Detection and Management of PTSD in Primary Care Settings

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Overview

- Prevalence of Trauma and PTSD in Primary Care
- Health Consequences of PTSD
- Detection and Screening
- Principles and Models of Behavioral Health in Primary Care
- Focused Interventions
  - PTSD symptom management
  - Management of related problems
  - Preparing patients to seeking more intensive services.
- Examples of primary care-based PTSD interventions
Prevalence of Trauma Exposure

General Population
- 61% men, 51% women (Kessler et al., 1995)
- 65% men, 50% women (Creamer et al., 2001)
- 83% men, 71% women (Norris et al., 2003)

Primary Care
- 65-88% Civilian (Bomyea et al., 2013)
- >90% Veterans (Freedy et al., 2010)

Criteria A Trauma Exposure (Kilpatrick et al., 2013)
- 93% DSM-IV
- 90% DSM-5
Prevalence of PTSD

General Population

- 6% men, 11% women (Breslau et al., 1991)
- 5% men, 10% women (Kessler et al., 1995)

DSM-5 criteria

- 5.7% men, 12.8% women (Kilpatrick, 2013)

Primary Care (Spoont et al., 2015)

- 12% University primary care clinics
- 12-20% VA primary care clinics
- 23% Urban primary care clinics
- 13.5% across all PC settings
Health Consequences

Self-Reported Health (+++)
  Symptoms (e.g., SCL-90)
  Global status (e.g., SF-36)
  Functioning (e.g., SF-36)
  Condition (e.g., Has a doctor ever told you...)

Health Care Utilization (++)
  Frequency and complexity of visits

Morbidity (+)
  Physician diagnosis

Mortality (-)

Schnurr & Jankowski (1999)
Table 3
Weighted mean effect sizes for physical health outcomes.

<table>
<thead>
<tr>
<th>Physical health outcome</th>
<th>k</th>
<th>r+</th>
<th>SE</th>
<th>z score</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>General physical symptoms(^a)</td>
<td>16</td>
<td>.48</td>
<td>.05</td>
<td>10.33***</td>
<td>.40 to .56</td>
</tr>
<tr>
<td>General medical conditions(^a)</td>
<td>10</td>
<td>.32</td>
<td>.02</td>
<td>18.26***</td>
<td>.28 to .35</td>
</tr>
<tr>
<td>Physical health-related quality of life(^a)</td>
<td>26</td>
<td>-.20</td>
<td>.09</td>
<td>-2.23*</td>
<td>-.36 to -.02</td>
</tr>
<tr>
<td>Pain(^a)</td>
<td>26</td>
<td>.23</td>
<td>.02</td>
<td>11.89***</td>
<td>.19 to .27</td>
</tr>
<tr>
<td>Gastrointestinal health(^a)</td>
<td>19</td>
<td>.19</td>
<td>.02</td>
<td>8.57***</td>
<td>.15 to .23</td>
</tr>
<tr>
<td>Cardio-respiratory health(^a)</td>
<td>21</td>
<td>.17</td>
<td>.03</td>
<td>7.70***</td>
<td>.12 to .22</td>
</tr>
</tbody>
</table>
PTSD correlates (Spoont et al., 2015)

• Health
  – Cardiovascular disease
  – Hypertension
  – Diabetes
  – Autoimmune diseases
  – Dementia
  – Hospitalizations

• Psychiatric comorbidities
  – Depression/suicide
  – Substance abuse
  – Anxiety disorders

• Social
  – Unemployment
  – Poverty
Multifactorial Model of Trauma, PTSD, & Health (Schnurr & Green, 2004)
Detection and Screening

- Primary Care: De facto Mental Health System
  - Long recognized (Regier et al., 1978, 1993)
  - 55-70% of primary care visits related to MH issues (Robinson & Reiter, 2007)
- Physician Recognition of PTSD
  - 11% civilian primary care (Liebschutz et al., 2007)
  - 46% VA primary care (Magruder et al., 2005)
- Physician’s knowledge and comfort
  - 28.3% (versus 89.8% for depression) able to recognize and treat PTSD (Munro et al., 2004)
  - Web-based PTSD training for PC Providers (Samuelson, 2014)
  - NC-PTSD Consultation program and educational materials
Screening for PTSD

- **Recommendations**
  - US Preventive Services Task Force – PTSD screening not recommended
  - NICE UK guidelines
    - High risk population (e.g., MVA, veterans, refugees, firefighters)
    - Clinical presentation suggestive of PTSD

- **Desirable features**
  - Short (2-4 items)
  - Easy to read and administer (e.g., 5th or 6th grade reading level)
  - Easy to score
  - Good operating characteristics
### Table 1 PTSD screening tests evaluated in primary care

<table>
<thead>
<tr>
<th>Test</th>
<th>Authors</th>
<th>Scale from which items derived</th>
<th>Items</th>
<th>Sample setting</th>
<th>Prevalence current PTSD (%)</th>
<th>Criterion standard</th>
<th>Cutoff score / max. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-PTSD</td>
<td>[12] Prins et al.</td>
<td>–</td>
<td>4</td>
<td>VAMC (N=188)</td>
<td>25</td>
<td>CAPS</td>
<td>3/4</td>
</tr>
<tr>
<td>PC-PTSD</td>
<td>[16] Freedy et al.</td>
<td>–</td>
<td>4</td>
<td>Civilian FP (N=411)</td>
<td>32</td>
<td>CAPS-mod</td>
<td>3/4</td>
</tr>
<tr>
<td>Breslau 7-Item scale</td>
<td>[20] Kimerling et al.</td>
<td>DIS for DSM-IV</td>
<td>7</td>
<td>VAMC (N=134)</td>
<td>25</td>
<td>CAPS</td>
<td>4/7</td>
</tr>
<tr>
<td>Breslau 7-Item scale</td>
<td>[16] Freedy et al.</td>
<td>DIS for DSM-IV</td>
<td>7</td>
<td>Civilian FP (N=411)</td>
<td>32</td>
<td>CAPS-mod</td>
<td>4/7</td>
</tr>
<tr>
<td>SPAN</td>
<td>[19] Yeager et al.</td>
<td>DTS</td>
<td></td>
<td>VAMC (N=840)</td>
<td>11</td>
<td>CAPS</td>
<td>5/16</td>
</tr>
<tr>
<td>SPAN</td>
<td>[16] Freedy et al.</td>
<td>DTS</td>
<td>4</td>
<td>Civilian FP (N=411)</td>
<td>32</td>
<td>CAPS-mod</td>
<td>3/16</td>
</tr>
<tr>
<td>Four-item PTSD Screen</td>
<td>[21] Gerrity et al.</td>
<td>–</td>
<td>4</td>
<td>VAMC (N=398)</td>
<td>37</td>
<td>PCL*d</td>
<td>3/4</td>
</tr>
<tr>
<td>Abbreviated PTSD-Checklist</td>
<td>[22] Lang et al.</td>
<td>PCL-C</td>
<td>2</td>
<td>VAMC (N=150)</td>
<td>16</td>
<td>PTSD module, CIDI 2.1</td>
<td>4/10</td>
</tr>
<tr>
<td>SIPS</td>
<td>[14] Gore et al.</td>
<td>–</td>
<td>1</td>
<td>Military (N=213)</td>
<td>9</td>
<td>PSS-I</td>
<td>2/3</td>
</tr>
</tbody>
</table>
### Table 3. Performance Characteristics of Screening Instruments

<table>
<thead>
<tr>
<th>Instrumentb</th>
<th>No. of Studies</th>
<th>Total Patients</th>
<th>Threshold</th>
<th>Variable (95% CI)b</th>
<th>Specificity</th>
<th>LR+</th>
<th>LR−</th>
<th>PPV, %c</th>
<th>NPV, %c</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD Instruments</strong></td>
<td></td>
<td></td>
<td></td>
<td>Sensitivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care PTSD Screen&lt;sup&gt;d&lt;/sup&gt;</td>
<td>4</td>
<td>952</td>
<td>≥4</td>
<td>0.52 (0.40-0.64)</td>
<td>0.96 (0.91-0.98)</td>
<td>12.4 (6.7-23.3)</td>
<td>I² = 66%</td>
<td>0.50 (0.38-0.62)</td>
<td>I² = 30%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1100</td>
<td>≥3</td>
<td>0.69 (0.55-0.81)</td>
<td>0.92 (0.86-0.95)</td>
<td>8.5 (5.6-13.0)</td>
<td>I² = 18%</td>
<td>0.34 (0.22-0.48)</td>
<td>I² = 58%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1100</td>
<td>≥2</td>
<td>0.86 (0.79-0.92)</td>
<td>0.79 (0.74-0.83)</td>
<td>4.0 (3.3-4.9)</td>
<td>I² = 45%</td>
<td>0.17 (0.11-0.26)</td>
<td>I² = 21%</td>
</tr>
<tr>
<td>PTSD Checklist&lt;sup&gt;d&lt;/sup&gt;</td>
<td>7</td>
<td>3578</td>
<td>45-50</td>
<td>0.53 (0.37-0.68)</td>
<td>0.94 (0.91-0.97)</td>
<td>9.4 (4.3-19.3)</td>
<td>I² = 45%</td>
<td>0.50 (0.33-0.69)</td>
<td>I² = 81%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>4906</td>
<td>38-44</td>
<td>0.70 (0.64-0.77)</td>
<td>0.90 (0.84-0.93)</td>
<td>6.8 (4.7-9.9)</td>
<td>I² = 77%</td>
<td>0.33 (0.27-0.40)</td>
<td>I² = 0%</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>3128</td>
<td>30-31</td>
<td>0.84 (0.78-0.89)</td>
<td>0.80 (0.70-0.87)</td>
<td>4.1 (2.9-6.1)</td>
<td>I² = 89%</td>
<td>0.21 (0.15-0.28)</td>
<td>I² = 81%</td>
</tr>
<tr>
<td>Breslau scale</td>
<td>2</td>
<td>545</td>
<td>≥5</td>
<td>0.71-0.76</td>
<td>0.88-0.91</td>
<td>5.3-5.9</td>
<td></td>
<td>0.18-0.33</td>
<td></td>
</tr>
<tr>
<td>Startle, Physiological Arousal, Anger, and Numbness</td>
<td>2</td>
<td>1059</td>
<td>≥4</td>
<td>0.75-0.89</td>
<td>0.78-0.79</td>
<td>3.4-4.2</td>
<td></td>
<td>0.14-0.32</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1059</td>
<td>≥3</td>
<td>0.77-0.96</td>
<td>0.73-0.76</td>
<td>2.8-4.0</td>
<td></td>
<td>0.05-0.32</td>
<td></td>
</tr>
<tr>
<td>Single-Item PTSD Screener</td>
<td>1</td>
<td>213</td>
<td>Bothered a little</td>
<td>0.77 (0.54-0.91)</td>
<td>0.79 (0.73-0.84)</td>
<td>3.7 (2.6-5.3)</td>
<td></td>
<td>0.28 (0.12-0.67)</td>
<td></td>
</tr>
<tr>
<td>Trauma Screening Questionnaire&lt;sup&gt;e&lt;/sup&gt;</td>
<td>1</td>
<td>152</td>
<td>≥6</td>
<td>0.95 (0.90-0.97)</td>
<td>0.26 (0.22-0.30)</td>
<td>1.3 (1.2-1.4)</td>
<td></td>
<td>0.20 (0.10-0.41)</td>
<td></td>
</tr>
</tbody>
</table>
### Primary Care PTSD Screen

**PC-PTSD-5**

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example, a serious accident or fire, physical or sexual assault or abuse, earthquake or flood, war, seeing someone be killed or seriously injured, or having a loved one die through homicide or suicide. Have you ever experienced this kind of event?

If no, screen total = 0; if yes, continue with screening. In the past month, have you...

**PC-PTSD**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?</td>
<td>Yes/No</td>
<td>1. Have you had nightmares or thought about it when you did not want to?</td>
</tr>
<tr>
<td>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)?</td>
<td>Yes/No</td>
<td>2. Tried hard not to think about it or went out of your want to avoid situations that reminded you of it?</td>
</tr>
<tr>
<td>3. Been constantly on guard, watchful, or easily startled?</td>
<td>Yes/No</td>
<td>3. Were constantly on guard, watchful, or easily startled?</td>
</tr>
<tr>
<td>4. Felt numb or detached from others, activities, or your surroundings?</td>
<td>Yes/No</td>
<td>4. Felt numb or detached from others, activities, or your surroundings?</td>
</tr>
<tr>
<td>5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?</td>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Estimates of Classification Quality of the PC-PTSD-5 for the DSM-5 Diagnosis of PTSD

<table>
<thead>
<tr>
<th>PC-PTSD-5 Score</th>
<th>Sens</th>
<th>Spec</th>
<th>Eff</th>
<th>PPV</th>
<th>NPV</th>
<th>LR+</th>
<th>LR-</th>
<th>κ(0)</th>
<th>κ(.5)</th>
<th>κ(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1</td>
<td>0.99</td>
<td>0.67</td>
<td>0.72</td>
<td>0.33</td>
<td>1.00</td>
<td>2.99</td>
<td>0.03</td>
<td>0.22</td>
<td>0.36</td>
<td>0.97</td>
</tr>
<tr>
<td>2</td>
<td>0.98</td>
<td>0.78</td>
<td>0.81</td>
<td>0.42</td>
<td>1.00</td>
<td>4.41</td>
<td>0.02</td>
<td>0.33</td>
<td>0.49</td>
<td>0.97</td>
</tr>
<tr>
<td>3</td>
<td>0.95</td>
<td>0.85</td>
<td>0.86</td>
<td>0.51</td>
<td>0.99</td>
<td>6.33</td>
<td>0.06</td>
<td>0.43</td>
<td>0.59</td>
<td>0.93</td>
</tr>
<tr>
<td>4</td>
<td>0.83</td>
<td>0.91</td>
<td>0.90</td>
<td>0.60</td>
<td>0.97</td>
<td>8.79</td>
<td>0.19</td>
<td>0.53</td>
<td>0.63</td>
<td>0.78</td>
</tr>
<tr>
<td>5</td>
<td>0.56</td>
<td>0.97</td>
<td>0.91</td>
<td>0.74</td>
<td>0.93</td>
<td>17.40</td>
<td>0.45</td>
<td>0.70</td>
<td>0.59</td>
<td>0.51</td>
</tr>
</tbody>
</table>

*Italics indicates optimally sensitive cutoff score. Sens sensitivity; Spec specificity; Eff efficiency; PPV positive predictive value; NPV negative predictive value; LR+ positive likelihood ratio; LR- negative likelihood ratio; κ(0) quality of specificity; κ(0.5) quality of efficiency; κ(1) quality of sensitivity*

Table 2. Patient Perceptions of PC-PTSD-5 Measure Administration

<table>
<thead>
<tr>
<th>Variables</th>
<th>Very Easy/Comfortable n (%)</th>
<th>Easy/Comfortable n (%)</th>
<th>Not Sure n (%)</th>
<th>Difficult/Uncomfortable n (%)</th>
<th>Very Difficult/Uncomfortable n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the question</td>
<td>111 (43.9)</td>
<td>114 (45.1)</td>
<td>14 (5.5)</td>
<td>14 (5.5)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Answer the question at a PC visit</td>
<td>117 (46.2)</td>
<td>104 (41.1)</td>
<td>14 (5.5)</td>
<td>13 (5.1)</td>
<td>5 (2.0)</td>
</tr>
<tr>
<td>Fill out a paper/e-form on own</td>
<td>79 (31.2)</td>
<td>113 (44.7)</td>
<td>33 (13.0)</td>
<td>18 (7.1)</td>
<td>10 (4.0)</td>
</tr>
<tr>
<td>Asked by PC doctor</td>
<td>97 (38.3)</td>
<td>127 (50.2)</td>
<td>13 (5.1)</td>
<td>11 (4.3)</td>
<td>5 (2.0)</td>
</tr>
<tr>
<td>Asked by a nurse/other providers</td>
<td>79 (31.2)</td>
<td>114 (45.1)</td>
<td>30 (11.9)</td>
<td>19 (7.5)</td>
<td>11 (4.3)</td>
</tr>
</tbody>
</table>
PCP follow-up (Sonis, 2013)

Patient reports some symptoms of PTSD

Yes

Evaluate for PTSD

PC-PTSD

Positive

PTSD-Checklist

Positive

PCP comfortable initiating treatment in primary care?

Yes

Begin pharmacotherapy

No

Refer to Psychology or Psychiatry

Negative

Consider referral to Psychiatry for evaluation

High

Clinical suspicion

Low

Low probability of PTSD

Negative

No

Higher risk of PTSD

Stay alert for PTSD

No

Patient and clinician agree to evaluate for PTSD

No

Do not evaluate for PTSD
PCL-5 (NC-PTSD)

• Replacing PCL-M, PCL-C and PCL-S; cannot be used interchangeably.
• 20 item (versus 17 item) questionnaire using a 0-4 (versus 1-5) ratings.
• For provisional diagnosis (options)
  1. Treat each item rated as 2 = "Moderately" or higher as a symptom endorsed, then following the DSM-5 diagnostic rule which requires at least: 1 B item (questions 1-5), 1 C item (questions 6-7), 2 D items (questions 8-14), 2 E items (questions 15-20).
  2. Preliminary validation work is sufficient to make initial cut-point suggestions, but this information may be subject to change. **A PCL-5 cut-point of 33 appears to be a reasonable value to propose until further psychometric work is available.**
• For monitoring treatment progress
  – 5 points as a minimum threshold for determining whether an individual has responded to treatment
  – 10 points as a minimum threshold for determining whether the improvement is clinically meaningful using the PCL.
Measurement Based Care

• VHA Initiative
• Measures for tracking outcome
• Proposed Measures
  • PTSD Symptom Checklist (PCL-5) for PTSD.
  • Brief Addiction Monitor (BAM-R) for substance use and risk and recovery factors.
  • 9 item Patient Health Questionnaire (PHQ-9) for depression.
  • Generalized Anxiety Disorder (GAD 7) for anxiety.
  • A global measure of functioning, to be determined soon.
Key References

Behavioral Health Treatment in Primary Care

• Population-based care
  – Brief: 30 minute appointments, 1-5 sessions
  – Stepped-Care

• Treatment Focus
  – Patient’s most pressing concern
  – Provider’s referral reason

• Present-focused and solution-oriented

• Self-management is emphasized

• Communicate with primary team is key
Models of Primary Care-Behavioral Health (PCBH)

- Care Management
  - Nurses provide support around the prescription of psychotropic medication
  - Protocol-driven
  - Often phone-based
  - More common on Department of Defense and Veterans Health Administration
  - Research indicates that this may be less effective for PTSD than it is for depression (Meredith et al., 2016 JGIM, 31, 509-517; Schnurr et al., 2012 JGIM, 28:32-40).
Models of Primary Care-Behavioral Health (PCBH)

• Co-located Collaborative Care (CCC)
  – Licensed, independent provider is located in PC
  – Functions as a member of PC team
  – Provide consultation to other team members and brief assessments and interventions to patients
  – Open access allows for warm-handoffs

• The rest of this presentation focus on CCC delivery
Focus of Intervention

- PTSD Symptom Management
  - Psychoeducation and normalizing
  - Relaxation
  - Cognitive therapy for maladaptive PTSD-related thoughts
- Nurse-assisted online CBT for PTSD reduced symptoms at post-treatment but symptom gains were not maintained (Engel et al., 2015. *Gen Hosp Psych*, 37, 323-328).
- Brief Exposure
  - Four 30 minute appointments that include written, imaginal and in-vivo exposure have good preliminary efficacy (Cigrang et al., 2015. *J of Anx Dis*, 36, 110-114).
Focus of Intervention

• Management of related problems
  – Sleep
  – Social functioning (at home, work or school)
  – Anger
  – Alcohol/ drug use
  – Pain
Focus of Intervention

- Preparing patients to engage in more intensive treatments
  - Exploring barriers, fears, and misconceptions of treatment
  - Motivational enhancement
  - Referral management
  - Research shows that VHA patients who receive same-day PCBH services are 3.4 times more likely to start PTSD treatment (Bohnert et al., 2016. Psychiatric Serv, 67, 1-7).
How to talk to patients about PTSD

• *I’m concerned about your problems with stress and anxiety.*
• *Problems like these are common and we have good treatments available to help.*
• *Problems like these can really affect your physical health. Good healthcare involves paying attention to physical and emotional health.*
• *I’d like you to talk my colleague here in primary care that I work with on these types of problems.*
  – *She can assess your concerns further, communicate with me, and then we can make a plan to address them.*
  – *Our behavioral health provider works as coach to suggest strategies to help you cope better with your stress.*
  – *What are your concerns about talking to a behavioral health provider?*
## Eliciting Referrals/ Warm-handoffs from Primary Care Providers

<table>
<thead>
<tr>
<th>Common patient concerns</th>
<th>Information to provide to address concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD can’t be helped.</td>
<td>There are talk therapies that are very effective</td>
</tr>
<tr>
<td>I don’t want meds.</td>
<td>Most treatment approaches for stress and anxiety do not involve medication.</td>
</tr>
<tr>
<td>I need to be strong and manage this myself.</td>
<td>How is that working for you? Are you willing to try something new?</td>
</tr>
<tr>
<td>Talking about past trauma will be too hard for me.</td>
<td>Yes, this can be difficult but you are a strong person. Are you willing to talk to someone to learn more about treatment, then you can decide if you are interested?</td>
</tr>
<tr>
<td>I don’t have time for treatment.</td>
<td>You can talk to someone by phone whenever its convenient for you. Also, we have Saturday clinic hours. Is there another concern you have about treatment?</td>
</tr>
<tr>
<td>I don’t want to be diagnosed or labeled.</td>
<td>My colleague can screen for problems and talk about treatment options. Making a diagnosis is not the purpose of this visit.</td>
</tr>
</tbody>
</table>
CBT for Treatment Seeking + Referral Management

– Goal: provide primary care patients with higher quality PTSD treatment by getting more patients with PTSD to engage in evidenced based PTSD treatment in specialty care.
  • CBT for Treatment Seeking
  • Phone-based Referral Management

– 3 phases:
  1. Primary care staff training and gathering feedback
  2. Implementation and evaluating clinic outcomes
  3. Provide staff results and gather more feedback
Does CBT-TS + referral management increase in treatment utilization?

<table>
<thead>
<tr>
<th></th>
<th>Clinic 1</th>
<th>Clinic 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to PTSD Clinic:</td>
<td>34</td>
<td>13</td>
</tr>
<tr>
<td>$x^2=18$, $p \geq 0.01$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended PTSD Intake:</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>$x^2=20$, $p \geq 0.01$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidenced-based Treatment:</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>$x^2=18$, $p \geq 0.01$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The National Center for PTSD and DoD Center for Telehealth and Technology jointly developed a mobile app focused on helping individuals self-manage their symptoms.
Clinician-Supported PTSD Coach

Prompted to rate distress before tool administered

Interactive Tools

Re-Rate Stress

Distress Decreased

Great! It looks like several exercises may have brought down your distress level. Try to remember this tool. Anything that works for you once can work for you again!

If a tool continues to work for you, you may want to “give it a thumbs up” by tapping the thumbs up button the next time you’re given this tool. That way, it will be more likely to come up again. The tool will also be saved in “Favorites.”

Try Another Tool | Done

Distress Evaluated
Clinician-Supported PTSD Coach

- Four 20 minute sessions focused on personalizing the symptom management strategies for the participant’s specific concerns.
  - Focus on one concern at a time and assigning the patients to use the app daily to manage that concern.
  - Focus on transitioning to other care if symptoms are still high at session 4.
- Pilot Study:
  - Does the addition of clinician-support increase the efficacy of the PTSD Coach Mobile App?
  - 20 person pilot that compares Clinician-Supported PTSD Coach to Self-Managed PTSD Coach
Mindfulness can teach skills to manage PTSD in a less direct manner
   - This can be appealing to patients who are hesitant to skill tradition treatment.

We developed a brief mindfulness training to be delivered in VA primary care

Adapted MBSR
   - Evidence-based tx developed by Kabat-Zinn
   - Mediation, basic yoga, group discussion

Modified 8, 2.5 hours sessions to 4, 1.5 hour sessions

Small trial (N=62) comparing brief mindfulness training to primary care treatment as usual.
Primary Care-Based Mindfulness Training

Changes in PTSD Severity

PTSD Checklist Scores

- Mindfulness
- Control

Pre | Post | Follow-up
--- | --- | ---
50 | 40 | 45
45 | 35 | 40
30 | 30 | 30

Conclusions

• Individuals with PTSD often present to the primary care setting.
• Brief primary care-based assessment and intervention can lead to better access to mental health care for individuals with PTSD.
• The PC-PTSD-5 is a valid brief screener and this can be followed up with the PCL-5 to better understand a patient’s symptoms.
• PCBH focuses on brief solution-focused intervention.
• For patients with PTSD, the focus of treatment can be management of PTSD or other related concerns, as well as, preparing patients for further treatment.
• There are several brief interventions for PTSD in primary care with promising preliminary support, but more research is needed.