This Month's Highlights

Telephone Support for Veterans With PTSD

The lead article describes disappointing findings from an aftercare protocol for veterans with posttraumatic stress disorder (PTSD) treated in residential rehabilitation programs. The U.S. Department of Veterans Affairs (VA) provides its most intensive PTSD treatment in such programs, but many veterans continue to have difficulties after discharge. The randomized controlled trial, conducted by a team led by Craig S. Rosen, Ph.D., assessed the effects of adding telephone care management to usual aftercare. More than 800 veterans from five residential programs were randomly assigned to usual aftercare or to aftercare enhanced with telephone care management. For the first three months, the latter group received biweekly calls from mental health specialists that involved brief assessment and support. Data from four- and 12-month follow-ups did not support any of the team's hypotheses about improved treatment engagement and outcomes. One reason for the negative findings, the authors note, was that the intervention was based on an incorrect assumption that poor outcomes are attributable to poor outpatient adherence. The study participants were high utilizers of postdischarge care, and there may have been little incremental value in providing a telephone contact every 14 days (page 13). In Taking Issue, B. Christopher Frueh, Ph.D., calls on VA leaders "to reflect on why veterans with PTSD are not benefiting from treatment, especially when civilians with PTSD do." He notes that most of the veterans in the study were receiving VA cash disability payments and that "virtually all patients have a powerful secondary-gain incentive to remain symptomatic" (page 1).

PTSD Pharmacotherapy: Clinical Uncertainty

Although practice guidelines recommend against using benzodiazepines to treat PTSD, nearly a third of veterans with the disorder who sought care in 2009 from the Veterans Health Administration (VHA) received a benzodiazepine prescription. To understand factors underlying the apparent uncertainty among VHA clinicians about the role of these drugs in PTSD treatment, Brian C. Lund, Pharm.D., M.S., and colleagues examined 1999–2009 data from 137 VA medical centers in 21 networks in four U.S. regions. Although the extent of variation in benzodiazepine prescribing practices decreased over time, particularly at the network and regional levels, substantial variation persisted between VA facilities. The authors suggest that targeting interventions to facilities with high rates of benzodiazepine prescribing may be an efficient strategy to promote guideline-concordant care (page 21).

Incarceration of Iraq and Afghanistan Veterans

According to a report by the U.S. Department of Justice, 10% of prison inmates are veterans. In 2007 the VHA created an outreach program called Health Care for Reentry Veterans (HCRV) to connect veterans with services after prison release to prevent recidivism. Studies of earlier generations of veterans found that a large proportion of those who became incarcerated had psychiatric and substance abuse problems and a high rate of homelessness. Jack Tsai, Ph.D., and colleagues examined data for veterans served by the HCRV program. They were particularly interested in identifying characteristics of a younger generation of veterans—those who served in Iraq and Afghanistan. Their data indicated that these veterans were less than half as likely as other veterans to end up in prison but three times more likely to have combat-related PTSD. The authors note that the HCRV program may be especially helpful for this subgroup (page 36).

Setting National Priorities for Suicide Prevention

More than 36,000 people in the United States die by suicide every year. Authors of this month's Open Forum call on researchers "to strategically apply science" to the public health problem of preventable suicide. Beverly Pringle, Ph.D., and coauthors note that research "can point to promising directions, but action—making improvements and monitoring success—is the purview of policy makers, agency heads, and system leaders. The key is in knowing whom to target, with which interventions, and in what order of priority." With this in mind, the authors outline a four-step conceptual approach to prioritizing research in this area (page 71).

Briefly Noted . . .

- Using the case of Anders Breivik, who murdered 77 people in Norway in 2011, the Law & Psychiatry column weighs issues involved when an insanity defense is imposed on an unwilling defendant (page 4).
- Living Well, a peer-led intervention, shows promise in helping people with mental illness manage general medical conditions (page 51).
- The Economic Grand Rounds column addresses whether it is possible for a state to implement an involuntary outpatient commitment program without the allocation of additional funds (page 7).