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Invited Commentary

Extending Collaborative Care for Posttraumatic Mental Health

Paula P. Schnurr, PhD

Since the wars in Iraq and Afghanistan, there has been increased awareness of the effect of military deployment on the mental health of the men and women who serve in uniform. Posttraumatic stress disorder (PTSD) and depression are among the most common mental health disorders in this population.¹ Collaborative care offers a promising strategy for meeting their needs.

There is robust evidence showing that collaborative care is effective for enhancing the treatment of mental disorders in primary care settings. For example, a recent review based on 79 randomized clinical trials and more than 24 000 patients found that collaborative care had positive effects on both anxiety and depression.² The strength of evidence for treating PTSD is more limited. There have been only 3 prior trials: 2 in veterans and 1 in nonveterans.³⁻⁵ The STEPS-UP study (Stepped Enhancement of PTSD Services Using Primary Care), reported by Engel et al⁶ in this issue of *JAMA Internal Medicine*, represents an important contri-

but, therefore, because it included PTSD as an intervention target. STEPS-UP did not require participants to meet diagnostic criteria for PTSD, but it is effectively a study of treatment for PTSD: 86% of participants had PTSD and symptom levels for the entire sample were at the high end of the moderate/severe range. STEPS-UP also is important because it is based on an active-duty military sample. Almost none of the trials reviewed in the PTSD practice guideline issued jointly by the Department of Veterans Affairs (VA) and Department of Defense (DoD)⁷ had included active-duty personnel. Results based on other populations may not generalize to active-duty personnel given the unique characteristics of this population, as well as contextual factors, including operational exposure to life-threatening war zone stressors.

Furthermore, the study is important because it found benefits of collaborative care. Two of the 3 prior trials of collaborative care for PTSD^{4,5} had negative results. In contrast, Engel et al⁶ report that their stepped care model led to improvements in PTSD, depression, and other outcomes, relative to the Army's



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usual integrated care. The magnitude of improvement in STEPS-UP was small, however, and Engel et al⁶ describe the gains as “modest.” Small effects can still have big impact at a population level, but the effects observed in STEPS-UP are smaller than the effects that have been observed for treatments recommended as first-line treatments in the VA/DoD PTSD practice guideline.⁷ This raises a question about whether it might be preferable to promote specialty mental health care instead of collaborative care for military personnel, and other populations, in order to facilitate recovery. The answer is No.

Engel et al⁶ cite several key reasons why collaborative care for military personnel is important. Collaborative care can reduce treatment delays and enhance access to care. Treatment in a primary care setting may be preferable for military populations, reducing the stigma of seeking mental health care and also increasing the convenience of treatment. These same factors are relevant for veteran and nonveteran populations as well. Primary care is an essential part of responding to people with postdeployment or posttraumatic mental health needs. So how can collaborative care be optimized for PTSD and other problems arising from deployment or significant traumatic experiences?

One possible answer, or at least one part of the answer, lies in using collaborative care to enhance access to effective treatment. The VA/DoD PTSD guideline⁷ recommends as first-line treatment several types of psychotherapy—trauma-focused cognitive-behavioral therapies such as prolonged exposure and cognitive processing therapy, eye movement desensitization and reprocessing, and stress-inoculation therapy—along with selective serotonin reuptake inhibitors and venlafaxine hydrochloride. Engel et al⁶ suggest the small increases in evidence-based medication use and psychotherapy in their collaborative care arm as one reason for the limited magnitude of the study’s effects.

The TOP study (Telemedicine Outreach for PTSD),³ which is the only prior trial of collaborative care for PTSD to have positive findings, illustrates why the effectiveness of the treatment delivered through collaborative care models matters. The study randomized veterans who were receiving care in VA community-based outpatient clinics to usual care for PTSD or usual care plus TOP, telemedicine-enhanced care. Usual care included a range of medications and psychotherapy provided at both the clinic and

the affiliated VA Medical Center. TOP care also included a telephone nurse care manager and telephone pharmacist who delivered services to patients at home, and video-teleconferencing access at the clinic to a telepsychiatrist for psychiatric consultation and a telepsychologist who provided cognitive processing therapy. Receiving the treatment turned out to be crucial. Although patients in both arms had access to cognitive processing therapy (in usual care it was available via social workers at the clinics), those in the TOP intervention were more likely to receive the treatment and to receive an adequate dose. Moreover, receiving 8 or more sessions fully mediated the effect of the TOP intervention on PTSD symptoms at 12-month follow-up. In other words, collaborative care was effective because it facilitated engagement in effective treatment.

Going forward, we need to continue to identify effective treatments for PTSD and ways to implement these treatments in settings outside psychiatrists’ and psychologists’ offices, incorporating technological strategies when appropriate to help patients to receive the kind of care they want, when and where it is convenient for them. One implication of the TOP study³ findings is that access to evidence-based psychotherapy, either on site or through telemedicine, may be an essential ingredient in collaborative care for PTSD. This presents a challenge to primary care management. Currently, the most effective types of psychotherapy, which require 10 to 12 sessions that are 60 to 90 minutes long, are not feasible to deliver in a typical primary care setting. However, research exploring briefer versions of psychotherapy for PTSD is ongoing, as is research on additional medications and on self-help strategies that can be accessed online or through mobile applications. But even now, collaborative care offers strategies to improve care for patients with PTSD through assessment, education, medication, counseling, and telephone care management. A key first step is recognizing that patients who may be presenting with depression, anxiety, insomnia, and other problems may have PTSD as a root cause of, or in addition to, these presenting problems.

Although the military health care system may be a context that has a particular need for primary care management of PTSD and other mental health concerns, this is a genuine need everywhere. STEPS-UP moves us closer to meeting that need.

ARTICLE INFORMATION

Author Affiliations: National Center for PTSD, Executive Division, White River Junction, Vermont; Department of Psychiatry, Geisel School of Medicine, Hanover, New Hampshire.

Corresponding Author: Paula P. Schnurr, PhD, National Center for PTSD (116D), VA Medical Center, 215 N Main St, White River Junction, VT 05009 (paula.schnurr@dartmouth.edu).

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