Massed Delivery of Evidence Based Psychotherapy for PTSD

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National Center for PTSD
Special thanks

• Ashley Fedynich, Psy.M.
• Kelly Maieritsch, Ph.D., & National Center for PTSD Mentoring Program
• Phillip Held, Ph.D. & the Warrior Care Network sites
• Heather Flores, Psy.D., VA Northeast Ohio Healthcare System
Objectives

SECTION 1: OVERVIEW OF EVIDENCE BASED PSYCHOTHERAPY FOR PTSD IMPLEMENTATION AND OUTCOMES

SECTION 2: RESEARCH OUTCOMES FOR MASSED EBP DELIVERY

SECTION 3: STRATEGIES FOR IMPLEMENTATION

SECTION 4: FUTURE DIRECTIONS
Why now?

- Changes to patients’ availability and commitments
- Challenges predicting future needs
- Importance of responsivity
- Team-based care
- Innovations to mitigate provider burn-out
Section 1: Overview of Evidence Based Psychotherapy for PTSD Implementation and Outcomes
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Strength</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment of PTSD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment Selection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. We recommend individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.</td>
<td>Strong for</td>
<td>Reviewed, New-added</td>
</tr>
<tr>
<td>10. When individual trauma-focused psychotherapy is not readily available or not preferred, we recommend pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12). With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other.</td>
<td>Strong for</td>
<td>Reviewed, New-added</td>
</tr>
</tbody>
</table>
### Clinical Practice Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Treatment of PTSD (cont.)</td>
</tr>
</tbody>
</table>

#### Psychotherapy

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Strength</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.</td>
<td>Strong for</td>
<td>Reviewed, New-replaced</td>
</tr>
<tr>
<td>12. We suggest the following individual, manualized non-trauma-focused therapies for patients diagnosed with PTSD: Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT).</td>
<td>Weak for</td>
<td>Reviewed, New-replaced</td>
</tr>
</tbody>
</table>
Cognitive Processing Therapy (CPT)

• Cognitions impact emotional responses/behaviors

• Previously developed schemas are activated:
  • **Assimilate** – alter incoming information to match belief
  • **Over-accommodate** – alter beliefs about oneself/world to the extreme

• Accommodating the trauma memory allows for incorporation of new information and a reduction in secondary emotions and negative cognitions

• 12 weekly sessions focused on identifying and learning to challenge “stuck points” that occur when beliefs prevent recovery from a trauma

Resick, Monson, and Chard, 2017
Prolonged Exposure (PE)

- Traumatic events can develop a fear network leading to escape and avoidance behaviors.
- Patients are assisted in confronting safe, but anxiety-evoking situations.
- Exposure to feared stimuli results in the activation of the relevant fear structure and provides realistic information about the likelihood of the feared consequence.
- Distorted cognitions are also disconfirmed during exposures.
  - Imaginal exposure
  - In-vivo exposure

Foa, Hembree, Rothbaum, 2007
Eye Movement Desensitization and Reprocessing (EMDR)

• Facilitates accessing and processing of traumatic memories and other stressors to bring an adaptive resolution

• EMDR can lead to reformulation of previously held negative beliefs, new learning, reduction of physiological arousal, and development of cognitive insight

• Veteran attends to emotionally disturbing material in-session while simultaneously focusing on an external stimuli (e.g. lateral eye movements, hand-tapping, or audio stimulation)

Shapiro, 2001
Written exposure therapy

• EBP for PTSD that includes 5 sessions (60 minutes each)

• WET is included as a recommended (first line) PTSD treatment in the VA/DoD Clinical Practice Guidelines for PTSD (2017)

• Significantly reduces the severity of PTSD symptoms in a variety of trauma survivors and low drop-out rates (Sloan et al., 2018)
Treatment Works

Resick et al., 2002

[Bar chart showing PTSD Symptoms (CAPS) for Prolonged Exposure Therapy, Cognitive Processing Therapy, and Waitlist groups with pre-treatment, post-treatment, 9 month follow-up, and completers only categories.]
PTSD EBP Outcomes and Completion Rates

• CPT and PE are equally effective at the reduction of PTSD symptomology (Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rutt, Oehlert, Krieshok, & Lichtenberg, 2018; Watts et al, 2013)

• Drop out from evidence-based treatment for PTSD proves problematic as **20-36% of patients do not complete PTSD treatment** (Imel, Laska, Jakcupcak, & Simpson, 2013; Szafranski et al., 2015)

• Veterans offered CPT or PE in a VAMC PTSD clinic (Kehle-Forbes, Meis, & Spoont, 2016)
  • **39% of veterans dropped out of PTSD evidence-based treatment**, most before the third session
Barriers and Challenges to EBPs

- Drop out rates
- Perceived readiness (Hamblen et al., 2015)
- Need for more positive support (Meis et al., 2019)
- Stigma
- Patient “logistical” barriers (Family, work, time, transportation)
- Clinician time constraints (Scheduling difficulties, caseload burden)
Section 2: Research Outcomes for Massed EBP Delivery
<table>
<thead>
<tr>
<th>Common models of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual EBP 3-5 days per week alone</td>
</tr>
<tr>
<td>Combination of individual and group EBP 3-5 times per week (modifications to protocols)</td>
</tr>
<tr>
<td>Individual EBP 3-5 times per week plus additional group interventions</td>
</tr>
</tbody>
</table>
Individual EBP 3-5 days per week alone
Effect of Prolonged Exposure Therapy Delivered Over 2 Weeks vs 8 Weeks vs Present-Centered Therapy on PTSD Symptom Severity in Military Personnel

A Randomized Clinical Trial

Edna B. Foa, PhD, Carmen P. McLean, PhD, Yinyin Zang, PhD, David Rosenfield, PhD, Elsa Yadin, PhD, Jeffrey S. Yarvis, PhD, Jim Mintz, PhD, Stacey Young-McCaughan, RN, PhD, Elisa V. Benah, PhD, Katherine A. Dondanville, PsyD, Brooke A. Fina, MSW, Brittany N. Hall-Clark, PhD, Tracey Lichner, PhD, Brett T. Litz, PhD, John Roache, PhD, Edward C. Wright, PhD, Alan L. Peterson, PhD, for the STRONG STAR Consortium

IMPACT: Effective and efficient treatment is needed for posttraumatic stress disorder (PTSD) in active duty military personnel.

OBJECTIVE: To examine the effects of massed prolonged exposure therapy (massed therapy), spaced prolonged exposure therapy (spaced therapy), present-centered therapy (PCT), and a minimal-contact control (MCC) on PTSD severity.

DESIGN, SETTING, AND PARTICIPANTS. Randomized clinical trial conducted at Fort Hood, Texas, from January 2011 through July 2016 and enrolling 370 military personnel with PTSD who had returned from Iraq, Afghanistan, or both. Final follow-up was July 11, 2016.
• RCT of 366 active duty military personnel with PTSD

• Treatment groups (randomized)
  1. PE delivered in massed format (10 sessions over 2 weeks)
  2. Spaced therapy (10 sessions over 8 weeks)
  3. PCT (non-trauma-focused therapy involving identifying daily stressors; 10 sessions over 8 weeks)
  4. Minimal Contact Control (MCC) telephone calls from therapists (1x/wk for 4 weeks)

• Findings
  • Massed delivery reduced PTSD symptom severity more than MCC
  • Massed delivery was noninferior to spaced therapy (concern that daily PE would be too emotionally taxing was not supported)
  • No significant difference between spaced therapy and PCT
**Research - Hendriks et al. (2018)**

**Participants (n=73)**
- Chronic PTSD
- Likely ICD-11 dx of Complex PTSD following multiple interpersonal trauma
- History of multiple treatment attempts

**Massed delivery**
- 12 90-minute sessions over 4 days (intensive phase)
- 4 weekly 90-minute booster sessions (booster phase)

**Results**
- Significant decrease in Baseline-posttreatment PTSD symptom severity
- Effects maintained at 3-month and 6-month follow-up
- No drop out during intensive phase and 5% drop out during booster phase
- Between-session fear habituation was predictive of fast responder trajectory
CPT offered on accelerated schedule (3-5x/week) as part of normal clinic operations

Follows regular treatment manual aside from timing

Sample:

• 27 total, mixed gender, trauma types, etc.
• 13 televideo; 14 face to face

Results:

• 25 completers, 2 dropout = ~7% (both dropouts reported significant gains – 16 and 18 point drops on PCL5)
• PCL5 – average drop of 22.08 (52.35 – 30.27)
• PHQ9 – average drop of 7.73 (17.44 - 9.71)

Weinstein (unpublished data)
Delivering CPT In a Single Week: Case study

Held et al., 2020

![Graph of PCL-5 and PHQ-9 scores over time](image-url)
Massed EBPs: Combination of Individual and Group Protocol Delivery
Warrior Care Network

Warrior Care Network Monthly Status Report: DEC FY2020

Warrior Care Network Participants

<table>
<thead>
<tr>
<th></th>
<th>JUNE 15 - DEC FY20</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP</td>
<td>2,133</td>
<td></td>
</tr>
<tr>
<td>IOP</td>
<td>239</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>1742</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,114</td>
<td>653</td>
</tr>
</tbody>
</table>

IOP OUTCOMES: JUN 15 – DEC FY20

- **Decrease in PTSD**
  - PTSD-PCL5 (n=1,787)
    - Pre IOP: 50
    - Post IOP: 31
  - CD-RISC 10 (n=1,723)
    - Pre IOP: 20
    - Post IOP: 23

- **Increase in Resilience**
  - Higher Score = Higher Resilience
  - D-29: Less Resilience, 30-49: Greater Resilience

- **Decrease in TBI Symptoms**
  - TBI-NSI (n=1,664)
    - Pre IOP: 43
    - Post IOP: 32

- **Decrease in Depression**
  - Depression-PHQ-9 (n=1,788)
    - Pre IOP: 16
    - Post IOP: 10

Satisfaction Results: JAN 2016 – DEC FY20

- Satisfied with clinical care received = 96%
- Able to overcome barriers/obstacles = 91%
- Care resulted in helping address needs = 90%
- Tell a fellow Warrior about WCN = 95%

Service Utilization Summary: JUN 2015 – DEC FY20

- Total Sessions in clinical care: 204,946
- Total clinical hours delivered: 218,773
- Average clinical hours per Warrior: IOP: 140,537, OP: 64,409

IOP Completion Rate: JUN 15 – DEC FY20

- 94% across all AMCs

VA LIAISON ASSISTANCE OCT 17 – AUG 2019

- Hours Worked: 7,445
- VA Referrals Worked: 1278
- VA Referral Briefings: 1214
- VA Consultations: 4,226
Road Home: Warrior Care Network

- 92% who start the program complete
- PTSD and depression symptoms decrease significantly over the course of the 3-week program
- 58% fall below the suggested cutoff for PTSD based on the PCL-5 by the end of the 3 weeks
- Pre-post PCL d is 1.53, p < .001
- Pre-post PHQ is 1.09, p < .001
- Pre-12mo PCL is 1.29, p < .001
- Pre-12mo PHQ is 1.18, p < .001
- Feasible treatment option
- Those with MST and non-MST respond equally well (Lofgreen et al, 2020)

Held et al., 2020; Held et al., 2019; Zalta et al., 2018
Emory Outcomes

Veterans Program

- Completion rate = 96.3%
- Patient satisfaction = 95%
- Clinically significant change and gains sustained post treatment
- PCL5 decrease = 22.4 (Maples-Keller et al, 2019)

PTSD and Depression Scores over IOP treatment

Yasinski et al., 2017 & 2019
Research - Bryan et al. (2018)

Open-label, prospective cohort pilot trial

- 20 U.S. military personnel and Veterans with PTSD/subthreshold PTSD

12 daily sessions of CPT during two-week period of time

Results

- PTSD severity significantly reduced at posttreatment and 6 month follow-up
- Slight decline in depression, but not statistically significant; reliable change in PHQ-8 in 21.7%
- Suicidal ideation significantly decreased at 6 month follow-up (reliable change in 55.6% )
Other Interventions

• Written Exposure Therapy: conducted over subsequent days

• Cognitive Therapy for PTSD intensive program (Ehlers et al. 2010)
  • 18 hours of therapy over 5-7 days
  • Feasible and acceptable
  • Comparable results as standard weekly cognitive therapy and in follow up study massed delivery more effective (Murray et al., 2017)
Individual EBP as Part of Program
Cleveland VAMC PTSD IOP

The target population for this level of care are Veterans who require higher level of structure and support that either do not meet full criteria for acceptance into a residential level of care or refuse to participate in residential programs. In addition, to provide options to Veterans seeking more rapid resolution of symptoms. The redesign was proposed to:

1. Minimize barriers to access by eliminating a cohort-model of treatment (weekly admissions);
2. Improve individualized care planning by providing additional options within treatment (e.g., type of Evidence-based psychotherapy; length of program; outpatient or residential);
3. Decrease length of time to complete intensive treatment with the anticipated benefit of decrease in frequency of adverse events and decreased drop-out;
4. Provide opportunities/access for intensive PTSD treatment locally for women and Veterans without co-occurring substance-use disorder.
5. Increase annual capacity for options in intensive treatment
### Daily Schedule for Both Programs

<table>
<thead>
<tr>
<th>Time</th>
<th>Intervention</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15-9</td>
<td>AM check-in</td>
<td></td>
</tr>
<tr>
<td>9-12</td>
<td>PE/CPT sessions</td>
<td>PE at either 9 or 10:30; CPT at either 9, 10, 11</td>
</tr>
<tr>
<td>9-12</td>
<td>Practice or psychiatrist</td>
<td>When not in individual session</td>
</tr>
<tr>
<td>10-11 M&amp;F</td>
<td>SUD aftercare (OPTIONAL)</td>
<td>Optional for those with co-occurring SUD</td>
</tr>
<tr>
<td>11-12 M&amp;F</td>
<td>Early recovery skills for SUD (OPTIONAL)</td>
<td>Optional for those with co-occurring SUD</td>
</tr>
<tr>
<td>12-1</td>
<td>lunch</td>
<td></td>
</tr>
<tr>
<td>1-1:30</td>
<td>PM check-in #1</td>
<td></td>
</tr>
<tr>
<td>1:30-3</td>
<td>Group exposure/outing</td>
<td>Therapeutic outings to practice skills</td>
</tr>
<tr>
<td>3-3:30</td>
<td>PM check-in #2</td>
<td></td>
</tr>
</tbody>
</table>
Early Results: Cleveland

<table>
<thead>
<tr>
<th>REASON FOR IOP PARTICIPATION</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of success at lower level of care</td>
<td>31.8%</td>
</tr>
<tr>
<td>Minimal coping skills</td>
<td>18.2%</td>
</tr>
<tr>
<td>Significant co-occurring mental health diagnosis (not SUD)</td>
<td>31.8%</td>
</tr>
<tr>
<td>Co-occurring substance use disorder/high risk of relapse</td>
<td>36.4%</td>
</tr>
<tr>
<td>Lack of supports</td>
<td>54.5%</td>
</tr>
<tr>
<td>Did not respond to previous IOP or residential program</td>
<td>18.2%</td>
</tr>
<tr>
<td>Need for increased structure</td>
<td>40.9%</td>
</tr>
<tr>
<td>Veteran preference</td>
<td>63.6%</td>
</tr>
<tr>
<td>Transportation barriers and required a bed</td>
<td>9.1%</td>
</tr>
<tr>
<td>Recommended for residential but Veteran refused/declined</td>
<td>4.5%</td>
</tr>
<tr>
<td>Not accepted into “traditional” residential program</td>
<td>27.3%</td>
</tr>
<tr>
<td>Veteran need to complete treatment more rapidly</td>
<td>18.2%</td>
</tr>
</tbody>
</table>
Clinical outcomes

Completion rate TAU

Completion rate IOP

82.05% clinically significant decreased in PTSD symptoms (10-point decrease)

Depression scores (PHQ9)

61.54% clinically significant decreased in depression symptoms (5-point decrease)
Early Results: Cleveland pilot data

Preparation sessions for program participation:
• Average 0.9 per Veteran
• 50% had no prep sessions

Off protocol sessions:
• 4 total for all participants in pilot

Additional skills work as part of individual sessions:
• Grounding/mindfulness: 7
• Relapse prevention: 4
• Suicide safety planning: 1

Negative treatment events:
• Increase in suicide risk: 1
• Increase substance use: 1
• No incidents of:
  • Self-directed violence (non-suicidal intent)
  • Acts of violence towards others
  • Property destruction
  • Mental health hospitalization
  • Psychosis/mania exacerbation
San Diego VAMC: Massed EBP for PTSD in Substance Use Program

- Veterans with PTSD offered opportunity to engage in either CPT or PE 3x per week while admitted into residential SUD program
- Early study, 100% completion (Norman et al., 2016)
- Option to also participate in PTSD track groups:
  1. In vivo exposure group
  2. Trauma-focused CBT group (based on CPT model with open enrollment)
  3. PTSD skills

<table>
<thead>
<tr>
<th></th>
<th>n=199</th>
<th>n=75</th>
<th>n=52</th>
<th>n=38</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Sample</strong></td>
<td>19.89</td>
<td>18.84</td>
<td>19.44</td>
<td>19.55</td>
</tr>
<tr>
<td><strong>Group Only</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in PCL-5</td>
<td>19.89</td>
<td>18.84</td>
<td>19.44</td>
<td>19.55</td>
</tr>
<tr>
<td>Change in PHQ9</td>
<td>9.09</td>
<td>9.81</td>
<td>6.08</td>
<td>8.29</td>
</tr>
</tbody>
</table>
EMDR-Based Programs

Daily EMDR and PE individual sessions over two weeks, plus psychoeducation and physical activities (Van Woudenberg et al., 2018):

- Post-treatment 82.9% of patients demonstrated a clinically meaningful response; 54.9% a loss of diagnosis; low drop-out rate of 2.3%
- Post-treatment to 6-month follow-up demonstrated a small, but significant increase in CAPS-5 scores and no difference between post-treatment to 6-month follow-up on PCL

5 day intensive EMDR plus yoga (Mayaris Zepeda Méndez et al., 2018):

- Medium-effect size change in PCL
- 9/11 patients that completed treatment reported recovery or improvement

Week-long EMDR and Equine-assisted psychotherapy, yoga, narrative writing (Steele et al., 2018):

- Pre- to post-treatment small to large effect size changes in PTSD, depression, moral injury, dissociation, and adult attachment
Section 3: Strategies for Implementation
Modifications to Protocol: CPT

The CPT protocol requires minimal modifications/adaptations when delivered individually in massed format.

For early responders or those attempting to complete in under 12 sessions, two themes/modules may be combined into one session.

For homework, Veterans complete three worksheets per day.
Modifications to Protocol: Prolonged Exposure

Prolonged Exposure (PE): minimal protocol modifications are required when delivering individually in massed format.

It is recommended that homework be assigned as follows:

- Session 1 recording: listen to entire session once
- Session 2 recording: listen to entire session once
- Sessions 3 and up: listen to imaginal exposure daily and processing at least once
- In-vivo exposures: 2-3 per day
Logistics with implementation

SCHEDULING CONCERNS

CLINICAL COVERAGE

STAFFING NEEDS

STEP-WISE IMPLEMENTATION
Willingness and Perceptions of Readiness

- High levels of patient satisfaction from all studies
- Over 50% of Veterans with PTSD shared comfortable with daily TFT (Yamokoski unpublished data) and positive reactions (Sherrill et al, 2020)
- Minimal skills work, preparation required or off-protocol sessions to successfully complete (Yamokoski & Flores, 2019)
- Provider report restored faith in the strength of our patients and improved morale working within teams (Yamokoski & Weinstein, 2019)
Considerations for virtual implementation: Preparing and/or transitioning program

- Research on telehealth and EBPs
- New challenges and stressors related to COVID-19
- Patient selection considerations
- Selection of platform
- Options for back up if technology failure
- Development of group content
- Emergency procedures
Considerations for virtual implementation: Conducting program/intervention

- Concerns about privacy
- Pre-admission/orientation
- Providing materials to participants
- Consideration of impact on group content and processes
- Measurement-based care
- Examples
- Preliminary findings
Section 4: Future Directions
Dismantling Studies

STRONG STAR Consortium and the Consortium to Alleviate PTSD (CAP; lead investigator: Alan Peterson, Ph.D.)

- Massed PE alone (daily over three weeks) compared to massed PE as part of IOP
- Military and Veteran sample
- Goal: randomize and treat 100
Shorter Programs

RCT in progress: Massed CPT with active duty military over five days (Wachen et al, 2019)

• Goal: 140 active duty, military service members
• Random assignment to standard or massed CPT over five days (both using the 12 session protocol)
• Standard CPT: 60-minute Individual sessions 2x/week for 6 weeks
• Massed CPT: Intensive outpatient setting (combined group and individual) in 12 60-minute sessions over 5 days.
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00am</td>
<td>Questionnaires</td>
<td>Questionnaires</td>
<td>Questionnaires</td>
<td>Questionnaires</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>10:00am</td>
<td>Practice</td>
<td>Practice</td>
<td>Practice</td>
<td>Practice</td>
<td>Practice</td>
</tr>
<tr>
<td>11:00am</td>
<td>Cohort A - Individual: CPT 2</td>
<td>Cohort B - Individual: CPT 4</td>
<td>Cohort A - Individual: CPT 7</td>
<td>Cohort B - Individual: CPT 10</td>
<td>Cohort A - Individual: CPT 12</td>
</tr>
<tr>
<td>12:00pm</td>
<td>BREAK</td>
<td>BREAK</td>
<td>BREAK</td>
<td>BREAK</td>
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</tr>
<tr>
<td>12:30pm</td>
<td>Cohort A - Practice</td>
<td>Cohort B - Practice</td>
<td>Cohort A - Practice</td>
<td>Cohort B - Practice</td>
<td>Cohort A - Qual Interviews</td>
</tr>
<tr>
<td>1:30pm</td>
<td>Cohort A - Free to leave</td>
<td>Cohort B - Practice</td>
<td>Cohort A - Practice</td>
<td>Cohort B - Practice</td>
<td>Cohort B - Qual Interviews</td>
</tr>
<tr>
<td>2:30pm</td>
<td>Free to leave</td>
<td>Group: CPT 5</td>
<td>Group: CPT 8</td>
<td>Free to leave</td>
<td>Graduation (2:30pm-3:00pm)</td>
</tr>
</tbody>
</table>
Implementation Plans within VHA

Development of IOP level of care based on massed EBP delivery

Piloted and plans to spread to additional medical centers as both IOP and individual massed EBPs

Acceptable, feasible and effective in pilot study
Please enter your questions in the Q&A box and be sure to include your email address.

The lines are muted to avoid background noise.
Welcome users of VHA TRAIN!

To obtain continuing education credit please return to www.vha.train.org after the lecture.

TRAIN help desk: VHATRAIN@va.gov
CEU Process for users of VHA TRAIN (non-VA)

Registration → Attendance → Evaluation → Certificate

Register in TRAIN.

Listen to the lecture.

Return to TRAIN for evaluation.

Follow the directions to print certificate.

TRAIN help desk: VHATRAIN@va.gov
CEU Process (for VA employees)

1. **Registration**
   - **TMS 2.0**
   - Register in TMS.

2. **Attendance**
   - Join via TMS and listen to the lecture.

3. **Post**
   - Posttest is no longer required for this lecture.

4. **Evaluation**
   - Return to TMS and complete evaluation.
   - Search “My Learning” to find it.

5. **Certificate**
   - Print certificate from “My History” section of TMS.
PTSD Consultation Program
We can help

**HEALTHCARE PROVIDERS:**
- Are you treating Veterans with PTSD? **We can help**
- Do you have questions about the mental health effects of the COVID-19 pandemic? **We can help**
- Are you looking for ways to care for yourself and your colleagues? **We can help**

PTSDconsult@va.gov
866-948-7880
www.ptsd.va.gov/consult
**UPCOMING TOPICS**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 19</td>
<td>Clinical Considerations and Guidance for the Treatment of trauma, PTSD, and co-occurring minority stress among LGBTQ individuals</td>
<td>Nicholas Livingston, PhD</td>
</tr>
<tr>
<td>September 16</td>
<td>Racism-related Stress and Trauma: Definitions and Interventions</td>
<td>Juliette McClendon, PhD</td>
</tr>
<tr>
<td>October 21</td>
<td>Case Conceptualization in the Treatment of PTSD</td>
<td>Gayle Iwamasa, PhD</td>
</tr>
</tbody>
</table>

**SAVE THE DATE:** Third Wednesday of the Month from 2-3PM (ET)

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