy but not document the offering in veterans' medical records. We were not able to quantify how frequently such offerings occurred because they were not always documented. In addition, we only considered non-pharmacologic therapies for each condition that VA officials indicated are provided by VAMC providers, rather than providers in the community.

[a]The clinical practice guideline (CPG) for the management of MDD recommends both evidence-based psychotropic medications (e.g., selective serotonin reuptake inhibitor) and non-pharmacologic therapy (e.g., cognitive behavioral therapy) as first-line treatments for veterans with uncomplicated mild to moderate MDD. For veterans at high risk for relapse, the CPG recommends a course of non-pharmacologic therapy even after remission is achieved to reduce the risk of relapse or recurrence.

[b]The CPG for the management of PTSD recommends certain individual trauma-focused non-pharmacologic therapy over other non-pharmacologic therapies and psychotropic medications. When individual trauma-focused psychotherapy is not readily available or not preferred, psychotropic medications or individual non-trauma-focused psychotherapy (e.g., stress inoculation training) are recommended—the evidence does not support recommending one of these secondary options over another.

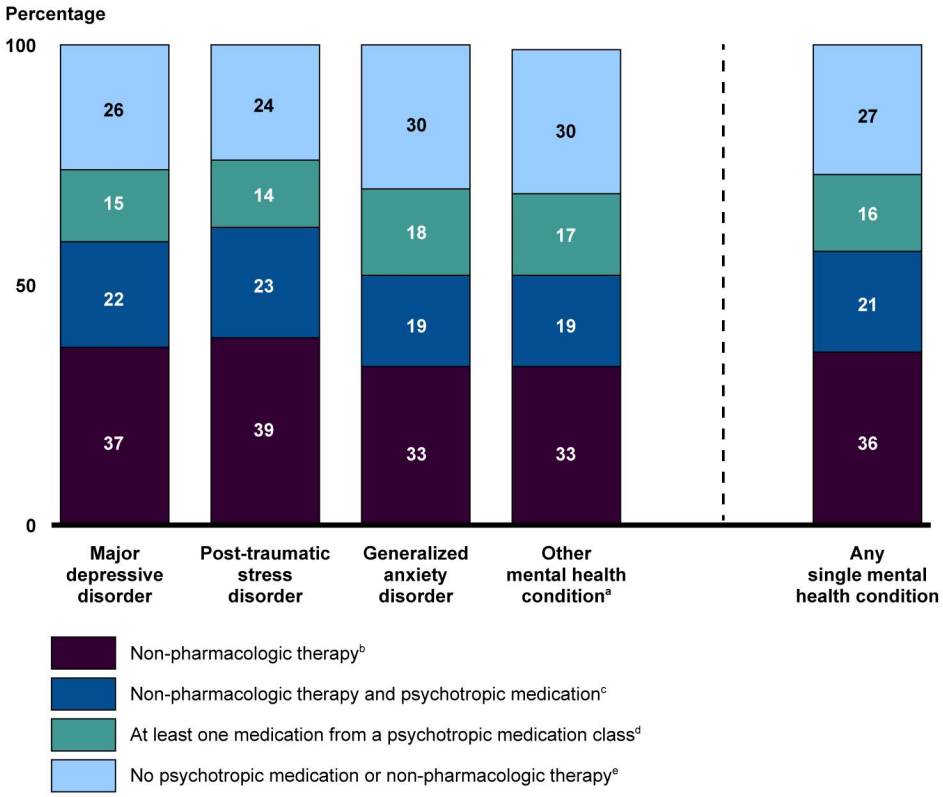
[c]As of March 2019, the Departments of Veterans Affairs and Defense, which jointly developed CPGs for the other conditions, have not developed a clinical practice guideline for GAD.

Appendix II: Information on the Treatment of Veterans with Certain Mental Health Conditions, Nationally, in Fiscal Year 2018

We analyzed national data obtained from VHA on the types of treatments received by veterans with a diagnosis of a single mental health condition who had encounters with VHA providers for that diagnosis in fiscal year 2018, including the three most prevalent mental health conditions diagnosed among veterans.[1] See Figure 5 for the percentages of veterans with these three conditions or another mental health condition who received (1) non-pharmacologic therapy (psychotherapy), (2) at least one medication from a psychotropic medication class, (3) a combination of the two, or (4) neither psychotropic medication nor non-pharmacologic therapy in fiscal year 2018.

[1]Encounter data record services provided to beneficiaries in health care settings—in this case, to veterans receiving services from VHA.

Figure 5: Percentage of Veterans with a Single Mental Health Condition, including the Three Most Prevalent Conditions, by Treatment Decision, in Fiscal Year 2018



Source: GAO analysis based on Veterans Health Administration (VHA) data. | GAO-19-465

Note: Veterans represented in the data shown in this figure were those who had a VHA encounter in fiscal year 2018. Further, the percentages represent veterans with only one diagnosed mental health condition (major depressive disorder, post-traumatic stress disorder, generalized anxiety disorder, or another single diagnosed mental health condition; they do not include veterans who had other, co-occurring diagnosed mental health conditions).

[a]"Other mental health condition" refers to a single mental health diagnosis that did not include major depressive disorder, post-traumatic stress disorder, or generalized anxiety disorder.

[b]Veterans who received non-pharmacologic therapy only received a form of outpatient non-pharmacologic therapy known as psychotherapy, which involves treating mental illnesses using psychological rather than medical means.

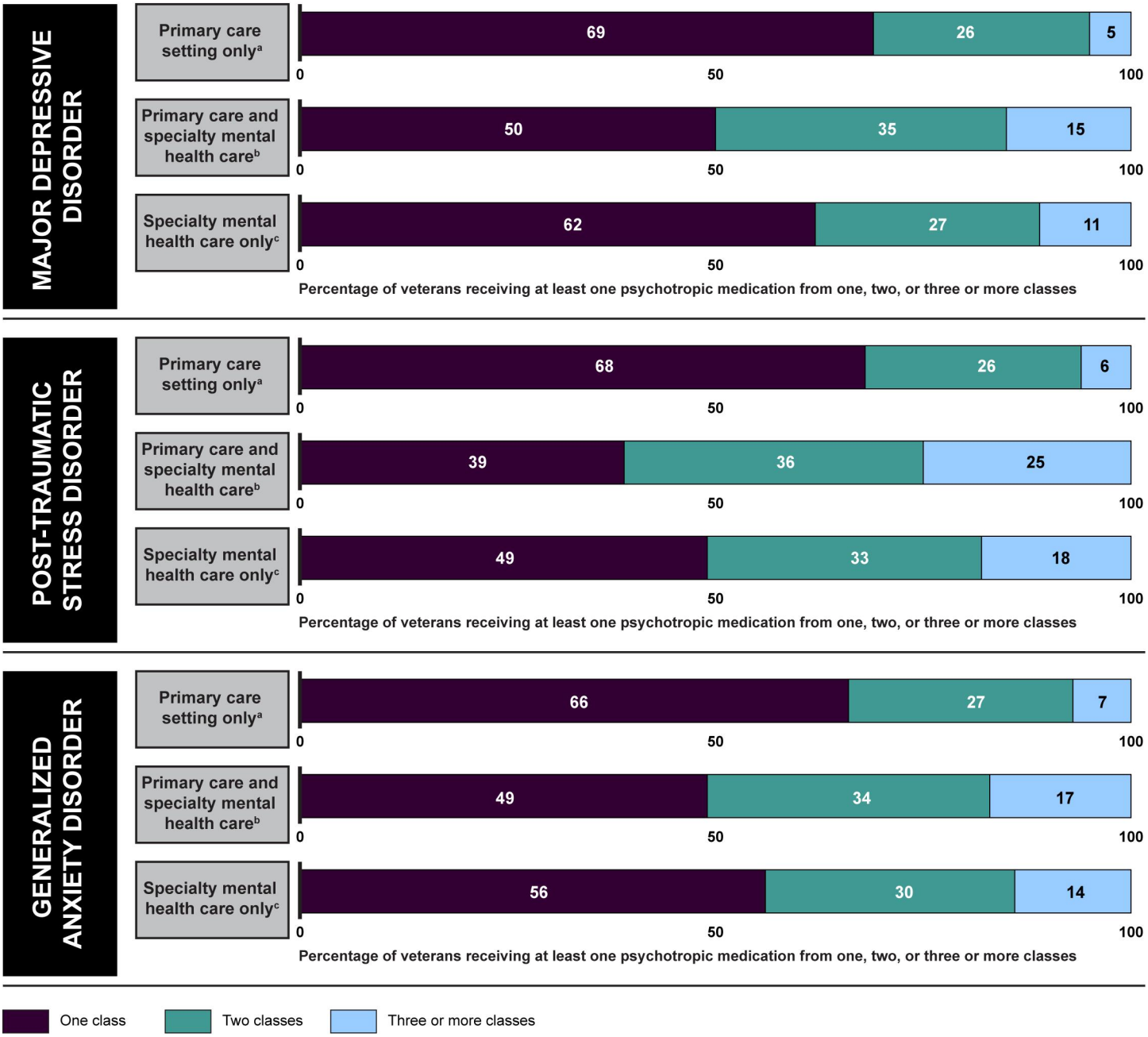
[c]Veterans who received non-pharmacologic therapy and psychotropic medication received a combination of treatments. These treatments may have been provided concurrently or sequentially; according to VHA officials, the data do not capture the order in which these types of treatments were received by a veteran or the amount of time that occurred between the initial receipts of each treatment type.

[d]Veterans who received a medication from at least one psychotropic drug class means that they received a form of pharmacologic therapy. VHA classifies psychotropic medications into different classes based on biological targets or drug effects. This analysis used data on the following four classes: (1) antidepressants, (2) antipsychotics, (3) anxiolytics, and (4) mood stabilizers.

[e]Veterans who did not receive psychotropic medication or non-pharmacologic therapy may have received other VHA services to help manage their mental health conditions, such as, according to VHA officials, evaluation and management services. These veterans may also not have received any treatment or services from VHA at all because they may have received treatment outside of the VHA system or they may have declined treatment.

We also analyzed national encounter data obtained from VHA for veterans with one of the three most prevalent mental health conditions and who received psychotropic medications in a VA medical center (VAMC) in fiscal year 2018. We found that for all three conditions, the largest percentage of veterans who received at least one psychotropic medication from one class were seen in the primary care setting only. The percentages of veterans with medications from two or three classes—typically veterans who had more complex mental health conditions, according to a VHA official—were larger for veterans seen by specialty care providers, compared to the percentages of veterans with medications from multiple classes seen in primary care only. See Figure 6.

Figure 6: Percentages of Veterans with One of the Three Most Prevalent Mental Health Conditions, in Fiscal Year 2018, by Number of Psychotropic Classes Received and Care Setting(s) in Which They Were Seen



Source: GAO analysis based on Veterans Health Administration (VHA) data. | GAO-19-465

Note: Veterans represented in the data shown in this figure were those who had a VHA encounter in fiscal year 2018 with a diagnosis of major depressive disorder, post-traumatic stress disorder, or generalized anxiety disorder—the data do not include veterans who had any other, co-occurring diagnosed mental health conditions. However, according to VHA officials, these veterans may have had co-occurring medical conditions for which a psychotropic medication may also be indicated; for example, some antidepressants may be used to treat pain. Further, VHA data do not capture information related to the specific type of provider who prescribed a psychotropic medication to a veteran. Thus, if a veteran had an encounter in both the primary and specialty care settings, the setting in which the prescription was made is unknown.

VHA classifies psychotropic medications into different classes based on biological targets or drug effects. This analysis used data on the following four classes: (1) antidepressants, (2) antipsychotics, (3) anxiolytics, and (4) mood stabilizers. A VHA official told us that the more psychotropic classes a veteran was prescribed was an indicator of the complexity of a veteran's mental health condition.

[a]Veterans seen in the primary care setting include veterans who only had encounters in the outpatient primary care clinic that year. For the purposes of our analyses, we included veterans who had encounters with primary care providers and encounters with mental health providers (e.g., psychologists and social workers) who are collocated within the primary care clinic and are available to collaborate with primary care providers before treatment decisions are made, since both of these providers types are located in the primary care setting. For example, collocated mental health providers can offer non-pharmacologic therapy to veterans without requiring a separate visit outside of primary care to receive such an order. However, in their data, VHA officials told us that they count veterans' encounters with the collocated mental health providers as mental health visits.

[b]Veterans seen in the primary and specialty care settings include those veterans who had encounters in both outpatient clinical settings that year.

[c]Veterans seen in the specialty care setting include those veterans who only had encounters in the outpatient mental health clinic that year.

Appendix III: PDSI's Planned Focus on Medication Tapering and Collaboration with VHA's Academic Detailing Program

The Veterans Health Administration (VHA) has taken steps to improve the safe and effective prescribing of certain psychotropic medications used to treat veterans with mental health conditions through the Psychotropic Drug Safety Initiative (PDSI). PDSI has consisted of three phases since 2013, when the initiative began. Each phase has focused on making improvements related to the prescribing of different classes or types of psychotropic medications, or treating different age groups or mental health conditions and substance use disorders. PDSI is currently in phase 3, and VHA is in the process of planning for phase 4.

According to a VHA official, PDSI phase 4 (expected to begin in July 2019) will, in part, increase the role of mental health providers in the monitoring and management of the co-prescribing of benzodiazepines (a type of antianxiety medication) and opioids. This includes tapering the use of these medications among this high-risk veteran population to a reduced dose or discontinuation entirely when the harms associated with their concurrent use outweigh the benefits.[1] The same official told us that, to date, VHA has primarily focused on monitoring the concurrent use of these medications—which the Department of Veterans Affairs' and the Department of Defense's clinical practice guideline (CPG) for opioid

[1]According to a VHA official, as of October 2018 (the most recent data available), 19,006 veterans with at least one diagnosed mental health condition had an active prescription for at least one benzodiazepine and at least one opioid.

therapy strongly recommends against—through the Opioid Safety Initiative and in the primary care setting (see text box).[2]

[2]The CPG strongly recommends against the concurrent use of benzodiazepines and opioids because the harms—such as an increased risk of overdose death—may outweigh the benefits. See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (Washington, D.C.: February 2017). We previously reported that there was a 6.6 percentage point change in the Opioid Safety Initiative metric measuring the number of veterans dispensed a benzodiazepine and an opioid between the fourth quarter of fiscal year 2013 and the first quarter of fiscal year 2018. See GAO, *VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed,* GAO-18-380 (Washington D.C.: May 29, 2018).

Veterans Health Administration's (VHA) Efforts to Taper Veterans Co-Prescribed Benzodiazepines and Opioids

Efforts focused on the establishment of safe and effective tapering programs in the primary care setting:

- VHA launched the Opioid Safety Initiative in 2013 to ensure that veterans are prescribed and use opioid pain medications in a safe and effective manner. This initiative seeks to establish safe and effective tapering programs for veterans who are co-prescribed opioids and benzodiazepines, among other goals.
- A VHA official told us that the initiative primarily focuses on monitoring and managing the concurrent use of these medications in the primary care setting.

Efforts conducted on an individualized, gradual basis:

- The Department of Veterans Affairs' and Department of Defense's clinical practice guideline (CPG) for opioid therapy strongly recommends that tapering of opioids be done on an individualized basis, weighing the benefits and risks to each veteran as well as the veteran's characteristics and needs.[a]
- The CPG also notes that the sudden stopping of benzodiazepines should be avoided, since doing so can lead to seizures or death.[b] Thus, according to VHA, veterans taking benzodiazepines for more than four weeks should be tapered, and this tapering should occur slowly, to the least dose necessary to maintain function and good symptom control.

[a]Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (Washington, D.C.: February 2017).

[b]Department of Veterans Affairs and Department of Defense, *Clinical Practice Guideline for Opioid Therapy*.Source: GAO analysis of VHA documentation and interviews with VHA officials. | GAO-19-465

To help achieve PDSI's goal of improving the prescribing of certain psychotropic medications, VHA officials leading PDSI collaborate with VHA's Academic Detailing program. Academic detailers, who are Veterans Integrated Service Networks (VISN) or Department of Veterans Affairs (VA) medical center (VAMC) clinical pharmacy specialists, disseminate resources and provide one-on-one educational outreach to providers to help them improve their psychotropic medication prescribing practices.[3] Pharmacy staff, including staff involved in academic detailing, from four VISNs told us that they provide education related to PDSI.[4] The Academic Detailing program has also implemented a campaign to improve the appropriate prescribing and monitoring of stimulants (see text box).

[3]Each VISN's or VAMC's academic detailing program typically implements one to three campaigns per fiscal year. These campaigns, which focus on changing providers' practices in a specific clinical area or related to the use of medications from a specific drug class to treat veterans, are chosen by each VISN or VAMC based upon local need or national VHA priorities.

[4]According to a VHA official, academic detailers made 4,139 PDSI-related staff interactions with providers between fiscal year 2015 and fiscal year 2018.

Veterans Health Administration's (VHA) Academic Detailing Program Prescription Stimulants Campaign

According to a VHA official, in February 2018, the Academic Detailing program implemented a campaign to improve the treatment of patients receiving prescription stimulant therapy for adult attention-deficit / hyperactivity disorder.[a]

- A VHA official told us that Veterans Integrated Service Networks (VISNs) or Department of Veterans Affairs (VA) medical centers (VAMCs) may choose, but are not required, to participate in this campaign.
- The stimulant campaign dashboard includes VAMC scores on 13 quality indicators related to (1) prescribing stimulants for off-label use, (2) assessing co-morbidities, (3) monitoring patients, and (4) managing medication. For example
  - One quality indicator measures the percentage of veterans co-prescribed a stimulant and a benzodiazepine, and
  - Another quality indicator measures the percentage of veterans co-prescribed a stimulant and an opioid.
- Academic detailers (VISN or VAMC clinical pharmacy specialists) may use the dashboard to identify providers who may benefit from changes to their stimulant prescribing practices.
- A VHA official reported that between February 2018 and the end of fiscal year 2018, academic detailers made 37 staff interactions with providers related to the national academic detailing program's stimulant campaign.

As of October 2018 (the most recent data available), 37,223 veterans with at least one diagnosed mental health condition had an active prescription for at least one stimulant, according to a VHA official. Among these veterans, 2,360 had a co-occurring cardiac condition.[b]

Further, the official reported to us that 4,338 veterans with at least one diagnosed mental health condition had active prescriptions for at least one stimulant and at least one benzodiazepine, and 4,160 had active prescriptions for at least one stimulant and at least one opioid.

[a]Attention-deficit / hyperactivity disorder is a brain disorder marked by an ongoing pattern of inattention or hyperactivity-impulsivity that interferes with functioning and development.

[b]Sudden death, stroke, or other cardiac events have been reported with stimulants. The U.S. Food and Drug Administration has stated that stimulants should generally not be used in patients with serious heart problems or for whom an increase in blood pressure or heart rate would be problematic. See U.S. Food and Drug Administration, *FDA Drug Safety Review Communication: Safety Review Update of Medications Used to Treat Attention-Deficit / Hyperactivity Disorder (ADHD) in Adults*, accessed March 1, 2019, https://www.fda.gov/Drugs/DrugSafety/ucm279858.htm.Source: GAO analysis of VHA documentation and interviews with VHA officials. | GAO-19-465

Appendix IV: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 20, 2019

Ms. Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA MENTAL HEALTH: VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight*** (GAO-19-465).

The enclosure contains the actions to be taken to address the draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Robert L. Wilkie

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
VA MENTAL HEALTH: VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight
(GAO-19-465)

Recommendation 1: The Veterans Health Administration should disseminate guidance for VISNs and VAMCs that more clearly reflects its expectation that mental health providers in specialty care should record mental health treatment plans within veterans' medical records in an easily identifiable way.

VA Comment: Concur. The presence of an easily identifiable mental health (MH) treatment plan in the medical record promotes meeting the Veterans Health Administration (VHA) and Joint Commission treatment plan requirements. A newly developed VHA memorandum regarding mental health treatment planning will explicitly state the requirement for MH providers in specialty care to record MH treatment plans as a separate, easily identifiable document in the medical record. This easily identifiable plan will ensure it is clear what treatment is being provided, that different treatments were considered, and that ongoing assessment is used to determine whether treatment changes are needed. Facilities must either use the current nationally available MH treatment planning software or another method which creates a distinct MH treatment plan note in the medical record. Additionally, this treatment plan note must use a distinct MH treatment plan note title that can be easily identified in the medical record. Target Completion Date: December 2019.

Recommendation 2: The Veterans Health Administration should develop and implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure that such plans include documentation that different evidence-based treatment options were considered.

VA Comment: Concur. As required in the Uniform Mental Health Services Handbook 1160.01 and reiterated in upcoming VHA memorandum on MH treatment planning (described in Recommendation 1), it is important that different evidence-based treatment options are considered and that MH treatment plans (initial and updates) include documentation of shared decision-making process. VHA will develop and implement an approach for monitoring standardized documentation in MH treatment plans by requiring each facility to establish a process for reviewing a sampling of five MH treatment plans biannually for each licensed independent provider. The monitoring process reviews whether the treatment plan is easily identifiable in the electronic health record, and whether there is documentation of the following:

1) the treatment being provided;
2) consideration of different evidence-based treatment options; and
3) evaluation of care on an ongoing basis and, as necessary, modifications to the care plan are made.

Target Completion Date: December 2019.

1

Agency Comment Letter

Text of Appendix IV: Comments from the Department of Veterans Affairs

Page 1

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U.S. Government Accountability Office
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Enclosure

Page 1

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Recommendation 2:

The Veterans Health Administration should develop and implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure that such plans include documentation that different evidence-based treatment options were considered.

VA Comment: Concur. As required in the Uniform Mental Health Services Handbook 1160.01 and reiterated in upcoming VHA memorandum on MH treatment planning (described in Recommendation 1), it is important that different evidence-based treatment options are considered and that MH treatment plans (initial and updates) include documentation of shared decision-making process. VHA will develop and implement an approach for monitoring standardized documentation in MH treatment plans by requiring each facility to establish a process for reviewing a sampling of five MH treatment plans biannually for each licensed independent provider. The

monitoring process reviews whether the treatment plan is easily identifiable in the electronic health record, and whether there is documentation of the following:

1. the treatment being provided;
2. consideration of different evidence-based treatment options; and
3. evaluation of care on an ongoing basis and, as necessary, modifications to the care plan are made.

Target Completion Date: December 2019.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper at (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Hernán Bozzolo (Assistant Director), Kaitlin Asaly (Analyst-in-Charge), Jennie F. Apter, Karen Belli, Topher Hoffmann, and Rebecca Rust Williamson made key contributions to this report. Also contributing were Rich Lipinski, Diona Martyn, Vikki Porter, and Jennifer Whitworth.

Appendix VI: Accessible Data

Data Tables

Data Table Figure 5: Percentage of Veterans with a Single Mental Health Condition, including the Three Most Prevalent Conditions, by Treatment Decision, in Fiscal Year 2018

Disorder Level	Non-pharmacologic therapy[b]	Non-pharmacologic therapy and psychotropic medication[c]	At least one medication from a psychotropic medication class[d]	No psychotropic medication or non-pharmacologic therapy[e]
Major depressive disorder	37%	22%	15%	26%
Post-traumatic stress disorder	39%	23%	14%	24%
Generalized anxiety disorder	33%	19%	18%	30%
Other mental health condition[a]	33%	19%	17%	30%
Any single mental health condition	36%	21%	16%	27%

Figure 6: Percentages of Veterans with One of the Three Most Prevalent Mental Health Conditions, in Fiscal Year 2018, by Number of Psychotropic Classes Received and Care Setting(s) in Which They Were Seen

Percentage of veterans receiving at least one psychotropic medication from one, two, or three or more classes

Disorder Level	Type of setting	One class	Two classes	Three or more classes
Major depressive disorder	Primary care setting only[a]	69%	26%	5%
	Primary care and specialty mental health care[b]	50%	35%	15%
	Specialty mental health care only[c]	62%	27%	11%
Post-traumatic stress disorder	Primary care setting only[a]	68%	26%	6%
	Primary care and specialty mental health care[b]	39%	36%	25%
	Specialty mental health care only[c]	49%	33%	18%
Generalized anxiety disorder	Primary care setting only[a]	66%	27%	7%
	Primary care and specialty mental health care[b]	49%	34%	17%
	Specialty mental health care only[c]	56%	30%	14%

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