PTSD: the need to use emerging knowledge to improve systems of care and clinical practice in Australia

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There is a major failure to develop an integrated public health policy for the health systems management of the morbidity of the effects of traumatic stress in Australia. The multiple and uncoordinated funding streams for care have led to fragmentation of services, which in turn has disrupted the opportunities for developing a national network of academic centres of clinical excellence. The magnitude of the problem was demonstrated by the 2007 National Mental Health and Wellbeing Survey that found posttraumatic stress disorder (PTSD) was the most prevalent disorder in the country, with a 12-month ICD-10 criteria prevalence of 4.4%.1 The morbidity of depression and PTSD have similar impacts in terms of function and impairment,2 yet any coordinated advocacy for PTSD lags significantly compared with depression.

The burden of disease arising from traumatic stress exposure is even greater, being an important aetiological factor across the spectrum of psychiatric disorders including affective disorders, schizophrenia, substance abuse and personality disorder.3,4 The devastating consequences of the inadequate management of childhood trauma are systemic problems, as highlighted by the Royal Commission into Institutional Response to Sexual Abuse.5 The fragmented approaches to the mental health of emergency service personnel and the stigma and prejudice driven by the management of compensation claims with these individuals are issues that have gained national focus.6 The challenge of providing adequate care for current military personnel and veterans has also been highlighted by the recent Mental Health Commission report into veterans’ suicide.7

The risk of downgrading the quality of care

Despite this weight of evidence, there is risk that the quality and range of services available for PTSD and other trauma-related disorders may decline. One important contributor is that Repatriation Hospitals have now largely been privatised or devolved to state health systems, and no longer provide the same coordinated network that provided critical opportunities for training the next generation of mental health professionals in the field of dealing with the effects of traumatic stress. The Department of Veterans’ Affairs (DVA) depends on contracting treatment services rather than developing, training and sustaining a national clinical network. This is occurring against the background of State Governments not providing any coordinated system of care for victims of trauma that arises in many domains, including motor vehicle accidents, sexual assault and domestic violence. To the contrary, State Government policies, given by their desire to decrease their liability for the psychological injuries arising from motor vehicle accidents and the compensation costs of injuries to emergency service personnel, have, if anything legislated to limit their insurance liabilities, and in so doing are deliberately limiting the ongoing funding for treatment and care for these groups.8 The absence of a ‘Whole of Government’ approach is a striking demonstration of attempts at ‘cost shifting’ to the Commonwealth Government. Furthermore, the fragmentation of health care due to the divide between the State and Federal Governments is further aggravated by the lack of co-ordination of the important contribution made by the private health system.

The superficial coverage of PTSD in some clinical psychology programmes and in the training of psychiatric registrars means that the next generation of therapists are not necessarily well prepared for the challenges of...
practice. There are limited opportunities for clinical placements in training, which means that there is the risk of there being an insufficient highly skilled workforce in Australia to provide evidence-based care in a coordinated and tiered structure of clinical services. Despite Australia having been a leader internationally in research in this field, this has not translated into innovative service delivery models. While Federal Government/DVA funding for Phoenix Australia has provided a critical centre of excellence, including for professional development, and there are pockets of clinical and research interest, demonstrated by the contributions this edition of the Journal, many challenges remain to improve the quality of care.

The need for neuroscience informed treatment

Although neuroscience research has contributed major understanding as to the mechanisms of psychopathology in PTSD, this has not led to any notable advances in treatment. The lack of innovative treatment is reflected when comparing the first treatment guidelines published by the International Society of Traumatic Stress Studies with those produced by the Australian Centre for Posttraumatic Mental Health in 2013, demonstrating few differences. While evidence-based care is critical to improving treatment outcomes for PTSD, 66% of patients in military populations who have received cognitive processing therapy after prolonged exposure remain with a diagnosis at the end of care. The significance of the substantial residual impairment remaining at the end of treatment is highlighted by the fact that approximately four-fifths of the participants in these treatment trials were also taking psychotropic medications. The repertoire of evidence-based care had been expanded, but substantial disability still remained. While it remains the case that the trauma-focussed therapies had the greatest benefits in treatment, their limitations emphasise the need for a coordinated strategy to improve treatment outcomes.

First, it remains that there is a need to have a more individualised approach to the targeting interventions offered in the treatment of PTSD according to the type and stage of a patient’s presentation. In contrast to depression, where there have been a series of recent innovations predicting treatment outcome, there is a poverty of such research in PTSD. For example, in major depressive disorder, amygdala reactivity to emotional faces has been found to predict non-response to Venlafaxine in contrast to selective serotonin reuptake inhibitors (SSRIs). C Reactive Protein (CRP) levels have a been able to predict the class of antidepressant response, with CRP greater than 1 mg/l predicting better response to a combination of SSRI and bupropion. It is worth noting that, in contrast to the considerable evidence base for the pharmacological treatment of depression, there is currently limited evidence about their effectiveness as frontline treatment for PTSD. This finding may partly be accounted for by their lack of efficacy in certain subtypes of PTSD that may be defined by yet to be identified biomarkers.

Despite the range of psychophysiological and neurobiological abnormalities demonstrated in PTSD, including inflammation, no predictive trials for treatment outcomes have been conducted to date. These type of trials need to be considered in the context of the significant percentage of people who do not adequately respond to evidence-based treatments. If neuroscience is to be integrated into clinical care in Australia, which is currently discouraged because of the structure of the medical benefits schedule, remunerating many well-established tests of information processing, specialised research clinics will need to do clinical pathological correlations where an agreed suite of neurobiological tests are conducted on patients prior to planning treatment interventions after an inadequate response to the primary evidence-based interventions. These will allow the development of predictive algorithms so as to optimise the choice of care. At the present time, the failure to develop a knowledge base or approach to treatment non-responsive populations is a major problem. Such an approach should be a driver for the establishment of ‘Centres of Excellence’ addressing national and local issues that are funded both by the Commonwealth and State Governments. Given the morbidity from motor vehicle accidents, victims of crime, child abuse and neglect as well as veterans and emergency service personnel, the clinical need is apparent for the development of these services. These centres would also be an invaluable resource for the management of disasters and terrorist attacks. There is a need for a shared vision that endorses the benefit of the development of such intervention strategies, rather than accepting relatively poor-quality outcomes.

Furthermore, treatment of PTSD needs to address the recent formulation that PTSD is a systemic disease. The extent of somatic symptoms, such as chronic pain and psychophysiological disorders and comorbid physical disorders, needs an integrated focus of treatment and rehabilitation.

The critical advocacy role of health professionals

Health professionals, particularly psychiatrists, psychologists and general practitioners, carry the accumulated intimate knowledge of the challenges the system presents to patients. This role brings with it the responsibility to advocate for improvements to the systems of care. Unfortunately, the inertia of some Federal and State Government bureaucracies creates little incentive for health professionals to proactively lobby for better mental health care for survivors of trauma. If we are to be an innovative nation regarding mental health care, we cannot afford to ignore knowledge or the opportunity for improving clinical outcomes and decreasing the substantial morbidity that accidents, disasters, crime and child abuse cost society in a multitude of ways. Treatment
services that address the impact of traumatic stress deserve the quality of oversight and integration that occurs with cancer and cardiac care.

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References

Podcast
An interview with Prof A McFarlane on PTSD
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Professor McFarlane is the current director of the University of Adelaide’s Centre for Traumatic Stress Studies. In this podcast, he talks about his work with the United Nations after the Iraq invasion of Kuwait, recording and responding to the trauma of modern warfare with its systematised brutalisation of an entire population. Professor McFarlane identifies current gaps in treatment and support of patients with traumatic illness, with a growing awareness of the importance of trauma responses in serious mental illness, the neurobiological underpinnings of resilience and sensitisation, and the need for greater attention to the recognition and treatment of mental health training.

Cover art
The cover art by Ruth Rich comes from the Cunningham Dax Collection. The artwork has been chosen to reflect the articles on posttraumatic stress disorder that are featured in this issue. The artist says about her artwork:

“I have dealt with the topic by focusing on my own personal journey, that of a contemporary artist coming to terms with and reconciling a family history that embraces the fact that my parents, brother, grandparents and most of my extended family underwent the horrors of Hitler’s death camps. Many perished, some survived but none escaped unscathed. I have sought to portray the agony and enlightenments of my personal journey.”

About the Cunningham Dax Collection
The Cunningham Dax Collection consists of over 15,000 artworks created by people with an experience of mental illness and/or psychological trauma. The art includes works on paper, paintings, photographs, poems, textiles, sculpture, journals and digital media. The unique Cunningham Dax Collection is now one of the largest of its kind, with only two other similar collections of comparable size and stature: the Musée Art Brut in Lausanne, Switzerland, and the Prinzhorn Collection in Heidelberg, Germany.

The Dax Centre is a not-for-profit organisation that relies on the generosity of the community to carry out its mission of promoting mental health through art. We aim to