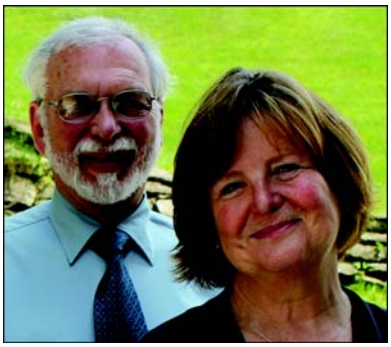

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JRRD Guest Editorial

2010 VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress: How busy clinicians can best adopt updated recommendations

The continued wars in Iraq and Afghanistan have brought an increased focus on posttraumatic stress disorder (PTSD) and have made PTSD a part of a national conversation. Since the first edition of the Department of Veterans Affairs (VA)/Department of Defense (DOD) Clinical Practice Guideline (CPG) for PTSD was issued in 2004 at the beginning of these conflicts, more than 750,000 returning new Veterans have sought mental health care in the VA. It is anticipated that this number will climb dramatically as more than 1 million Veterans will leave the military in the next 5 years. This makes it all the more important that VA and DOD healthcare providers have clear guidance on best management practices for PTSD and an understanding of how they can best use the revised *VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress* issued in the fall of 2010. As coeditors, our goal with the production of this special issue of *JRRD* is to publish a series of articles that go beyond the recommendations in the new CPG by providing, in addition to a comprehensive overview of the latest scientific evidence, practical guidance for busy clinicians who wish to adopt the CPG recommendations within their various clinical settings.

The Veterans Health Administration (VHA) has taken significant steps to meet the needs of returning Veterans. In the guest editorials that follow, leadership in VHA's Office of Mental Health Services outlines the transformation that has occurred in the effectiveness of mental health care in the VA. For the first time, a standard for providing mental health treatments across VHA was established in the Uniform Mental Health Services Handbook that defines the clinical services any Veteran can expect from any VA facility. Foremost among available treatments are very effective evidence-based psychotherapies for PTSD. As reviewed in the guest editorials, large numbers of clinicians have been trained in PTSD first-line psychotherapy treatments, such as prolonged exposure and cognitive processing therapies. In addition, substance use disorder (SUD)/PTSD specialists have been hired to manage the common co-occurring disorders. Postdeployment clinics have been created to address specific reintegration needs of returning Veterans. Primary Care Mental Health Integration Teams have been established to assess and offer brief mental health treatments in an interdisciplinary, coordinated primary care environment. PTSD residential treatment settings have gone through significant system redesigns to meet the needs of returning Veterans, and their treatments have significantly improved outcomes. Perhaps the biggest paradigm shift has been the emphasis on a recovery-oriented model in which individually-focused treatment plans, services that go well beyond symptom management, are developed that also address the unique needs of the

Veteran and his or her family.

The National Center for PTSD (NCPTSD) has worked within the VA's Office of Mental Health Services to meet the demands of increasingly complex clinical presentations in which PTSD is often accompanied by comorbid diagnoses (such as depression, SUD, and traumatic brain injury [TBI]) and co-occurring problems (such as insomnia, pain, and aggressive behavior). Specifically, NCPTSD has developed new programs, such as the PTSD Mentoring Program and the PTSD Consultation Program. The PTSD Mentoring Program provides administrative support to PTSD specialty clinic directors through a sharing of best practices and creating a working network of PTSD clinicians. It has now been complemented by the PTSD Consultation Program, which offers expert, one-on-one consultation to any VHA provider or contractor treating any Veteran with PTSD. This program offers providers an opportunity to discuss complex case presentations and get treatment suggestions, medication advice, and recommendations for care management from top experts in PTSD treatment. During the past 3 years, NCPTSD has provided a monthly series of national lectures by authorities in the field. NCPTSD has also developed online courses on its Web site at www.ptsd.va.gov that illustrate the recommendations in the PTSD CPG and allow clinicians to take these courses to obtain continuing education credits at their own pace. All of this work has been done to disseminate the recommendations in the updated CPG.

The last special issue on PTSD in *JRRD* was edited by our NCPTSD colleague, Dr. Terry Keane, in 2008. With the update of the CPG, we appreciate the opportunity to showcase articles written by some of the outstanding clinicians in the field to illustrate best practices regarding first-line pharmacotherapy and psychotherapy treatment recommendations as well as to offer guidance on early interventions and family and group treatments. Specific symptoms such as pain, TBI, anger/aggression, and insomnia are addressed separately and offer particular guidance for primary care clinicians to whom returning Veterans often present with these symptoms. A discussion about the role of functional impairment is also included. We hope that the articles serve as a useful resource for clinicians working with patients with a diagnosis of PTSD and offer guidance in a format that is more user-friendly than diagrams and tables.

A guest editorial written by three members of the CPG workgroup describes the rigorous and arduous process through which the new recommendations were developed. The workgroup that developed the CPG did its best to provide an overview of the current state of knowledge by reviewing the entire scientific literature on PTSD treatment. As noted by Dr. Keane in 2008, there remains a great deal that we still do not know, and therefore, a great deal of research that needs to be done. Future research will have to address questions such as who will benefit most from particular psychotherapy treatments, what should be done to evaluate the best choice of a specific medication, how we will know whether someone will benefit from group treatment versus individual therapy, and a multitude of other questions. We recognize that a CPG is a living document that will be challenged by new research in the future. But for now, this issue of *JRRD* presents the best evidence-based recommendations and practices that can be offered, with our hope that it helps move the field forward and provides useful guidance for treating Veterans with PTSD.

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