Capsule Commentary on Meredith et al., Impact of Collaborative Care for Underserved Patients with PTSD in Primary Care: A Randomized Controlled Trial

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The randomized clinical trial by Meredith et al. showed that collaborative care and minimally enhanced usual care were equally effective for post-traumatic stress disorder (PTSD).[1] The improvement rates in both groups were remarkably high, with effect sizes for PTSD severity reduction exceeding 1.5 SD and nearly 60 % of participants no longer meeting diagnostic criteria for PTSD at 1 year. Reasons for a negative trial might include enrollment of patients with less severe PTSD and a more favorable natural history, a stronger than expected effect of training in the enhanced usual care group, or a weaker than expected collaborative care intervention.

The CALM trial for anxiety disorders in 1004 primary care patients showed a moderate but nonsignificant effect size of 0.48 for PTSD; however, only 6 % of participants had a principal diagnosis of PTSD.[2] In two primary care trials involving Veterans, one showed a minimal effect on PTSD severity,[3] whereas the second showed a modest effect size of 0.31 to 0.45.[4] However, the first trial[3] was conducted in VA Medical Centers where patients had ready access to mental health, resulting in an average of 4.2 psychotherapy visits in both collaborative care and usual care groups. In contrast, the second trial[4] enrolled from community-based clinics often located in rural areas, leading to far more psychotherapy sessions in the telecare group compared to usual care group (4.2 vs. 0.8). Notably, both this latter trial and the CALM trial assured more uniform delivery of evidence-based psychotherapy than either of the two negative trials.

In contrast to this small number of collaborative care trials with mixed results for PTSD, there have been more than 70 trials establishing the benefits of collaborative care for depression.[5] Whereas medications and psychotherapy are equally effective for depression, psychotherapy may be especially important for optimal outcomes in PTSD. It is also possible that the type of trauma (e.g., combat, interpersonal violence or abuse, accidents or natural disasters) and severity of symptoms may lead to differential treatment responses. The movement towards integrating medical and behavioral health services may be most critical for disorders where pharmacotherapy alone is insufficient.

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Compliance with Ethical Standards:

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