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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

PTSD IN PRIMARY CARE

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Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- ✓ No conflicts of interest

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OBJECTIVES

1. Scope and Impact of Trauma Exposure
2. What is Trauma-Informed Care?
3. Current state of the research on PTSD treatment
4. PTSD treatment in primary care settings
5. When and how to refer out to specialty care

DSM-5 STRESSOR CRITERION

- Exposure to actual or threatened death, serious injury, or sexual violence:
  - Directly
  - Witnessed in person
  - Learning the event(s) occurred to close friend or family member. Actual or threatened death - event must have been violent or accidental.
- Repeated or extreme exposure to aversive details of traumatic event

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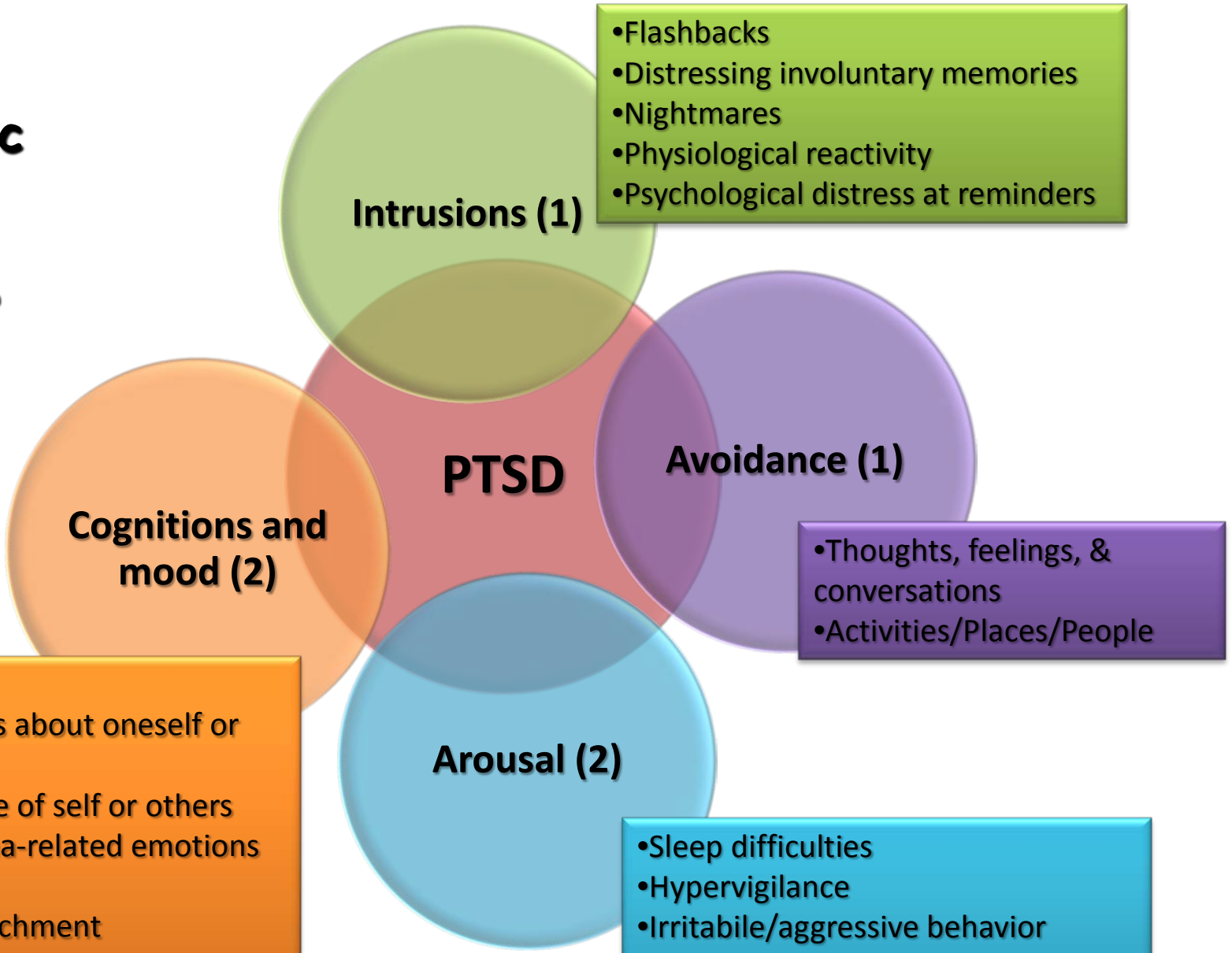
Post Traumatic Stress Disorder



DSM V

EXPOSURE TO TRAUMATIC EVENTS IS RELATIVELY COMMON.

39% - 90% of Americans endorse lifetime traumatic stress exposure

20% endorse current (past year) exposure

50% of people exposed to one event have multiple incident exposures.

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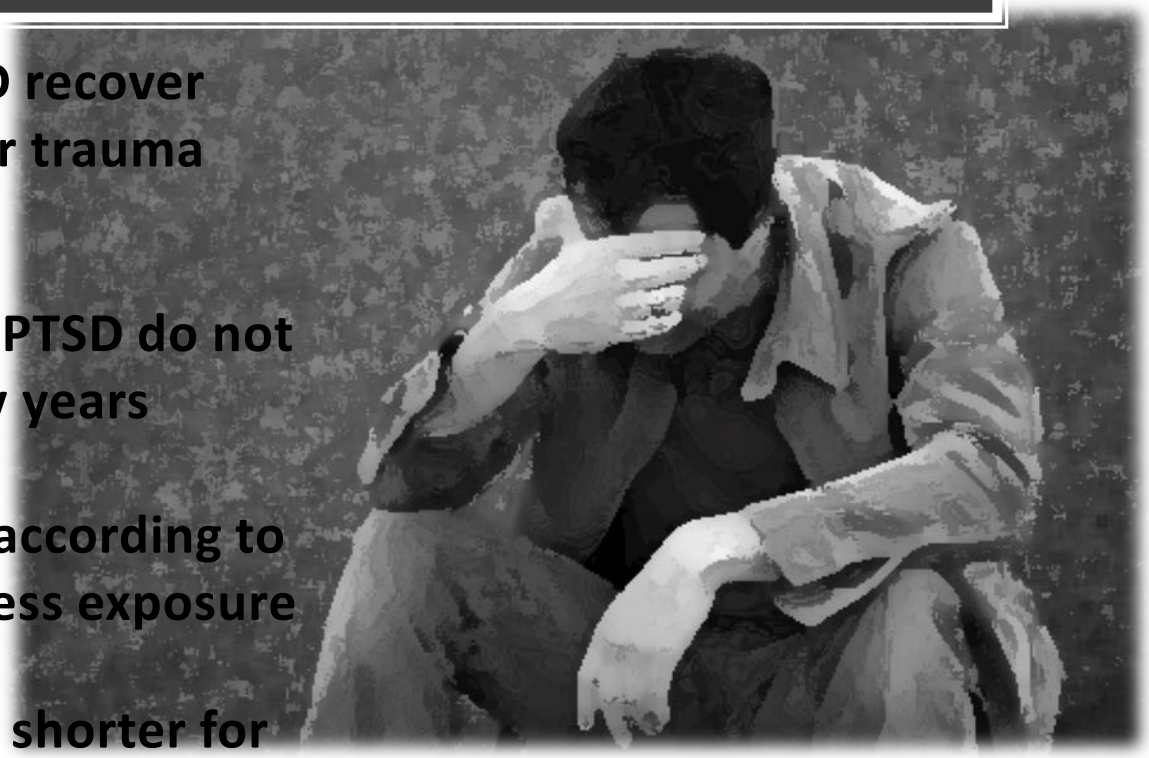
Course of PTSD

- 40% of people with PTSD recover within the first year after trauma exposure
- 1/3 to 1/2 of those with PTSD do not recover, even after many years
- Duration of PTSD varies according to severity of traumatic stress exposure
- Duration of symptoms is shorter for survivors who obtain treatment (36 vs. 64 months)



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PTSD + PATIENTS AND PRIMARY CARE

- More likely to seek treatment from a PCP or medical specialist then from a mental health provider
- 6-25% of primary care clinic (PCC) patients suffer from PTSD
- **Only 11% of primary care patients with PTSD had the diagnosis listed in their medical charts**

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TRAUMA INFORMED CARE

"A philosophical/cultural stance that integrates awareness and understanding of trauma"

- May or may not include Trauma-Specific Services
- Refers to awareness and sensitivity of healthcare system and providers to effects of trauma on patients

Hopper et al., 2010

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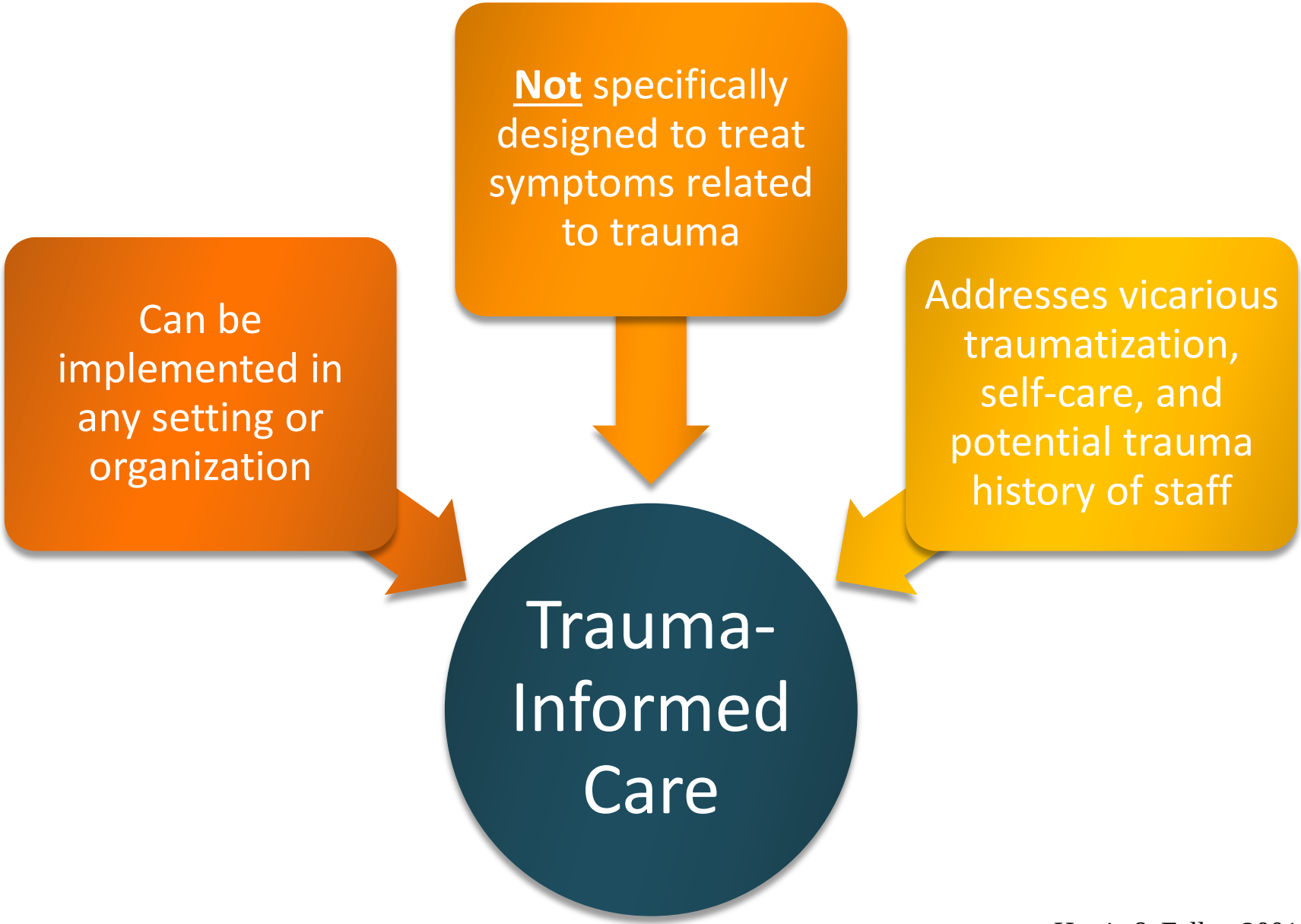

Harris & Fallot, 2001

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PC-PTSD
YES TO 3 ITEMS IS A POSITIVE SCREEN

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

1. Have had nightmares about it or thought about it when you did not want to? YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? YES NO
3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings? YES NO

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THERE IS A RELATIVE PAUCITY OF RESEARCH ON TREATMENT OF PTSD IN PRIMARY CARE SETTINGS.

What is known more broadly about treatment of PTSD?

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NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE GUIDELINES FOR PTSD TREATMENT IN ADULTS

Drug treatments for adults

- Should not be used as a routine first-line treatment for adults in preference to a trauma-focused psychological therapy.

Trauma-focused psychological treatment

- Trauma-focused CBT or EMDR should be offered to those with severe post-traumatic symptoms.
- Individual outpatient format
- Duration normally 8–12 sessions.
- Non-trauma-focused interventions (e.g., relaxation, non-directive therapy) not indicated for chronic PTSD

Psychiatric Medication Management

Significant Benefit	Some Benefit	Unknown	No Benefit/harm
• SSRIs – 1st line agents	• Sympatholytics • Prazosin • Propranolol • Novel Antidepressants • Atypical antipsychotics • Bupropion, Venlafaxine, Mirtazapine, Trazadone	• Anticonvulsants • Buspirone • Non-benzo hypnotic	• Benzodiazepines • Typical antipsychotics

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EVIDENCE-BASED PSYCHOTHERAPIES FOR PTSD IN ADULTS

Significant Benefit

- Exposure Therapy*
- Cognitive Processing Therapy*
- EMDR
- Cognitive Therapy
- Present Centered Therapy

Some Benefit

- Anxiety/Symptom Management
- Supportive Therapy
- Psychodynamic Therapy
- IPT

Emerging Evidence

- Acceptance and Commitment Therapy
- Behavioral Activation

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COMMONALITIES ACROSS EFFECTIVE PTSD PSYCHOTHERAPIES

- ✓ Imaginal Exposure
- ✓ In Vivo Exposure
- ✓ Cognitive Reprocessing around the meaning and implications of the event

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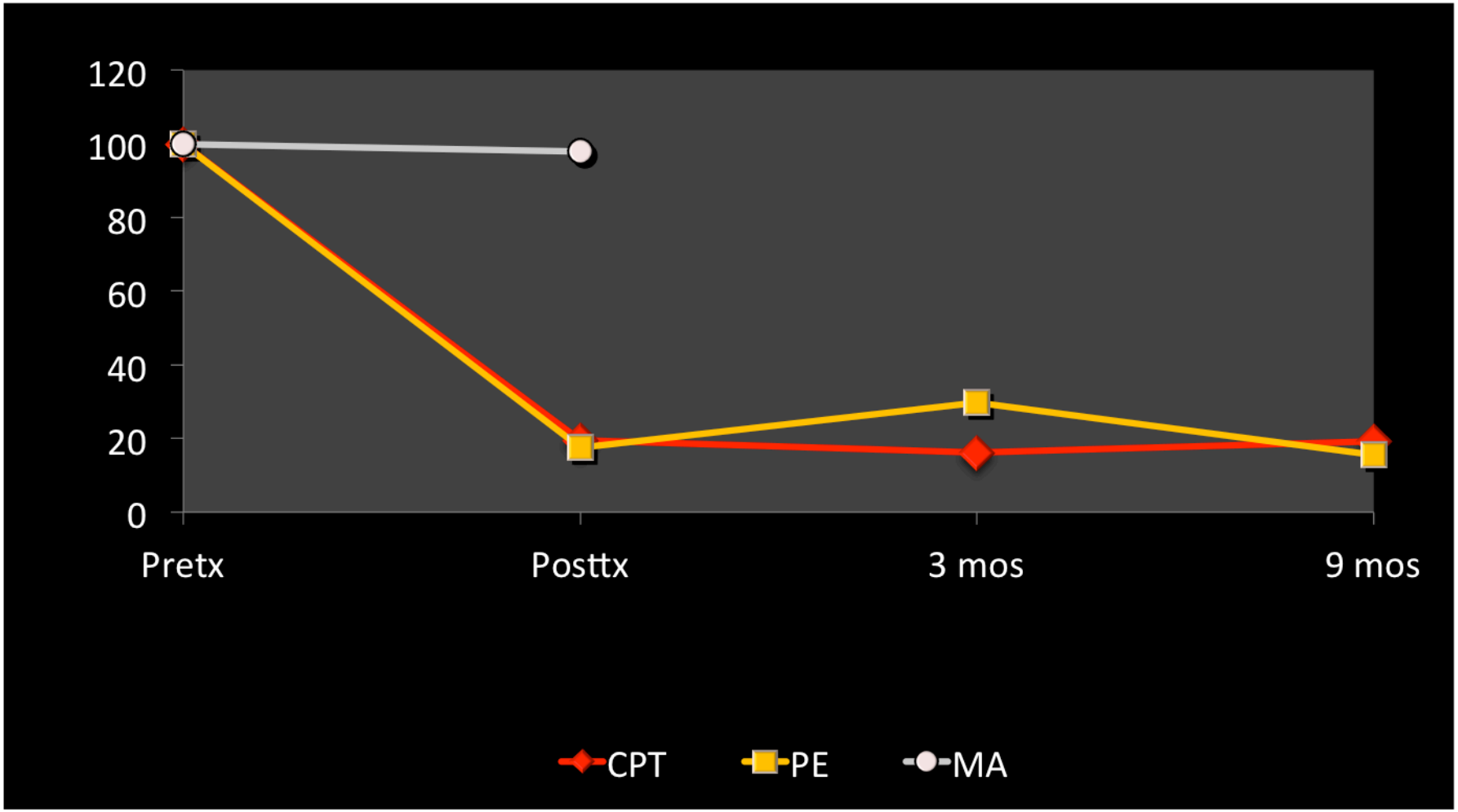
PTSD Treatment Outcome



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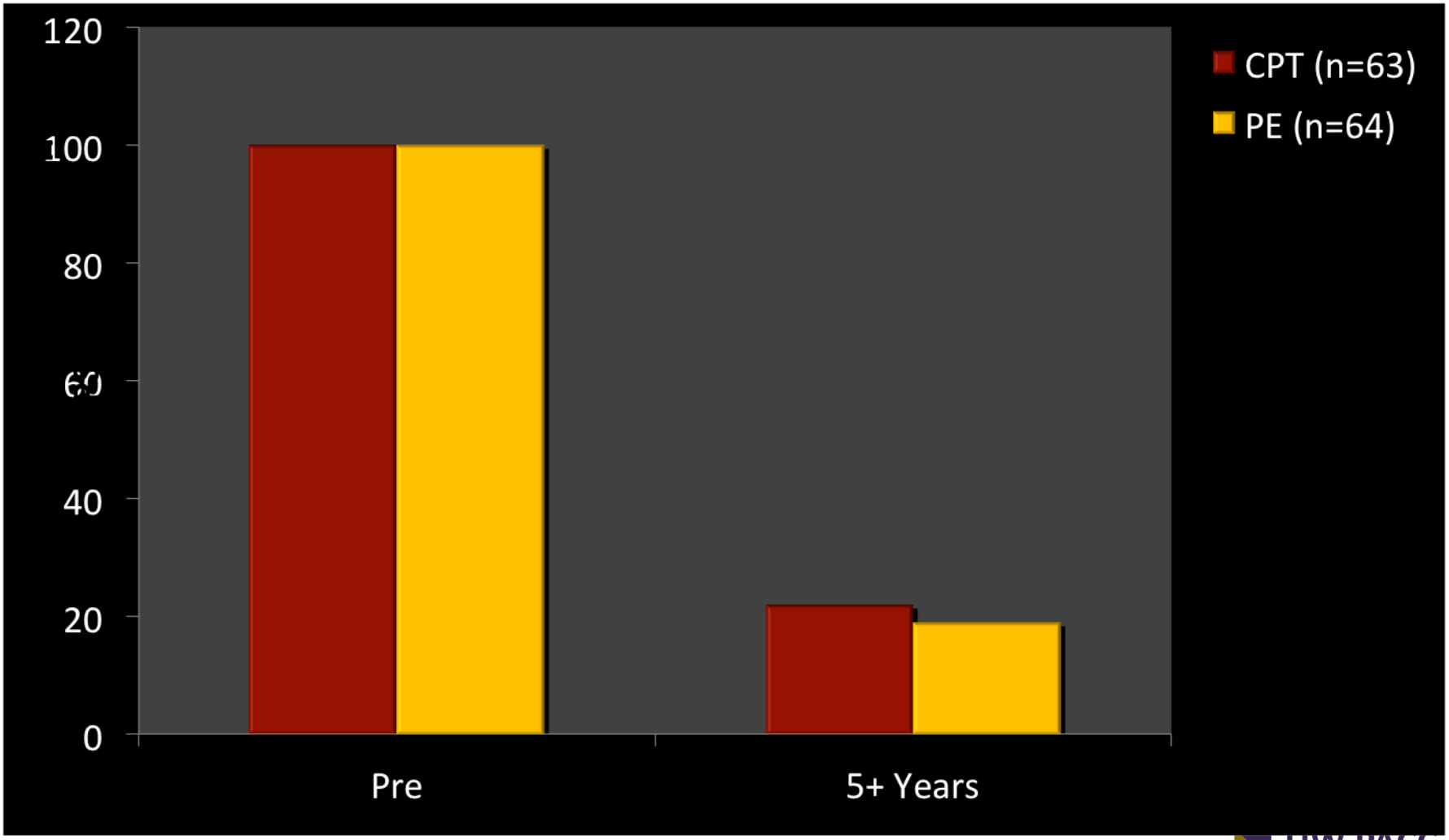
CPT & PE ITT ON PTSD DIAGNOSIS AT PRE-TREATMENT AND LONG TERM



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BOTH EXPOSURE THERAPY AND COGNITIVE THERAPIES HAVE BEEN ADMINISTERED BY NON-EXPERTS SUCCESSFULLY

Exposure therapy – administered by rape crisis counselors

Cognitive therapy – administered by lay counselors in Iraq & DRC

- In northern Iraq therapists were nested within health clinics and provided non-mental health services as well
- In DRC clinical supervisors were all RN's

Both have been rolled-out successfully at VA's across the US in specialty care

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PTSD responds very well to specific types of psychotherapy

The effects last up to 5-10 years post-treatment

Can be administered successfully by non-specialists

BUT

These treatments typically take 9-15 sessions to complete

Take time to learn to do well

CONSIDERATIONS FOR INTERVENING IN PTSD IN PRIMARY CARE SETTINGS

- Briefer interventions are better accepted by patients and providers
- Co-located collaborative care may be helpful, provides immediate access to behavioral health provider
- Time-limited, problem-focused, & solution focused interventions
- In some settings referral to specialty care may be difficult because of a lack of access to trained specialty care providers

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PTSD IN PRIMARY CARE
WHAT DO WE KNOW BASED ON THE RCT'S?

- Five RCTs in primary care
  - Psychoeducation, collaborative care are main components

- Emerging evidence suggests:
  - Findings around collaborative models are more mixed.
  - Most primary care interventions leave out the effective elements from evidence-based psychotherapies for PTSD.
    - Little exposure or trauma-focused cognitive restructuring
    - Focus on psychoeducation, support, and medications

WHAT STRATEGIES ARE AVAILABLE FOR MANAGING PTSD IN PRIMARY CARE?

Collaborative care has some evidence it is effective

- Use of regular monitoring of symptoms and changing interventions based on treatment response
- Providing psychoeducation about PTSD symptoms
- Telepsychology/telepsychiatry

Use of CBT skills in primary care settings

- May want to use auxiliary tools to help with addressing PTSD
  - Websites (http://www.ptsd.va.gov/PTSD/apps/ptsdcoachonline/default.htm)
  - Smartphone apps (PTSDCoach)
- Interventions like behavioral activation have some promise

WHEN TO REFER TO A HIGHER LEVEL OF CARE?

- More severe symptom presentation
- Treatment non-response
- Multiple complex comorbidities
- Safety concerns
- Client is motivated!

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REFERRALS

Seattle area (PE and/or CPT)

- HCSATS (206-744-1600)
  - Seattle, Bellevue, Redmond, Shoreline
- UW Outpatient Psychiatry (206-598-7792)
- Evidence-Based Treatment Center (206- 374-0109)

Skagit county (CETA)

- Mt. Vernon Compass Health

Yakima county (PE and CPT)

Yakima Comprehensive Health

Snohomish (CETA)

- Seamar
- Compass

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OTHER RESOURCES

- International Society for Traumatic Stress Studies
  - www.istss.org
  - Multidisciplinary community of practitioners and researchers
  - CEU's, webinars, conferences
- National Centers for PTSD
  - www.ptsd.org
  - Videos, assessment materials, tutorials

QUESTIONS? CASE EXAMPLES?

Thank you!

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