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Treatment

The VA/DoD Clinical Practice Guideline for PTSD recommends SSRIs and SNRIs as first-line treatments for PTSD. Other psychotropic medications may be used for patients who do not respond to first-line treatments or to address comorbid conditions, but some of these medications come with significant risk. Three recent studies by VA researchers examined prescribing practices for PTSD within the VA. The news is generally good, although the studies also found opportunities for improvement. The first study found a rise in recommended antidepressants and decreases in antipsychotics and benzodiazepines within the last 10 years. Changes were modest, however. This study was not designed to determine which medications were used for PTSD specifically, but the second study was. It found that clinicians are most commonly reaching for first-line PTSD treatments and generally augmenting these as recommended. Lastly, the third study found that, with or without a pain diagnosis, Veterans with PTSD are more likely to be prescribed opioids relative to Veterans with other or no mental health diagnoses. Moreover, the risk of negative outcomes is greater in Veterans with PTSD compared with other Veterans. Taken together, the studies indicate that, for the most part, pharmacotherapy for PTSD in the VA has been concordant with the VA/DoD Guideline. However, the studies also identify the need to reduce off-label use of antipsychotics, improve management of sleep issues, and address overuse of opioid therapies in patients with PTSD.

Promising trends in antidepressant and benzodiazepine prescribing practices

Concerns regarding polypharmacy and over-prescribing of benzodiazepines among Veterans with PTSD have led to several cross-

Journal Special Issues

Rural Veterans: A recent special issue of Journal of Rural Social Sciences features 11 articles addressing the characteristics and needs of America’s rural Veterans. The issue is available at http://www.ag auburn edu/auxiliary/srsa/index htm


Suicide Among Veterans: The March 2012 supplement to the American Journal of Public Health explores the prevalence, associated factors, assessment, and prevention of suicide in military and Veteran populations. The issue is available at http://ajph apha publications org/toc/ajph/102/S1


Sexual Health and Functioning in Veterans: The March 2012 issue of the International Journal of Sexual Health is the first ever special issue on the topic of sexuality in Veterans. The issue is available at http://www tandfonline com/toc/wijs20/24/1

sectional reports of psychotropic prescribing in the VA. A new study from the National Center for PTSD and Iowa VAMC expands the picture by offering a longitudinal perspective. Researchers used VA administrative pharmacy utilization data for fiscal years 1999 through 2009 to examine longitudinal prescribing trends for Veterans with PTSD. Although the frequency of SSRI or SNRI use increased by 10% from 1999 to 2004, it stabilized at that point. Frequency of antipsychotic and benzodiazepine prescribing each declined 6.1% over the 10-year period. However, benzodiazepine use was still at 30.6% in 2009 and prescriptions for low dose quetiapine (Seroquel, an anti-psychotic) increased 9.7%. Decreases in benzodiazepine use appeared to coincide with increased prazosin use, which suggests that sleep problems are a significant clinical challenge in patients with PTSD. Cognitive-behavioral therapy for insomnia offers a non-pharmacological but evidenced-based approach to sleep problems that may decrease benzodiazepine use further and help curb prescribing of quetiapine. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id38012.pdf


Factors predicting prescribing decisions for Veterans with PTSD

Understanding prescribing trends is necessary in order to identify treatment practices that need improvement. Researchers from the National Center for PTSD and the Sierra-Pacific MIRECC also examined how prescriptions vary as a function of patient characteristics. The study included 482 VA patients with PTSD recruited as part of the Longitudinal Veterans Health Survey. Half (51%) were OEF/OIF Veterans. Data were collected between 2006 and 2008. Among the 392 (81%) Veterans who were prescribed at least one antipsychotic medication, long-term benzodiazepines (> 60 days) were prescribed to 91 (23%). Having an anxiety disorder was the only significant predictor of benzodiazepine receipt. Among Veterans without a co-occurring anxiety disorder, 36% did not receive an SSRI or SNRI before, during, or after receiving a benzodiazepine. Among Veterans who received an atypical antipsychotic, 69% did not have a co-occurring psychotic or bipolar disorder, although 77% of these patients were either also on or had previously been on a SSRI or SNRI. The most frequently prescribed antipsychotic was quetiapine (Seroquel). Higher self-reported PTSD symptoms was associated with the prescription of a mood stabilizer. Overall, the study indicates that clinicians are generally basing pharmacotherapy choices on valid clinical factors. However, use of atypical antipsychotics and mood stabilizers in the absence of a clearly indicated diagnosis remains a concern. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id38331.pdf


Opioid use associated with greater risks for Veterans with PTSD

Given the comorbidity of PTSD and pain, it may not be surprising to see higher frequency of opioid prescribing in Veterans with PTSD. What is surprising, however, are the findings from a study led by researchers at the San Diego VA showing an elevated rate of opioid prescriptions among Veterans with PTSD who do not have comorbid pain. The researchers used administrative data for 291,205 OEF/OIF Veterans who entered into VA care between 2005 through 2008. Regardless of whether comorbid pain was present, Veterans with PTSD were over four times more likely to get an opioid (12.4% received a prescription) relative to Veterans without a mental health diagnosis (2.7% received a prescription); Veterans with other mental health diagnoses were 2.5 times more likely. Veterans with a drug use disorder and comorbid PTSD were most likely to receive opioids (RR = 4.19). Among Veterans prescribed opioids, those with PTSD took higher doses for longer periods and had a higher prevalence of adverse clinical outcomes compared with Veterans with a mental health diagnosis other than PTSD or no mental health diagnosis. Adverse outcomes included alcohol-, opioid-, and non-opioid drug-related overdose, as well as self-inflicted injuries. This study highlights the importance of clinician and patient education about the risks of opioids. The findings also suggest use of lower risk non-pharmacological approaches to pain management, particularly for Veterans with comorbid substance use disorders. Read the article...http://dx.doi.org/10.1001/jama.2012.234


Vietnam Veterans account for a substantial amount of growth in use of VA mental health services

A study by investigators at the West Haven VAMC indicates that the number of Veterans who used VA mental health care rose by almost 120% from 1997 to 2010, an annual growth rate of 9.0%. A prior study had examined trends thru 2005. The new findings indicate that the rate of growth in a variety of indicators has increased since then, especially for Veterans with PTSD. For example, annual growth in the number of Veterans with PTSD who received treatment was 12.6% between 1997 and 2005 and 14.8% between 2005 and 2010. Although the number of OEF/OIF Veterans with PTSD who received treat-
Prolonged Exposure benefit may differ by Veteran cohort

VA’s rollout of Prolonged Exposure was based on demonstrations of the treatment’s efficacy in randomized clinical trials, which are sometimes criticized for not providing a realistic estimate of treatment effects in clinical settings. But a new study from researchers at the Charleston VA shows how effective Prolonged Exposure can be in routine clinical practice, and also suggests that the effectiveness may be greater for some Veteran cohorts. Researchers analyzed outcomes for 112 Veterans treated with Prolonged Exposure between 2008 and 2011 in a PTSD outpatient clinic. The overall completion rate was high (84%). As in prior randomized trials, the treatment was very effective at reducing PTSD and depression. Gulf War Veterans experienced less improvement compared with Vietnam or OEF/OIF Veterans and also had a slower rate of improvement. The factors that may account for this differential effectiveness have yet to be explored. Generalizability of the findings to other clinics may be somewhat compromised by a high level of therapist expertise in the clinic and the fact that the Veterans were required to attend PTSD orientation classes, which may have selected for more motivated patients. Nevertheless, the potential impact of Prolonged Exposure for addressing PTSD is substantial. As the authors note, in one PTSD clinic, 3 therapists were able to significantly reduce PTSD symptoms in over 100 Veterans over the span of 3 years.

Mantram meditation intervention for PTSD

In the February 2012 CTU-Online, we reported the results of a randomized clinical trial that found mindfulness meditation was effective in reducing symptoms of PTSD. Recently, researchers from the San Diego VA conducted a randomized clinical trial of another type of meditation-based treatment, mantram repetition, for treating PTSD. The researchers randomized 146 Veterans with PTSD to treatment-as-usual, consisting of medication and case management, or treatment-as-usual plus a mantram repetition program. The program involved six 90-minute group classes, covering lectures, discussion, and mantram practice (i.e., repetition of a chosen spiritual word or phrase), along with at-home mantram practice. As in the mindfulness trial, the mantram repetition program was well-received, with minimal drop-out (7%). Compared to only treatment-as-usual, participation in the mantram program resulted in fewer PTSD and depression symptoms and more improvements in quality of life and spiritual well-being. Improvements in PTSD were clinically meaningful (≥10 points on the Clinician Administered PTSD Scale) for a quarter of the patients in the mantram program (versus only 12% in the comparison group) and were sustained at 6-week follow up. Compared to outcomes observed after evidence-based treatments for PTSD, the effects of mantram repetition were modest, however. Even so, the program could be a useful adjunctive treatment to a regimen of medication and case management.

Assessment

Room for improvement in VA’s TBI screen

In 2007, VA created a clinical reminder to screen OEF/OIF Veterans for TBI. Investigators at the Tampa VAMC recently reported new data on a national sample of almost 50,000 Veterans that raise questions about the screen’s psychometric properties but also suggest a way to improve the screen’s performance. The screen consists of questions about 4 domains: (1) exposure to an event that could cause a head injury; (2) immediate neurocognitive reactions to the exposure; (3) problems beginning or worsening after the exposure; and (4) symptoms occurring in the past week. All 4 items are required for a Veteran to screen positive for TBI. The investigators compared screening results with the results of the VA’s Comprehensive TBI Evaluation that is performed by a clinician with expertise in TBI. Eighty-seven percent of the Veterans screened positive for TBI, whereas clinicians made a diagnosis in only 53%. The screen had excellent sensitivity (.87), which is desirable for a screen. However, specificity was .15, indicating that it tends to
Primary Care

Benefits if increased integration of mental health in primary care

VHA began to integrate mental health within primary care in 2006. Preliminary evaluations of the Primary Care-Mental Health Integration (PC-MHI) effort indicated improved clinical outcomes and treatment engagement. A team led by a researchers from the Buffalo VAMC recently performed more extensive evaluation—and found encouraging results. The researchers examined data from the 2010 National PC-MHI Evaluation survey and PC-MHI encounter records from VA’s National Patient Care Database. Out of all 165 VA service locations within the VA healthcare system, 160 (97%) had PC-MHI programs. The majority of these programs (83.1%) provided treatment for PTSD. On average, programs were staffed with 1 full-time psychologist and a half-time psychiatrist, along with other mental health providers and support staff. Use of PC-MHI services increased substantially from October 2007 through April 2011; in each month since June 2009, more than 10,000 new Veterans received PC-MHI services for the first time. Among 92,190 primary care patients who had a first-time specialty mental health visit in 2009, having a second visit was associated with being seen in a PC-MHI clinic on the day of the first mental health visit or within 3 months prior and by seeing a psychologist (vs. a nurse) in the PC-MHI clinic. The study highlights the importance of short time lags between PC-MHI and initial specialty mental health visits and the value of psychologist staffing to promote use of specialty mental health care. Read the article...http://dx.doi.org/10.1007/s10880-011-9285-9


Strategies that work to increase MST screening

Rates of screening for MST in the VA have increased since the universal mandate in 2000, but facilities vary in the percentage of Veterans who are screened. A study led by VA’s Military Sexual Assault Support Team and the National Center for PTSD indicates that some factors have a particular impact on the likelihood of screening. The investigators examined clinical data for female (n = 50,763) and male (n = 1,004,758) Veterans who used outpatient services in fiscal year 2005 at 119 VHA facilities. None of the Veterans had previously received an MST screen. Just over half of the women (51%) and under half of the men (44%) were new patients, defined as not having an outpatient visit at a VHA facility in the previous fiscal year. The overall MST screening rate was 72% among women and 68% among men. Although facility size did not affect screening, other organizational factors did. Their influence varied by Veteran gender and new versus continuing patient status. For example, audits and feedback of MST screening nearly doubled the odds of screening among new patients only. A mandatory universal MST screening policy was associated with greater odds of being screened in all male patients but in only new female patients. Based on these findings, facilities may want to implement multiple strategies in order to ensure that all Veterans—male and female—are adequately screened. Read the article...http://www(ptsd.va.gov/professional/articles/article-pdf/id38468.pdf