

Letters

Trajectory of PTSD Symptom Change in the Course of Exposure Therapy Among Veterans With Severe Mental Illness

TO THE EDITOR: The posttraumatic stress disorder (PTSD) treatment outcome literature for individuals with severe mental illness is growing but remains underdeveloped compared with outcome literature for other traumatized groups (1–3). Collectively, these studies suggest that specialized PTSD interventions are effective for this population and result in statistically significant reductions in PTSD severity from baseline to postintervention or between active and control group conditions. Data further suggest that PTSD interventions can be delivered without significant distress to this patient population or without exacerbations in the primary symptoms of severe mental illness. To better understand how individuals with severe mental illness respond to PTSD treatment, we compared the trajectory of PTSD symptom change between a sample of 55 veterans with PTSD and severe mental illness and a sample of 65 veterans with PTSD but without severe mental illness who presented for treatment at a southeastern Veterans Affairs medical center and who were enrolled to receive prolonged exposure therapy for PTSD (4).

Assessments for the study were conducted between January of 2008 and June of 2014 with full approval from appropriate institutional review boards. Structured diagnostic interviews were used to confirm a diagnosis of PTSD in both groups and to confirm the presence of a diagnosis of severe mental illness in the PTSD–severe mental illness group (including psychotic disorder, bipolar disorder, or severe depression coupled with history of psychiatric hospitalization, medication management, or assistance in daily living). PTSD symptoms were monitored with the PTSD Checklist (PCL) during treatment (5). A mixed-methods repeated-measures (MMRM) model with unstructured covariance was used for comparing PCL posttreatment means and response profiles for veterans with and without a severe mental illness.

Results revealed that veterans with PTSD and a severe mental illness had higher PCL scores at baseline (mean $\pm$ SD = 66.7 ± 8.9 versus 61.4 ± 12.3 , $p = .009$), were more likely to be female (35%, $N = 19$ of 55, versus 0%, $N = 0$ of 62, $p < .001$), and were less likely to be veterans of Operation Iraqi Freedom or Operation Enduring Freedom (36%, $N = 20$ of 55, versus 66%, $N = 43$ of 65) compared with veterans with PTSD only. Despite these baseline differences, veterans in the two groups completed a comparable number of treatment sessions (median = 8.0, mean $\pm$ SD = 7.5 ± 4.4 , versus median = 9.5, mean $\pm$ SD = 7.9 ± 3.8 , for PTSD/severe mental illness and PTSD-only

groups, respectively; $p = .687$, Wilcoxon rank sum test). Comparisons between veterans with and without a severe mental illness revealed that the two groups had similar PCL response profiles (MMRM: diagnosis group $\times$ time interaction, $p = .434$). Difference in least-squares-adjusted means at post-treatment for the PTSD/severe mental illness group versus the PTSD-only group was not statistically significant, and both groups significantly improved over the course of treatment (from MMRM: main effect of time, $p < .001$). Coupled with other published data, the study suggested that frontline PTSD interventions can be delivered as developed for persons with and without a severe mental illness with fairly comparable gains. That is, individuals with a severe mental illness do not appear to respond to PTSD interventions in a way dramatically different from their PTSD-only counterparts or in a manner that suggests the need to modify how PTSD interventions such as prolonged exposure are delivered.

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An Automated Text-Messaging System to Monitor Emotional Recovery After Pediatric Injury: Pilot Feasibility Study

TO THE EDITOR: We piloted in 2015 an automated daily text-message-based self-monitoring service to track emotional

recovery of adults hospitalized after traumatic injury in our level I trauma center (1). Data indicated high feasibility and patient satisfaction with this service, which yielded an 83% participation rate and 63% daily response rate and has since been integrated into standard care within our trauma center. Self-monitoring of symptoms after traumatic events, also characterized as “watchful waiting,” is consistent with best practice guidelines and may improve continuity of care, particularly in trauma centers and other settings in which mental health risk is high and mental health screening and follow-up are generally poor (2). We extended our prior work with adults by examining the feasibility of this approach with adolescents and their caregivers recruited from our level I trauma center.

Nineteen traumatically injured adolescents (ages 11–18 years) and their caregivers were enrolled at the time of their hospital admission. Each adolescent and caregiver received one daily symptom-tracking text over a period of 30 days. Each text administered one item from the well-established Kessler-6 measure of psychological distress (sample item: “How much of the time today did you feel hopeless?”). These messages were sent on a rotating schedule and staggered across participants. Patients were advised that the system was not actively monitored for sensitive or urgent content and that alternative channels should be used for urgent or emergency communications. No sensitive or urgent communications were received throughout the study. Semistructured interviews were administered via telephone one month post-injury. Youths completed the posttraumatic stress disorder and depression modules of the National Survey of Adolescents (3), and caregivers completed the Kessler-6.

Nearly all adolescents (95%, $N=18$) and all caregivers (100%) responded to at least one text message. The mean $\pm$ SD daily response rate for adolescents and caregivers was $88\% \pm 26\%$ and $97\% \pm 6\%$, respectively. Caregiver and adolescent response rates were moderately correlated ($r=.51$). Caregiver response rates were associated with caregivers’ own distress at baseline ($r=.37$) and at one month ($r=.41$); they were moderately correlated with adolescent PTSD symptoms ($r=.43$) and depressive symptoms ($r=.36$). Most adolescents (81%, $N=15$) and caregivers (58%, $N=11$) found the messages helpful. Four (21%) adolescents met criteria for PTSD; three (16%) met criteria for depression. These patients received treatment referrals.

These data are encouraging and reflect very high adolescent and caregiver engagement rates, with a daily response rate that was 25 percentage points higher than and that used methodology consistent with what we reported in our pilot with adults. Text-messaging services are highly accessible because approximately 95% of the total U.S. population owns a cell phone. Integrating such services into routine trauma care therefore appears to be highly feasible and consistent with recommendations from the American College of Surgeons 2014 guidebook (4) to screen for emotional recovery after injury. Moreover, because text-messaging systems can be automated with low cost to maintain, this approach

has the potential to be efficiently integrated into stepped-care models to monitor and facilitate emotional recovery after traumatic injury. Finally, this approach has relevance to a wide range of vulnerable populations, such as disaster survivors, primary care patients, and others for whom stepped-care intervention models might be suitable.

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Follow-Up After Discharge From an Inpatient Psychiatric Facility

TO THE EDITOR: Individuals discharged from inpatient psychiatric facilities (IPFs) require timely follow-up care to maintain their functioning and avoid or delay future hospitalizations (1,2). Despite the importance of follow-up care, there is surprisingly little national data to describe whether individuals discharged from IPFs receive timely services in the community.

We used calendar year 2008 Medicare fee-for-service (FFS) claims data that included 50 states and the District of Columbia to measure the receipt of follow-up care within seven and 30 days of IPF discharge. We implemented the specifications for the Follow-up After Hospitalization for Mental Illness measure that health plans report for the Healthcare Effectiveness and Information Data Set (HEDIS) (3). Follow-up care was defined as a visit with a psychiatrist, psychologist, psychiatric nurse, or social worker. We calculated facility-level follow-up rates and then aggregated rates by state and region. Medicare enrollees who were also enrolled in Medicaid or Medicare Special Needs Plans were excluded because we did not have their complete data. A

data use agreement with the Centers for Medicare and Medicaid Services (CMS) governed data security.

We identified 61,871 FFS Medicare discharges with a principal mental health diagnosis from 1,669 IPFs (both freestanding facilities and hospital psychiatric units). On average, 28.7% of discharges received follow-up care within seven days and 53.5% within 30 days across all facilities and states. Average facility-level 30-day follow-up rates ranged from 35.7% to 73.7% across states. [A table showing state-level follow-up rates is available as an online supplement.] On average, 30-day IPF follow-up rates were lower in southern and western states (49.1% and 46.2%, respectively) relative to eastern and midwestern states (59.0% and 58.6%, respectively).

Compared with Medicare health maintenance organizations (HMOs) that reported this measure to HEDIS in 2008, the average seven-day follow-up rate for the Medicare FFS population included in this study was 10 points lower (38.1% versus 28.7%, respectively), whereas the 30-day follow-up rates were similar (56.5% among Medicare HMOs versus 53.5% in this study) (4). It is possible that HMOs use care management strategies that result in a higher proportion of their enrollees' receiving timely follow-up care relative to the Medicare FFS population.

We report these findings to stimulate quality improvement efforts and further research. In the future, CMS plans to report facility-level follow-up rates for IPFs via the Inpatient Psychiatric Facility Quality Reporting program. These findings serve as a benchmark from which to measure progress. Given that our findings are based on claims, we cannot fully explain the source of variation in follow-up care. Some variation could be attributable to differences across states or regions in the availability of providers who accept Medicare or wait times for those providers. Follow-up rates may reflect broader investments in community mental health services; it is notable that per capita state spending on community mental health services was lower in many southern and western states relative to midwestern and eastern states during the study period (5). These findings provide a foundation for policymakers and researchers to investigate these possible sources of variation and identify strategies to improve the receipt of follow-up care.

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Exacerbation of Psychiatric Symptoms of Undocumented Immigrant Patients Under a New Administration

TO THE EDITOR: Although 11 million undocumented immigrants live in the United States (1), there has been no research on the psychiatric effects of President Trump's executive orders restricting immigration. Many psychiatric providers care for immigrants. We report clinical interviews of three undocumented immigrants seen in the adult outpatient clinic at NYC Health+Hospitals/Kings County in Brooklyn, New York, since the 2016 Presidential election. These patients now experience psychiatric symptoms after changes in immigration policies.

Patient 1 is a 23-year-old female from El Salvador with prior depression. In recent weeks, she has been increasingly anxious about the threat of deportation. She has described new symptoms of believing that immigration officials are "watching me through the window." She has two young children, ages two and three, who are U.S. citizens. Her biggest fear is separation from her children if she is deported.

Patient 2 is a 44-year-old male from Jamaica with no past psychiatric history who recently came to our clinic reporting increased anxiety and worry that he may get picked up off the street at any moment and deported. He reports being more hypervigilant and having more insomnia since the election. He is most fearful of being separated from his two children, ages five and seven.

Patient 3 is a 41-year-old male from Mexico with prior posttraumatic stress disorder (PTSD) and panic disorder. He was maimed with a knife in 2005. In the past three weeks this patient has had increased frequency of panic after reports in the media of immigrants being picked up and deported. He avoids going out into public places. He saw a man with a two-way radio device on the subway who he perceived to be an immigration officer. He fears he may become separated from his 18-year-old son if he is forced to return to Mexico.

The threat of being separated from their children exacerbated symptoms of all three patients. Undocumented patients have a significantly greater number of psychosocial stressors compared with legal residents and U.S.-born citizens (2). Deportation is an additional trauma that should be

addressed as another dimension in the biopsychosocial formulation. Included in the clinical interview should be inquiry into a patient's legal status and how the individual feels about recent political events. These patients may fear that having a psychiatric diagnosis could impair their future ability to secure legal immigrant status. Therefore, sensitivity to and reassurance of confidentiality is required (3). Clinicians can sympathize with these patients' very human fears of being separated from their family rather than viewing them as "illegals."

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Datapoints columns must include one figure or table, and because the column is limited to one printed page, it is therefore limited to 350–400 words. Submissions with multiple authors are discouraged because of space constraints.

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