Screening Military Veterans for Post-Traumatic Stress Disorder (PTSD) in the Civilian Primary Care Setting

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Abstract

Purpose: According to the National Center for Post-Traumatic Stress Disorder (PTSD), practitioners under-recognize and diagnose PTSD. Additionally, a common symptom of PTSD is avoidance of trauma reminders, which means that patients are likely to not report traumatic experiences or symptoms of PTSD they may be experiencing without being specifically asked by their health care provider. Thus, there is a need for routine screening of PTSD symptoms in the primary care setting. The purpose of the quality improvement project was to increase civilian primary care provider knowledge regarding the following: screening adult patients for veteran status and PTSD symptoms, knowledge of recommended interventions for those screening positive, and consistent use of standardized screening tools for veteran status and presence of PTSD symptoms.

Theoretical Framework: The theoretical framework for this project was the Donabedian Model of structure, process, and outcomes.

Methods: The process implemented included asking all adult patients their veteran status. If patients identified as being a veteran, they were administered validated PTSD screening instruments. Positive screens initiated a referral to treatment as outlined by the U.S. Department of Veterans Affairs (VA). Descriptive statistics will be used to evaluate the data collected in this project.

Results: Of the 239 patients screened, 26 patients (10.9%) were veterans. Out of the 26 veterans, one patient (3.8% of veterans; 0.42% of total screened) screened positive on both the PC-PTSD and PCL-5, indicating a need for referral to treatment for PTSD. Therefore, the incidence of positive PTSD symptoms for this pilot study was 4.18 per 1,000. Mean age of participants was 52 years, while mean age of veterans was 71 years. For the total participants, 49.8% were male

and 50.2% were female. The largest racial group represented was Caucasian, with 86.2% of participants identifying in this group. Almost half of participating patients were covered by commercial insurance (49.4%).

Conclusion: This project implemented a new screening process in a rural primary care clinic to address potential PTSD symptoms in the veteran population. In the process, providers were given a toolkit for screening, resources, and additional training if desired. Patient were connected to resources for mental health crisis if screening positive for veteran status. Through implementation in the clinic, the screening of patients in the general population for PTSD was raised.

Table of Contents

Statement of Problem 6

Background and Significance 7

Prevalence of PTSD in Veterans 7

Impacts of PTSD on the Lives of Veterans 7

Primary Care Provider Assessment of Veterans for Presence of PTSD 8

Care Guidelines for Veterans with PTSD and Barriers to Care 9

Project Aims 14

Project Questions 14

Theoretical Framework 14

Definition 15

PTSD Screening 15

Methods 15

Design 15

Setting and Sample 15

Data Collection Plan 16

Human Subject Protection 18

Evaluation Plan 18

Timeline 18

Results 19

Discussion 20

Recommendations 22

Conclusion 22

References 24

Appendix A – Demographics 28

Appendix B – Initial Screening Questions 29

Appendix C – Primary Care PTSD Screen (PC-PTSD) 30

Appendix D – PTSD Checklist for DSM-V (PCL-5) 31

Appendix E – Screening Toolkit 32

Appendix F – Veterans Crisis Line Pocket Card 36

Appendix G – PTSD Treatment Form 37

Appendix H – Provider Toolkit 38

Screening Military Veterans for Post-Traumatic Stress Disorder (PTSD) in the Civilian Primary Care Setting

Post-traumatic stress disorder (PTSD) is a condition that is common among United States (US) veterans (Coll, Weiss, & Yarvis, 2011). It is estimated that a mere 23% to 40% of veterans with mental health needs actually seek care (Kane, Saperstein, Bunt, & Stephens, 2013). Of all health care providers, those in primary care are most likely to be in contact with patients who are veterans with PTSD (Prins, Kimerling, & Leskin, 2004). As such, primary care providers are in a unique position to aid this population.

During Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), over 2.4 million men and women in the United States Armed Forces were deployed, and of these, approximately 60% are no longer serving in active duty (Kane et al., 2013). It is estimated that the United States Department of Veterans Affairs (VA) provides care to only half of these 60%, and as such, a large number of veterans seek their care from civilian primary care providers (Kane et al., 2013). Therefore, civilian primary care providers must be knowledgeable regarding the unique needs of this population and how to engage in dialogue with patients regarding PTSD (Coll et al., 2011; Kane et al., 2013).

Of the over two million service members involved with OIF/OEF, approximately 20-30% report symptoms of PTSD (Yeomans & Ross, 2016). The effects of PTSD are often pervasive and can lead to a multitude of problems including physical health, interpersonal relationships, work, and school (Coll et al., 2011; Jankowsi, 2016). In addition, without proper mental health care, combat veterans with PTSD are susceptible to adopting maladaptive coping mechanisms including substance abuse, further complicating potential treatment (Coll et al., 2011). Because PTSD has such profound impacts, the National Center for PTSD, which is part of the VA, offers

information regarding PTSD screening, referral, and treatment practices for civilian primary care providers.

Primary care providers have the greatest amount of contact with this population (Prins et al., 2004). Providing adequate care to combat veterans with PTSD is important and relevant for advanced practice registered nurses (APRNs), particularly the family nurse practitioner, who is a primary care provider. Therefore, APRNs must be educated on proper screening practices for PTSD in this population and how to facilitate treatment.

Statement of Problem

According to the National Center for PTSD, practitioners under recognize PTSD (2016). This means that patients with undiagnosed PTSD are not receiving the appropriate care they need. Additionally, a common symptom of PTSD is avoidance of trauma reminders, which means that patients are likely to not report traumatic experiences or symptoms of PTSD without being specifically asked by their health care provider (National Center for PTSD, 2016). Therefore, screening of PTSD symptoms should be integrated as a routine component of care in the primary care setting.

Atchison Internal Medicine and Family Practice is a clinic in a rural setting in the state of Kansas. The clinic is approximately twenty-five miles away from Leavenworth, Kansas, which is home to a U.S. Army fort and VA medical center. The clinic was already assessing patients for military service history, but not for symptoms of related PTSD. The purpose of this project was to establish a screening process for all adult patients in this primary care setting for veteran status and the presence of PTSD symptoms. The process included referral resources and treatment as outlined by the National Center for PTSD for patients with a positive screening.

Background and Significance

In this section, the literature reviewed will be organized by the following topics: prevalence of PTSD in veterans, impacts of PTSD on the lives of veterans, primary care provider assessment of veterans for presence of PTSD, and care guidelines for veterans with PTSD in conjunction with barriers to care.

Prevalence of PTSD in Veterans

During the course of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), over 2.4 million men and women in the United States Armed Forces were deployed, and of these, approximately 60% are no longer serving in active duty (Kane et al., 2013).

Of the over two million service members involved with OIF/OEF, approximately 20-30% report symptoms of PTSD (Yeomans & Ross, 2016). This particular group of combat veterans is thought to be at an increased risk of developing various mental health conditions when compared to veterans in other conflicts due in part to multiple deployments with longer lengths of tour (Coll et al., 2011).

Impacts of PTSD on the Lives of Veterans

The resulting effects of PTSD are often pervasive in the lives of those who suffer from it, resulting in clinical and functional impairments. PTSD and its associated symptoms have been found to impact physical health, interpersonal relationships, work, and school (Coll et al., 2011; Jankowsi, K., 2016) in the lives of veterans.

In addition, without proper mental health care, combat veterans with PTSD are susceptible to adopting maladaptive coping mechanisms including substance abuse, further complicating potential treatment (Coll et al., 2011). Self-medication of symptoms with substances, such as drugs and alcohol, is common in the population of veterans with PTSD. It is

estimated that 64-84% of veterans with PTSD with have concurrent life-long alcohol abuse disorder (Brady and Sinha, 2005). Additionally, veterans with PTSD and alcohol use disorder typically have more severe PTSD symptoms (McDevitt-Murphy et. al., 2015).

Individuals with PTSD can also develop autonomic hyper-arousal. This is a state of near-constant vigilance and fear of re-encountering the thoughts, feelings, and circumstances surrounding their PTSD. Along with hyper-arousal, self-isolation is common as trust in others is challenging to commit to, and the need for protection and self-preservation supersedes other interpersonal needs (Coll et al., 2011).

Primary Care Provider Assessment of Veterans for Presence of PTSD

Suggestions for ways of beginning dialogue are common throughout the literature. Asking, "Have you or a loved one ever served in the military?" is suggested by Kane et al. (2013) as the starting point for family practitioners to engage with veterans. There are low rates of spontaneous self-reporting of mental conditions, so screening is critical (Kane et al., 2013). It is cited that civilian and military family practitioners will often be the first providers to interact with the combat veteran population.

The study discusses the need to routinely ask patients if they or a family member have ever served in the armed forces, which was also illustrated by many studies in this review (Coll et al., 2011; Lawson, 2014; Kane et al., 2013; Kudler & Straits-Tröster, 2008).

Lawson (2014) recommends using the Primary Care PTSD Screen (PC-PTSD), which was developed by the National Center for PTSD. This scale is desirable as it is a quick, four-question survey with high sensitivity and specificity. It is then suggested to utilize the Clinician-Administered PTSD scale (CAPS) if the patient screens positive on the PC-PTSD. The CAPS is cited as the "gold standard" PTSD assessment although it is noted that it requires a significant

amount of time to complete (Lawson, 2014; Weathers et al., 2013). According to the National Center for PTSD, the PTSD Checklist for Primary Care (PCL-5) is an acceptable alternative to CAPS (Weathers et al., 2013). Of note, early diagnosis of PTSD is seen as critical according to Lawson (2014).

Kudler and Straits-Tröster (2008) communicate the importance of screening in primary care for the identification of those with combat related PTSD. Similar to Kane et al. (2013), this article states that the first and most important question to ask in the screening process is, "Are you a veteran or are you the family member of a veteran?". It is then suggested to use the PC-PTSD screening tool, as was suggested by Lawson (2014). These recommendations as well as the subsequent screening recommendations if the patient is positive on the PC-PTSD are based upon Department of Defense (DoD) and VA recommendations, and are stated as such.

These commentaries cite facts from other studies and point toward the necessity of utilization of validated assessment tools in primary care and serve as an invaluable resource to civilian primary care providers. Providers must be aware that every veteran encountered is not going to respond in the same way to the screenings and interventions put forth in such guidelines.

Care Guidelines for Veterans with PTSD and Barriers to Care

Care guidelines for veterans with PTSD encompass provider training, increasing access to care, and appropriate referral to treatment.

Coll et al. (2011) sought to educate providers on the culture, experience, and health concerns of OEF/OIF combat veterans. In the article, treatment options were also briefly discussed. This study cites the importance of civilian providers becoming familiar with military culture and values to better understand and provide culturally competent care to the combat

veteran population. It is also noted that it is necessary for the provider to create a safe and neutral environment to foster open discussion.

The commentary by Lawson (2014) also addresses the fact that civilian primary care providers must be prepared to adequately serve the combat veteran population. This article serves as a guide for recognizing and managing this patient population in primary care. It includes information on pharmacologic treatment and the ability of the primary care provider to refer the patient to specialized treatment as well.

Straits-Tröster et al. (2011) also focused on the issue of screening and caring for the large population of OEF/OIF veterans but did so though focusing on educating civilian health care providers through developing a public health initiative. It is discussed that the majority of veterans from Iraq and Afghanistan have not sought care from the VA, and thus are getting care from civilian care providers. The authors developed a population-based approach to help address stigmas associated with mental illness, increase public knowledge and awareness, and increase access to care. What started as all-day, face-to-face workshops has expanded to include free online courses. This program teaches civilian providers to connect current symptoms a veteran may be experiencing to their past deployment experiences. Connecting presenting symptoms to PTSD is imperative, as avoidance is a common part of PTSD, and many present for care when they are experiencing secondary symptoms (Lawson, 2014; Straits-Tröster et al., 2011).

Also of interest, the workshops provided information for providers to become in-network providers for TRICARE military insurance to be able to more effectively reach more veterans and their family members. It should be noted that TRICARE provides insurance for active duty, National Guard, Reserve, retired military members, and family members of the previously listed

groups (Straits-Tröster et al., 2011). Milliken, Auchterlonie, and Hoge (2007) noted that access to care within TRICARE can be difficult for families, so increasing the pool of eligible providers within this network would serve to truly benefit this population. It was noted by Straits-Tröster et al. (2011) that the number of in-network TRICARE providers had increased since the start of the training program.

Upon patients screening positive for symptoms of PTSD, patients should be provided individualized treatment. There are guidelines for the primary care provider in the treatment of PTSD put forth by the VA and DoD (VA and DoD, 2017). In these guidelines, it discussed the need for patients to be provided with psychotherapy. Additionally, the guidelines provide recommendations of pharmacotherapy should the primary care provider feel comfortable with such. Treatment within the VA can be located on the National Center for PTSD website. For veterans wishing to have treatment outside of the VA, providers and clinics can be found via the Substance Abuse and Mental Health Services Administration (SAMHSA), which is part of the U.S. Department of Health and Human Services (VA, 2018).

In the review of literature, three studies were found whose primary aim was to address the barriers to mental health care that are present for combat veterans. Two of the studies were cross-sectional in design (Brown et al., 2011; Garcia et al. 2014), and one was observational (Tsai, Mota, & Pietrzak, 2015).

Brown et al. (2011) used data from 577 combat veterans who were surveyed three months after returning from deployment to Iraq. The study cites the reasoning for using data from the three-month time point as that veterans are more likely to reveal mental health problems at the three month mark than at the initial return time point. In the study the primary measure was, “Are you currently interested in receiving help for a stress, emotional, alcohol, or

family problem?". Of the 577 total in the study, there were 345 who were not interested in receiving help, and 232 who were. Comparative analyses that took place for various factors were completed between these two groups, with the group not interested in help being the reference group. Demographics, recognition of a current problem, past care, perceived barriers to care, and unit and deployment characteristics were all assessed. Various multivariate and univariate logistic regressions were completed. It was found that more negative attitudes toward mental health care were related to a lower interest in receiving help. Interestingly, those who were part of a unit with perceived stigma related to mental health care had increased likelihood of interest related to seeking help. This is thought to be due to the fact that this study examined veterans who screened positive for mental disorders, and it is noted in the study that those who are interested in receiving care have a heightened perception of stigma from those around them. Higher-ranking veterans, specifically rank of E7 and higher, were significantly less likely to have an interest in seeking help.

While the other cross-sectional study, which was completed by Garcia et al. (2014), primarily assessed a similar population as Brown et al. (2011), it also compared perceived barriers and attitudes toward mental health care of OEF/OIF veterans to veterans from the Vietnam and Persian Gulf war eras. 434 veterans from nine VA outpatient mental health care clinics in southern Texas participated. The following elements were assessed through 5-point Likert scale responses: demographics, logistical barriers to mental health care, attitudes related to psychotherapy. It was found that OEF/OIF veterans felt more strongly than other eras that they should be able to handle their own problems and that therapy did not help. Also, OEF/OIF veterans reported feeling too busy for help seeking and they disliked talking in groups.

OEF/OIF veterans were more impacted by negative treatment attitudes as a barrier than logistical barriers such as, but not limited to, affordability of care and transportation.

The final study reviewed addressing barriers to mental health treatment was part of the National Health and Resilience in Veterans Study (NHRVS). Tsai, Mota, and Pietrzak (2015) examined female veterans using VA care, male veterans using VA care, and female veterans not using VA care. This study found that there were no differences in mental health care utilization across these groups. In fact, among the groups, similar barriers were recognized including the cost of treatment and the fear of being seen as “weak” for seeking treatment. The barriers identified by this study are aligned with the barriers identified by the other studies reviewed relating to barriers (Brown et al., 2011; Garcia et al., 2014).

Overall, negative attitudes toward seeking mental health care have been shown to be a major barrier to mental health care (Brown et al., 2011; Garcia et al., 2014; Tsai, Mota, Pietrzak, 2015). It is also important to note that internal barriers to care, such as negative attitudes can be very difficult for veterans to overcome (Brown et al., 2011). While negative internal attitudes are related to less care seeking, it is important to note that seeing ones unit as having a stigma toward mental disorders serves as a motivating factor (Brown et al., 2011). Recognizing that attitudes toward care strongly influence care seeking is key for providers, as it helps to underscore the need to create and foster a safe, confidential, respectful environment where patients may then become comfortable opening up dialogue. Limitations, however, do exist for this group of studies reviewed. The cross-sectional nature of Brown et al. (2011) and Garcia et al. (2014) limits causal inference. Additionally, all of the studies relied upon self-report for data collection.

Project Aims

This quality improvement project had the following aims: (1) increase civilian primary care provider knowledge regarding screening all adult patients for veteran status and PTSD symptoms; (2) implement consistent use of the Primary Care PTSD Screen (PC-PTSD) and Primary Care Checklist for DSM-V (PCL-5), which are standardized screening tools for veteran status and presence of PTSD symptoms; (3) provide civilian primary care providers with recommended interventions for patients screening positive for symptoms of PTSD.

Project Questions

1. What is the current knowledge and practice of civilian primary care providers regarding screening patients for veteran status and PTSD symptoms?
2. What is the incidence of positive PTSD screens in civilian primary care?
3. Are there significant demographic differences among those screening positive and negative for PTSD symptoms?

Theoretical Framework

The Donabedian Model by Avedis Donabedian was the theoretical framework used to guide the project. This theory is a quality improvement model examining structure, processes, and outcomes in the setting of quality improvement (AHRQ, 2011).

The goal of the project was to implement a screening procedure in civilian primary care for military veteran status and subsequently screening for symptoms of PTSD. As the clinic site for the project is not currently completing this type of screening, the project addresses the clinic structure as well as the processes of screening and connection to resources and treatment.

Various outcomes were measured and analyzed. Outcomes of interest included the number of patients with veteran status, PTSD symptoms, and those who wish to then be connected to resources and treatment.

Definition

PTSD Screening

Conceptually, PTSD screening is defined as assessing for the presence of PTSD symptoms. Operationally, PTSD screening is defined as the use of a standardized tool to assess each adult patient encountered in a primary care setting for the presence of PTSD symptoms.

Methods

Design

This quality improvement project used an observational, descriptive design. The project aimed to evaluate the number of patients screening positive for veteran status and PTSD symptoms in a civilian primary care setting.

Setting and Sample

This project took place at Atchison Internal Medicine and Family Practice. This clinic is in a rural setting in the state of Kansas. The clinic is approximately twenty-five miles away from Leavenworth, Kansas, which is home to a U.S. Army fort and a VA medical center. At the Atchison Internal Medicine and Family Practice clinic, there are eleven providers comprised of one APRN, six MDs, two DOs, and two PAs. The clinic sees approximately 150 to 200 patients per day, with approximately ten new adult patients per week**.** The clinic was already assessing patients for military service history, but not for symptoms of related PTSD.

Convenience sampling was utilized. All adult patients aged eighteen years or older regardless of gender identity were eligible for screening. This pilot project took place with two

primary care physicians and the rooming nurse for each physician. Initial screening was completed by the rooming nurse, utilizing a screening packet compiled by the DNP student (Appendix E). The DNP student then collected completed paper packets to compile data. The pilot project took place across eight weeks that the clinic was open. There was not a target number of participants. Rather, all adult patients aged eighteen years or older were to be screened.

Data Collection Plan

The variables assessed were veteran status and presence of PTSD symptoms. Patients were first assessed for prior participation in this project by asking, "Have you been asked about your veteran status in the past two months at this clinic?". If the patient stated that they have been asked, screening stopped. If the patient answered "no", they were then assessed for veteran status. Veteran status was assessed during the rooming process by asking the question, "Are you currently or have you ever served in the military?" (Kane et al., 2013) (Appendix A). This question served to broach the sensitive subject of PTSD (Kane et al., 2013). If the patient answered "yes" to the veteran status question, the PC-PTSD-5 screen (Appendix B) was then administered. The PC-PTSD-5 is a quick, five-question survey that was developed by the National Center for PTSD. Answering "yes" to 4 of the 5 questions is considered the most efficient scoring for further interventions (VA, 2018). If the PC-PTSD-5 was positive, the patient was directed to complete the PTSD Checklist for DSM-V (PCL-5) (Appendix C). This is a self-report Likert-scale questionnaire. The PCL-5 is scored by summing the score indicated for each of the 20 items, with a cut-point score of 33 being indicative of provisional PTSD diagnosis (VA, 2018). As such, patients with a score of 33 or greater on the PCL-5 were then passed on to the provider by the rooming nurse as screening positive for PTSD and needing referral to resources

and treatment. Patients were then referred to treatment either within the VA system or if patients did not wish to seek treatment within the VA, a provider was located using the following website: https://findtreatment.samhsa.gov (VA, 2018).

The providers participating in the project were provided with a provider toolkit created by the DNP student (Appendix G). This toolkit had information such as phone numbers to PTSD treatment clinics at local VA medical centers, the SAMHSA website for those wishing to have treatment outside of the VA system, as well as a link to provider guidelines from the VA regarding PTSD care in the civilian primary care setting. The providers were also provided with a handout to give patients with resource contact information.

Additionally, basic demographic information was collected by the rooming nurse at the time of screening. This information was the following: age (in years), gender, race, and insurance. Gender and insurance information were selected by circling a given choice. Gender options included: male, female, other. Insurance options included: uninsured, commercial, VA/TRICARE, Medicare, and Medicaid. Age and race were free text fields on the paper form.

Data collection took place throughout the Summer 2019 semester. The rooming nurse collected the screening data on paper/pencil forms provided by the DNP student completing this project. The DNP student visited the clinic periodically throughout the Summer 2019 to collect completed forms. The DNP student maintained an electronic spreadsheet with tracking of basic demographics, the total number of screened patients as well as the total number of positive screens.

Intervention for those screening positive for PTSD was completed by the participating primary care providers utilizing the information provided by the DNP student which was set forth by the VA.

Human Subject Protection

Approval from the University of Kansas Medical Center Internal Review Board (IRB) was sought and obtained in the standard fashion outlined by the committee. Additionally, Atchison Hospital, the covering entity of the clinic for the study, did not have their own IRB for approval. Therefore, only IRB approval from the University of Kansas Medical Center IRB was obtained.

No identifying protected health information was collected during this project. The questionnaire was administered by the rooming nurse in-person at the selected clinic. The scores were recorded on a piece of paper, however, there was not any identifying patient information. There was a document to track simply the total number of patients screened and the total number of positive screens. This document also contains age, gender, race, and insurance. Due to these being unidentified and aggregated, there was not a need for a secure server and additional device protections. As this project was observational, there was not a need to link data with specific participants later in the study. Completed PC-PTSD and PCL-5 forms did not need to be kept, as there was no need to re-screen participants or link information. As such, the paper forms were disposed of after the DNP student had logged the numbers at the conclusion of each visit to the clinic. Forms were disposed of in the clinic's disposal bin for protected health information.

Evaluation Plan

Descriptive statistics of positive screens for PTSD symptoms was completed. Additionally, demographic data was analyzed s such as age, gender, race, and insurance. This information will to describe the patients who participated in this project as well as the groups who screened positive and negative.

Timeline

The proposal and institutional review board approval was completed during the spring 2019 semester. The DNP student met with the participating providers and nurses at the clinic on June 3, 2019 to discuss the project and implementation, as well as to provide screening materials, toolkits, and Veterans Crisis Line contact cards and treatment plan sheets. Data collection ran from June 4, 2019 through July 26, 2019. Postimplementation data was collected periodically throughout the study. Data was analyzed during the Fall 2019 semester. The formal report will be completed by mid-December 2019. Project findings will be disseminated to the Atchison Internal Medicine and Family Practice clinic.

Results

During the project there were a total of 239 unique patient screenings. Patients were first asked, "Have you been asked about your veteran status in the past two months at this clinic?”. An answer of “No” indicated a unique screen. There were nine patients in the 239 who did not did not answer this question but did have demographics and further screening information completed. These patients were counted as “unique” for the purposes of data analysis.

Of the 239 patients screened, 26 patients (10.9%) were veterans. Out of the 26 veterans, one patient (3.8% of veterans; 0.42% of total screened) screened positive on both the PC-PTSD and PCL-5, indicating a need for referral to treatment for PTSD. Therefore, the incidence of positive PTSD symptoms for this pilot study was 4.18 per 1,000.

Descriptive statistics for demographics information were completed. The mean age of all patients screened was 52 years, while mean veteran age was 71 years. Gender was a fairly even split with 49.8% male (n=119), 50.2% female (n=120), and 0% (n=0) identifying as other. The overwhelming majority of respondents were Caucasian (86.2%; n=206), with the next largest group being 10.9% (n=26) as “not reported”. Full characteristics of race can be found in Table 1.

The two largest groups of insurance type were commercial insurance (49.4%, n=118) and Medicare (34.3%, n = 82). There were three patients screened (1.3%) whose only insurance was VA/TRICARE, and one patient (0.4%) who had dual coverage with Medicare and VA/TRICARE. Full characteristics for insurance type can be found in Table 2.

Table 1 – Racial and Ethnic Distribution

Race	**Number Screened**	**Percentage Screened**
African American	4	1.7%
Caucasian	206	86.2%
Hispanic	1	0.4%
Multi-Racial	2	0.8%
Not Reported	26	10.9%

Table 2 – Insurance Distribution

Insurance	**Number Screened**	**Percentage Screened**
Commercial	118	49.4%
Commercial; Medicaid	1	0.4%
Commercial; Medicare	0	0.0%
Medicaid	29	12.1%
Medicare	82	34.3%
Not Reported	2	0.8%
Uninsured	3	1.3%
VA/TRICARE	3	1.3%
VA/TRICARE; Medicare	1	0.4%

Discussion

This quality improvement project served to implement a screening process for veteran status and presence of PTSD symptoms as recommended by the DoD and the VA. Additionally, the project helped to connect veterans with information regarding how to contact the Veterans

Crisis Line regardless of current presence of PTSD symptoms. As a part of the project, those screening positive on both the PC-PTSD and the PCL-5 were to be connected with a clinic for treatment of PTSD either within the VA system or via the clinic locator on the SAMSHA website.

Through discussion with participating providers and nurses, it was found that the screening process was felt to have been implemented smoothly. There were no concerns voiced regarding ways to improve the implementation and screening process, as well as the interventions if necessary. During initial discussions of implementing the project with the clinic manager, there was interest in incorporating the screening process into the clinic's electronic medical record for the purposes of the DNP project. However, due to the scope and nature of the DNP project, screening was piloted with paper forms.

While only a small percentage of the sample size screened positive for symptoms of PTSD (3.8% of veterans; 0.42% of total screened), the project was still significant and impactful. This one patient was able to be connected to resources that he was otherwise unaware of. Additionally, every patient screening positive for veteran status was given the resource of how to contact the Veteran Crisis Line on a discreet appearing business card-sized piece of paper. This allows for veterans to have a potential connection and helpful resource should the begin to develop symptoms of PTSD or mental health crisis. This project also served to educate clinic providers.

Screening for veteran status in civilian primary care is widely recommended throughout the literature (Coll et al., 2011; Lawson, 2014; Kane et al., 2013; Kudler & Straits-Tröster, 2008). While the clinic was already screening for veteran status, it was not routinely assessing for the presence of PTSD symptoms. In the literature it is shown that providers in primary care

are most likely to be in contact with patients who are veterans with PTSD (Prins, Kimerling, & Leskin, 2004), putting primary care providers are in a unique position to aid this population. This project served to educate providers on the importance of screening for PTSD symptoms, as well as provide them with a toolkit for helping patients who are veterans that do screen positive for PTSD symptoms. The toolkits provided included resources for locating clinics for PTSD treatment, as well as links to VA/DoD Clinical Practice Guidelines for treatment of PTSD, and links to free continuing education through the National Center for PTSD to learn how to treat veterans with PTSD in the civilian primary care setting.

Recommendations

Recommendations would include implementing this screening process on a larger scale. This would allow to assess for impact on a broader scale. Additionally, it would be recommended that civilian primary care providers complete available trainings from the National Center for PTSD to begin to start treating PTSD symptoms within the patient's primary care setting.

Through discussion with the participating providers, concerns were voiced that they feel there are patients in their clinic suffering from PTSD symptoms unrelated to military service who are not being adequately assessed and treated. As a result of this conversation, the DNP student developed a toolkit for screening the general primary care. Therefore, a recommendation would also be to implement broader screening for PTSD symptoms.

Conclusion

This quality improvement project served to pilot a screening process for veteran status and the presence of PTSD symptoms among adults in the civilian primary care setting. As a part of the process, providers were supplied with "toolkits" for screening, resources, and additional

training for the treatment of PTSD if desired. All patients screening positive for veteran status were supplied with a contact card for the Veterans Crisis Line. Those screening positive for PTSD symptoms were aided in locating a clinic for PTSD treatment either within the VA system or via the Substance Abuse and Mental Health Services Administration (SAMHSA). Patients screening positive were also given a treatment plan form that included contact information for the clinic as well as contact information for the clinic they selected and online resources regarding PTSD. Patients received the intervention of developing a treatment plan from their primary care provider.

Of the 239 patients screened, 26 patients (10.9%) were veterans, and thus were provided with contact information for the Veterans Crisis Line. Out of the 26 veterans, one patient (3.8% of veterans; 0.42% of total screened) screened positive for PTSD symptoms, necessitating a need for referral to treatment for PTSD. The incidence of positive PTSD symptoms for this pilot study was 4.18 per 1,000.

Results of this pilot study as well as results of additional research regarding screening the general primary care population for PTSD symptoms will be shared with the participating clinic. At the time of this writing, coordination for a meeting time is ongoing.

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Appendix A – Demographics

Demographics:

Age (years): ______

Gender (circle one): Female – Male – Other

Race:

Insurance (circle one): Uninsured – Commercial – VA/TRICARE – Medicare – Medicaid

Appendix B – Initial Screening Questions

"Have you been asked about your veteran status in the past two months at this clinic?"

___Yes ___No

Question adapted from Kane, et al., 2013:

"Are you currently or have you ever served in the military?"

___Yes ___No

Appendix C – Primary Care PTSD Screen (PC-PTSD)

The following form is from the U.S. Department of Veterans Affairs National Center for PTSD (retrieved from: https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp):

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?
YES / NO
If no, screen total = 0. Please stop here.
If yes, please answer the questions below.
In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
   YES / NO
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   YES / NO
3. Been constantly on guard, watchful, or easily startled?
   YES / NO
4. Felt numb or detached from people, activities, or your surroundings?
   YES / NO
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   YES / NO

Appendix D – PTSD Checklist for DSM-V (PCL-5)

The following form is from the U.S. Department of Veterans Affairs National Center for PTSD (retrieved from https://www.ptsd.va.gov/professional/assessment/documents/PCL-5_Standard.pdf):

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (14 August 2013) National Center for PTSD Page 1 of 1

Appendix E – Screening Toolkit

Demographics:

Age (years): _____

Gender (circle one): Female – Male – Other

Race:

Insurance (circle one): Uninsured – Commercial – VA/TRICARE – Medicare – Medicaid

**Can be filled out by nurse based on EMR information.

Initial Screening Questions – Nurse to ask patient questions.

"Have you been asked about your veteran status in the past two months at this clinic?"

___Yes ___No

If the answer is "Yes", stop screening; if it is "No" continue.

"Are you currently or have you ever served in the military?"

___Yes ___No

If the answer is "Yes" proceed to next screening, PC-PTSD.

Primary Care PTSD Screen (PC-PTSD) – Nurse to ask patient the following questions.

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?
YES / NO
If no, screen total = 0. Please stop here.
If yes, please answer the questions below.
In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
   YES / NO
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   YES / NO
3. Been constantly on guard, watchful, or easily startled?
   YES / NO
4. Felt numb or detached from people, activities, or your surroundings?
   YES / NO
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   YES / NO

If patient answers "Yes" to 4 of 5 questions, proceed to the next screening, PTSD Checklist for DSM-V (PCL-5).

PTSD Checklist for DSM-V (PCL-5) – Patient to read and complete form; Nurse to score.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (14 August 2013) National Center for PTSD Page 1 of 1

****If patient scores 33 or more points, screen is positive; notify provider.****

Appendix F – Veterans Crisis Line Pocket Card

Veterans Crisis Line

Phone: 1-800-273-8255; Press 1
or call 911

Text: 838255

Deaf and Hard of Hearing: 1-800-799-4889

Online chat: https://www.veteranscrisisline.net/get-help/chat

Confidential, Available 24/7/365

Appendix G – PTSD Treatment Form

PTSD Treatment Plan

You have screened positive for symptoms of PTSD, and it is recommended that further treatment and information could be helpful to you.

Veterans Crisis Line:

-Phone: 1-800-273-8255, press 1
-Text: 838255
-Deaf and hard of hearing: 1-800-799-4889
-Online chat: https://www.veteranscrisisline.net/get-help/chat

Veterans Crisis Line is confidential and available 24/7/365

About Face:

-This is a website where other veterans share their experiences with PTSD and treatment of it.
- https://www.ptsd.va.gov/apps/AboutFace/learn/aboutface.html

Follow-up Appointment:

-Please contact the following clinic to establish a follow-up appointment regarding you PTSD screening:

Clinic Name: ____________________
Clinic Phone: ____________________

****If you are in immediate need of mental healthcare, please call 911.**

Appendix H – Provider Toolkit

For patients scoring 33 or greater on the PCL-5, offer the following resources:

Please provide ALL positive screens with the Veterans Crisis Line card.

Facilitate connection to PTSD treatment through the VA:

-Visit the following website with the patient (see screenshot below):
https://www.va.gov/directory/guide/PTSD.asp

This website has a drop down field to search for specific types of PTSD programs and is also searchable by clicking on a specific state.

Screenshots from clicking on Kansas and Missouri on the above map:

Location

Kansas

PTSD Program

Learn more about PTSD: VA National Center for PTSD

NOTE: The contacts provided for the PTSD Programs are for information inquiries and are not continuously monitored.

All VA Medical Centers offer PTSD treatment, even if there is no specific PTSD program. Contact your local VA Medical Center and ask for the Mental Health clinic. Many Vet Centers and VA Community Based Outpatient Clinics also offer PTSD treatment.

If you need immediate assistance, call 911 or 1–800–273–TALK/8255, press 1.

Robert J. Dole VA Medical Center

5500 E. Kellogg
Wichita, KS 67218
Phone: 316-685-2221 Or 316-685-2221

PTSD Clinical Team (PCT) Outpatient

Barbara M. Harrison, ARNP, BC (888) 878-6881 X 53131

VA Eastern Kansas Health Care System - Colmery-O'Neil VA Medical Center

2200 SW Gage Boulevard
Topeka, KS 66622
Phone: 785-350-3111 Or 785-350-3111

Specialized Inpatient PTSD Unit (SIPU) Inpatient

Kirsten Watkins, Psy.D. (785) 350-3111 X 52139

PTSD Clinical Team (PCT) Outpatient

Timothy Rot, PsyD (785) 350-3111 X 52133

Location

Missouri

PTSD Program

Learn more about PTSD: VA National Center for PTSD

NOTE: The contacts provided for the PTSD Programs are for information inquiries and are not continuously monitored.

All VA Medical Centers offer PTSD treatment, even if there is no specific PTSD program. Contact your local VA Medical Center and ask for the Mental Health clinic. Many Vet Centers and VA Community Based Outpatient Clinics also offer PTSD treatment.

If you need immediate assistance, call 911 or 1–800–273–TALK/8255, press 1.

Harry S. Truman Memorial

800 Hospital Drive
Columbia, MO 65201-5297
Phone: 573-814-6000 Or 573-814-6000

PTSD Clinical Team (PCT) Outpatient

Grant O'Neal, PhD (573) 814-6000 X 56486

John J. Pershing VA Medical Center

1500 N. Westwood Blvd.
Poplar Bluff, MO 63901
Phone: 573-686-4151 Or 573-686-4151

PTSD Clinical Team (PCT) Outpatient

Kevin Wagner, MSW, LCSW (573) 778-4631

Kansas City VA Medical Center

4801 Linwood Boulevard
Kansas City, MO 64128
Phone: 816-861-4700

PTSD Clinical Team (PCT) Outpatient

Hemant Thakur, MD (816) 922-2647

VA St. Louis Health Care System - Jefferson Barracks Division

1 Jefferson Barracks Drive
Saint Louis, MO 63125
Phone: 314-652-4100

PTSD Clinical Team (PCT) Outpatient

PTSD Clinical Team (314) 894-6653

You may also provide the patient with contact information for local VA medical centers:

-Dwight D. Eisenhower VA Medical Center
4101 4th Street Trafficway
Leavenworth, KS 66048
Phone: 913.682.2000; 800.952.8387

-Colmery-O'Neil VA Medical Center
2200 SW Gage Blvd
Topeka, KS 66622
Phone: 785.350.3111; 800.574.8387

If patient is **not** wishing to have treatment through the VA, please go to the following website with them:

https://findtreatment.samhsa.gov

U.S. Department of Health & Human Services

SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA Home | Newsroom | Site Map | Contact Us

Search SAMHSA.gov | Search

Home | About | FAQ's | Locator Map | State Agencies | Widgets | Contact Us | Help

Home

SHARE+

Behavioral Health Links
Federal Government
Health and Human Services Agencies
Behavioral Health Agencies
Informational Websites
Self-Help, Peer Support, and Consumer Groups
Self-Help Groups (Addiction)
Peer Support (Mental Health)
Mental Health Consumer Assistance

Behavioral Health Treatment Services Locator

Welcome to the Behavioral Health Treatment Services Locator, a confidential and anonymous source of information for persons seeking treatment facilities in the United States or U.S. Territories for substance abuse/addiction and/or mental health problems.

PLEASE NOTE: Your personal information and the search criteria you enter into the Locator is secure and anonymous. SAMHSA does not collect or maintain any information you provide.

Find treatment facilities confidentially and anonymously.

Enter an Address, City, or ZIP code | Search Facilities

Get Help

Suicide prevention lifeline
1-800-237-TALK (8255)
Free and confidential support for people in distress, 24/7.

National Helpline
1-800-662-HELP (4357)
Treatment referral and information, 24/7.

Disaster Distress Helpline
1-800-985-5990
Immediate crisis counseling related to disasters, 24/7.

-Please put in patient's address or ZIP code with them to locate treatment centers.

****Please provide ALL positive screens with the Veterans Crisis Line pocket card and completed treatment plan form. ****

Treatment plan form:

PTSD Treatment Plan

You have screened positive for symptoms of PTSD, and it is recommended that further treatment and information could be helpful to you.

Veterans Crisis Line:
-Phone: 1-800-273-8255, press 1
-Text: 838255
-Deaf and hard of hearing: 1-800-799-4889
-Online chat: https://www.veteranscrisisline.net/get-help/chat

Veterans Crisis Line is confidential and available 24/7/365

About Face:
-This is a website where other veterans share their experiences with PTSD and treatment of it.
- https://www.ptsd.va.gov/apps/AboutFace/learn/aboutface.html

Follow-up Appointment:
-Please contact the following clinic to establish a follow-up appointment regarding you PTSD screening:
Clinic Name: ____________________
Clinic Phone: ____________________

****If you are in immediate need of mental healthcare, please call 911.**

The following website has information for the civilian primary care provider regarding care of veterans with PTSD:

https://www.healthquality.va.gov/guidelines/MH/ptsd/

-Screenshot from website above:

Continuing education opportunities related to PTSD care can be found at the following link:

https://www.ptsd.va.gov/professional/continuing_ed/index.asp

-Screenshot from the above website:

Please contact Megan Campbell, DNP Student with any questions or concerns related to this project.

-E-mail: mgodwin@kumc.edu

-Phone: 620-704-5643