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REVIEW ARTICLE

Redesigning trauma-focused interventions to address capacity challenges in mental health systems

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Abstract

Despite strong evidence supporting the use of trauma-focused evidence-based psychotherapies (EBPs) to treat posttraumatic stress disorder (PTSD), health care systems experience meaningful challenges in delivering these treatments at scale. With a focus on two large, integrated health care systems (Military Health System, Veterans Health Administration), we discuss the challenges to scaling up access to EBPs for PTSD, as well as proposed strategies to mitigate these challenges. We identify three primary barriers to delivery of EBPs for PTSD: insufficient staffing, difficulty connecting patients with EBP-trained providers, and structural inefficiencies characteristic of the weekly therapy model. We review emerging strategies to redesign the delivery of EBPs for PTSD, including accelerated delivery formats, alternative delivery settings, task-sharing, web- and app-based interventions, and the use of artificial intelligence. Taken together, these strategies represent promising opportunities to efficiently use limited staffing to increase access to EBPs for PTSD, while retaining or increasing intervention effectiveness. Further research is needed to determine how to most effectively integrate these strategies into a stepped-care model of treatment delivery, where redesigned approaches complement traditional EBP delivery models to address the real-world constraints of health care systems.

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Mental health systems in the United States face significant challenges in delivering first-line, trauma-focused evidence-based psychotherapy (EBP) for posttraumatic stress disorder (PTSD). A chronic shortage of specialty providers, which is a global problem, makes it nearly impossible to meet the need for behavioral health care while relying on the traditional outpatient model of weekly, 1-hr psychotherapy sessions. In this review, we describe the scope of the challenge for mental health systems to deliver recommended EBPs for PTSD, which include prolonged exposure therapy (PE; Foa et al., 2019), cognitive processing therapy (CPT; Resick et al., 2024), and eye movement desensitization and reprocessing (Shapiro, 2018; U.S. Department of Veterans Affairs/Department of Defense [VA/DoD], 2023) as well as suggested EBPs for PTSD, such as written exposure therapy (WET; Sloan & Marx, 2019). We focus on the Military Health System (MHS) and Veterans Health Administration (VHA), two integrated health systems in the United States with a long history of monitoring behavioral health care quality; however, most of the issues discussed herein are also relevant to community behavioral health care. We then focus on the need for alternative strategies for disseminating and delivering EBPs for PTSD that optimize efficient use of scarce staff time while retaining or increasing intervention effectiveness.

IMPLEMENTATION OF EBPs FOR PTSD

The MHS provides behavioral health services through direct care at military treatment facilities (MTFs), where most active duty personnel receive care, and through private-sector care contracted through TRICARE (i.e., the main health care program for active and retired military personnel and their families), where most beneficiaries receive care. Active duty personnel may be referred for private-sector care when MTFs are unable to provide access to timely care, which is increasingly common. In Fiscal Year 2023, private-sector care accounted for 30.6% of specialty care visits covered by TRICARE, twice the proportion that was covered only 2 years prior (Defense Health Agency, 2024). Data from a multisite trial of eight MTFs found that half of all service members with PTSD seeking behavioral health care receive one or more sessions of an EBP for PTSD, and fewer than one in 12 received eight or more sessions of an EBP (McLean et al., 2026; Rosen et al., 2020).

Similar to the MHS, behavioral health care in the VHA can be received directly at a VHA facility or purchased by the VHA and received in the community. The vast majority of behavioral health care in the VHA, however, is provided directly. For example, recent research shows that only 3% of outpatient behavioral health visits are received in the community (Vanneman et al., 2023). Within the VHA, veterans with PTSD may be seen in a variety of contexts, including primary care mental health settings, general outpatient behavioral health settings, or specialty PTSD clinics. Further, for individuals with especially clinically complex presentations, the VHA offers residential PTSD treatment, which can provide access to services while minimizing the impact of concurrent psychosocial stressors (e.g., housing instability) or comorbidity (e.g., substance misuse). Clinicians are expected to offer EBPs for PTSD within these settings, consistent with the VA/DoD (2023) clinical practice guideline (CPG), as part of shared decision-making. However, research shows that only 22% of veterans with PTSD who are receiving psychotherapy within the VHA initiate either PE or CPT, the two most commonly used EBPs for PTSD in the VHA (Holder et al., 2020). Among veterans who receive an EBP for PTSD, only half (46.7%) receive an adequate dose of eight sessions within 6 months, with an average of 12 days between sessions in the 6-month treatment course (Holder et al., 2025).

The limited research on the provision of EBPs for PTSD in community settings in the United States suggests that fewer than one in five providers regularly implement VA/DoD CPG–recommended EBPs for PTSD (e.g., Franklin et al., 2026). In a recent investigation of community care records, significant incongruencies with VHA standards were observed in community care records, including a lack of shared decision-making, measurement-based care, and suicide risk assessment. Survey studies of providers outside the DoD found that only 30% "often" or "always" used the psychotherapy techniques associated with EBPs for PTSD and depression (Tanielian et al., 2014), and only 24% of TRICARE providers reported high military cultural competency, in contrast to 70% of MHS and VHA providers.

FACTORS THAT LIMIT ACCESS TO EBPs FOR PTSD

Research on PTSD treatment for both veterans and military service members highlights three major factors that limit the delivery of EBPs for PTSD: overall mental health workforce capacity, access to providers skilled in delivering EBPs for PTSD, and an overreliance on weekly provider-delivered care.

Mental health workforce capacity

Demand for psychotherapy continues to increase (Gao & Olfson, 2026). However, the supply of mental health

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providers is not increasing as quickly as the need for care. This disparity between psychotherapy demand and supply constrains the availability of psychotherapy and limits access to EBPs for PTSD. The MHS and VHA leverage a population-health approach. These systems prioritize timely access to an intake appointment for everyone in their patient populations who needs care. Ensuring this timely access often requires increasing caseloads. Larger caseloads can contribute to longer wait times, especially for appointments after the initial intake, and reduce the average amount of care available per patient. Data from our multisite trial of eight MTFs (Rosen et al., 2020) demonstrated that higher patient (demand)-to-appointment (supply) ratios were linked to longer wait periods between appointments, and both were linked with a lower probability of receiving a minimally adequate dosage of care (McLean et al., 2025). These data showed that the average number of psychotherapy sessions for behavioral health patients was 2.5, and the average wait time between appointments was 21 days, including high-risk patients who are seen weekly. At this limited dosage, EBPs for PTSD are generally not feasible. Indeed, studies in both the MHS and VHA have found that longer intervals between EBP sessions predict a lower likelihood of completing treatment (McLean et al., 2026; Sayer et al., 2023).

Provider shortages are not limited to the MHS and VHA (Kakuma et al., 2011), and capacity challenges also impact access to EBPs for PTSD in community care. In the United States, one third of publicly listed psychotherapy providers do not accept insurance, further limiting the supply of providers available at affordable rates (Zhu et al., 2024). Community fee-for-service providers, especially individuals in private practice, have control over their caseloads and can decide whether and when to take on new patients. Smaller caseloads can make it easier for these individuals to provide psychotherapy at a weekly tempo, but in areas that are underserved, patients may experience long waits before they can find a provider with an opening for a new patient (Peipert et al., 2022).

Access to trained providers

In addition to overall staffing shortages, a second challenge is connecting patients with providers who have the training and skills to deliver EBPs for PTSD. The VHA provides much of its EBP care via a network of PTSD specialty clinics, which have trained staff and prioritize time-limited episodes of EBPs for PTSD. However, patients' initial intake is often in another setting (i.e., primary care, general mental health), resulting in the need to transfer between multiple providers before being assigned to a clinician who is able to provide an EBP for PTSD (Ranney et al., 2022). Approximately two thirds of veterans who initiate EBPs for PTSD do so more than a year after their first mental health visit (Holder et al., 2020). Additionally, veterans diagnosed with PTSD receive an average of 25 sessions of other types of psychotherapy before initiating an EBP for PTSD (Maguen et al., 2018). In recent qualitative work, we investigated both veteran and clinician perspectives on making the transition from other types of psychotherapy to an EBP for PTSD (Holder et al., 2025, 2026). These results highlighted poor communication about treatment options and treatment plans, as well as high perceived risks (and low perceived benefits) of changing from generalist to specialty providers. Such findings suggest that critical efforts are necessary to determine how to best support veterans' trajectory of care, given both delays in accessing recommended care and provider burden.

The MHS provides PTSD care in general mental health clinics and does not have PTSD specialty clinics. Over 70% of mental health providers report having some training in EBPs for PTSD (Hepner et al., 2018). However, most military treatment facilities do not have formal processes for routing patients to EBP-trained providers or ensuring protected time for repeated EBP sessions (McLean, Cook, et al., 2024). Thus, the PTSD treatment that service members receive is determined by the skill set and scheduling capacity of the provider they first see at intake.

In addition to the limited number of community providers who use EBPs for PTSD, there are also no good systems in place for identifying these providers. Patients often have little or no information about providers' training or skills. Moreover, patients are often unaware of their mental health diagnoses. As a result, they may not know what kind of expertise to search for, or they may search for providers with expertise in trauma, which could lead to a wider range of results. Insurance panel lists provide little information about providers' specialties. Some providers have websites detailing their services, but many do not. Patients are, therefore, often in the position of selecting whichever provider can see them soonest, without knowing much about the provider's treatment philosophy and/or level of expertise in trauma or PTSD.

Overreliance on weekly, provider-delivered care

Given these challenges (i.e., staffing shortages and difficulty identifying and accessing EBP-trained providers), solutions are needed that can increase access to EBPs for PTSD within the constraints of existing system resources. We argue that overreliance on individual, specialty, once-weekly psychotherapy as the primary format for behavioral health care is a key limiting factor for access to EBPs

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for PTSD. The standard model for delivering psychotherapy is through once-weekly sessions delivered by a highly trained mental health expert. Traditionally, sessions are delivered in person, though telehealth is now also considered standard care. This weekly care model, which is deeply rooted in historical practices and practical considerations (e.g., health care insurance billing, specialty care referrals from generalist clinics), may be therapeutically and practically appropriate for many patients. Indeed, when possible, patients' clinical needs and preferences can drive the scheduling of treatment sessions. However, the ubiquity of this model has downstream effects on system capacity that severely limit access to effective treatment, particularly in the context of provider shortages and other organizational barriers to EBP delivery (e.g., McGowan et al., 2026). When the default format is weekly sessions for all patients, the frequency of care can quickly expand to every other week or every month when the demand for services outstrips the supply of providers. As noted, when sessions occur less than weekly, the probability of receiving an EBP for PTSD or an adequate dosage of any intervention plummets.

Most of the evidence supporting EBPs for PTSD is from trials employing expert providers, and many patients with PTSD prefer in-person care. However, there are too few providers in general, and too few who use EBPs for PTSD in particular, to meet the demand for effective treatment. Moreover, patients with PTSD are open to receiving care in other ways. In one study we conducted, nearly half of VHA care–connected veterans with PTSD were open to receiving PTSD care through computer-based or app-based programs (Rosenfeld et al., 2026). Access to EBPs for PTSD will remain limited if providers and health care systems do not leverage a broader range of delivery formats, provider types, and modalities.

STRATEGIES TO INCREASE ACCESS TO EBPs FOR PTSD

Here, we outline several possible strategies for redesigning the delivery of EBPs for PTSD to maximize access within current system constraints.

Accelerated treatment delivery

Although once-weekly therapy is standard, it may not be the most effective tempo of care for all patients, particularly for disorders characterized by avoidance, including PTSD, or for trauma-focused treatments, which are emotionally demanding. In particular, increasing the frequency of EBP sessions can limit avoidance while increasing the therapeutic momentum and rate of learning, which can be reinforcing to patients and providers (see Roberge et al., 2025). Accelerated (i.e., massed) treatment formats, wherein sessions are provided multiple times per week, have been found to hasten recovery from PTSD and lower the risk of dropout (Hoppen et al., 2023). One of the first studies of accelerated PTSD treatment was conducted within the MHS. Foa and colleagues (2018) found that weekly PE delivered over 8 weeks was noninferior to daily PE delivered over 2–3 weeks, with significantly lower dropout. Subsequent studies have also supported the efficacy of accelerated EBPs for PTSD in military populations (e.g., Held et al., 2022).

The established network of residential PTSD programming makes the VHA uniquely poised for the implementation of accelerated formats in these settings. The VHA recently piloted an accelerated PTSD treatment program in six residential treatment programs nationwide that offer access to PTSD treatment, associated health services (e.g., primary care), and adjunctive care (e.g., substance use disorder programming). The results of the pilot showed that veterans who received accelerated PTSD treatment had significantly shorter lengths of stay as well as higher rates of treatment completion (R. Holliday et al., 2025). Critically, serious adverse events in intensive care were relatively rare, and rates of serious adverse events did not differ between the accelerated and standard modalities. At present, accelerated formats are not commonly implemented outside of established residential treatment programs and intensive outpatient programs in VHA.

For more widespread adoption of accelerated treatment models, provider training and administrative policy changes would be needed. For example, the VHA uses structured clinic scheduling grids that indicate availability for veteran appointments; these are not currently designed for accelerated treatment formats with multiple appointment times within a week. This is a barrier to establishing accelerated treatment in settings where therapists do not control their own clinic grids (Roberge et al., 2025). However, once established, broader adoption of accelerated treatment delivery models could increase access to EBPs for PTSD in two ways. First, a brief, intensive course of treatment may be more feasible for some patients than spaced therapy models, thereby expanding access to care to a subgroup of underserved patients. Second, accelerated treatment models may increase access to care, as patients complete treatment more quickly, freeing space for new patients to initiate care. Relatedly, if patients are more likely to get a full dose of care and recover from PTSD, this could result in fewer episodes of care and reduced health care utilization long term, thereby increasing the overall efficiency of the health care system.

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For service members, having a wider range of treatment tempo options increases the likelihood of finding a workable option that meets their needs. For commanders, intensive treatments offer an efficient platform for completing PTSD treatments, which may be an ideal way to support service members interested in remaining in the military after a traumatic experience or supporting them as they transition out of the military. By offering a wider array of intensive treatment options, including in-person and telehealth formats, the MHS may be able to more readily provide accessible mental health care to military service members, improving both readiness and wellness.

New delivery settings

Another approach to restructuring the delivery of EBPs for PTSD is expanding the settings in which treatment is delivered. Since the COVID-19 pandemic, most trauma-focused EBP care has been delivered through video telehealth rather than in person (Holder et al., 2025). Consistent with this reality of care, the VHA has established "clinical resource hubs" (CRHs), which are regional telehealth centers that can provide contingency staffing to overcome brick-and-mortar medical facility staffing shortages and geographic barriers for veterans (McGowan et al., 2026). CRHs often prioritize staffing specialty providers, ensuring access to specialty treatments regardless of where veterans live. During the early implementation phase of CRHs, specialty treatments are limited (e.g., suicide prevention); however, in the long term, this provides a model that can be used to expand access to EBPs for PTSD.

Other restructured versions of EBPs for PTSD can similarly improve the efficiency of the health care system by engaging patients in the spaces where they are already seeking care (e.g., primary care settings) and minimizing the need for referrals and transitions to provide access to effective care. Trauma-focused EBPs (e.g., WET) can be delivered in primary care (Fortney et al., 2025) or adapted to meet the demands of such settings. For example, PE for primary care (PE-PC; Rauch et al., 2017) distills the standard PE protocol of eight to 15 sessions of 90 min each into four to six sessions of 30 min each, while retaining critical therapeutic elements (i.e., in vivo exposure, imaginal exposure, emotional processing). The redesign overcomes often-cited administrative barriers to PE implementation that result from 90-min sessions (e.g., Sayer et al., 2017), as well as barriers that result from the transfer of care to specialty clinics through embedding in primary care mental health settings. Given this, it is plausible that other settings where individuals may be accessing services may hold merit as critical intercepts for providing EBPs for PTSD (e.g., VA Domiciliary Care for Homeless Veterans; VA Homeless Programs, n.d.).

A final consideration is how to translate alternative delivery models to the general community. The emergence of online therapy companies with large panels of telehealth providers could potentially provide an infrastructure for linking patients with therapists who have specialized skills. However, as noted, it is unknown how many of these community-based providers offer EBPs for PTSD. Moreover, it is unclear whether the staffing or expertise within community-based non–metal health service settings (e.g., community primary care) can support EBPs for PTSD; as such, further research remains necessary.

Task-sharing

Task-sharing the role of mental health therapist to involve less-expert professionals is an approach to increasing the availability of providers at a relatively low cost (Patel et al., 2011). Several studies have found that task-sharing can be used effectively to deliver skills-based, time-limited mental health interventions, including EBPs for PTSD. For example, one study found that PE was efficacious in reducing PTSD symptoms when delivered by trained non-specialist health workers (Rossouw et al., 2018). Another study found that an online version of WET delivered by peer coaches was effective in reducing PTSD symptoms (McLean, Malek, & Straud, 2024). In that trial, the peer coaches were VHA-certified peer counselors who had completed a 2-hr training in the delivery of WET and were provided with session-by-session guidance based on the WET manual. Fidelity to the treatment was acceptable; the peer coaches completed 82.5% of the intervention components based on a review of a random 15% of peer coach–patient chat transcripts. Thus, prior work indicates that task-sharing is feasible for certain EBPs for PTSD and can yield successful clinical outcomes.

The VHA has worked to incorporate peers into its continuum of mental health services in several ways. Although this does not currently include the direct provision of behavioral health treatment, there are many ways that peers could help support EBPs for PTSD, including facilitating connections and access to treatment as mentors and care coaches to augment and support treatment retention. Indeed, research has found that augmenting PE with instrumental peer support during in vivo exposure homework can reduce dropout (Hernandez-Tejada et al., 2025).

In the MHS, behavioral health technicians could be leveraged to increase access to EBPs for PTSD. Behavioral health technicians already serve as "provider extenders," supporting providers in delivering care to service members

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and their families (S. B. Holliday et al., 2019). These individuals are trained to perform various clinical tasks and are often involved in intake assessments, triaging patients, conducting risk assessments, and supporting the delivery of behavioral health interventions. The Office of the Surgeon General and the U.S. Army Medical Command Policy require that behavioral health technicians perform the full scope of their approved clinical duties, which could include assisting in the treatment of patients with trauma-related disorders (Psychological Health Center of Excellence Behavioral Health Technician Work Group, 2019). Moreover, a recent systematic review of studies of behavioral health technicians found that clinical outcomes when using behavioral health technicians were positive and that technician job satisfaction was positively linked with engagement in clinical care (Hodge et al., 2023). Moreover, the vast majority of both behavioral health technicians and behavioral health providers agreed that technicians could have a greater impact if they were trained to deliver psychosocial interventions (Hepner et al., 2022). This suggests that task-sharing the therapist role to behavioral health technicians may be an effective solution to increasing access to EBPs for PTSD in the MHS. Research is underway to evaluate this implementation strategy (McLean et al., 2026).

EBPs for PTSD vary in their complexity and corresponding provider training requirements. Thus, some treatments may be more well-suited for task-sharing than others. WET may be particularly suited for task-sharing because it is brief, highly structured, and requires less provider time relative to other EBPs for PTSD. For this reason, it may be more feasible to train behavioral health technicians or peer coaches in WET than other EBPs for PTSD. Either way, it is important to note that task-sharing would require time and resources for training and ongoing supervision to address licensure requirements. Further, interventions may need to be adapted to be within the professional scope for behavioral health technicians or peer support specialists. However, once established, task-sharing models could improve access to EBPs for PTSD by expanding the mental health workforce. Moreover, because some of the candidate staff may have greater availability to deliver sessions weekly or more frequently than behavioral health providers, these individuals may be able to provide care in accelerated treatment formats, which could improve treatment completion.

Web- and app-based interventions

Connecting patients with PTSD with digital resources that deliver evidence-based interventions or self-management tools is another strategy for increasing access to effective care within constrained mental health systems. For example, several studies have shown that exposure therapy for PTSD can be delivered safely and effectively through digital programs, with human support integrated in various ways. In one study, participants completed online PE sessions independently and received asynchronous provider support. In an open trial of this model ($N = 34$), 87% of participants achieved clinically meaningful PTSD improvement (McLean et al., 2021). As noted, another trial testing an online version of WET supported by peer coaches found that participants ($N = 124$) experienced large, clinically meaningful reductions in PTSD symptoms (McLean, Malek, & Straud, 2024). In addition, other research has examined the use of asynchronous text messaging to deliver CPT, showing good preliminary results for feasibility and effectiveness (Wiltsey Stirman et al., 2021).

Qualitative data suggest that some individuals prefer to complete therapy without having to discuss their traumatic experience with a provider and report perceived advantages related to anonymity, privacy, and comfort (McLean, Malek, & Straud, 2024; Miller et al., 2024). Taken together, these findings suggest that for some individuals, the prospect of completing digital EBPs for PTSD will be perceived favorably and that EBPs can be translated for digital delivery with good effects and adequate acceptability for individuals with PTSD.

Digital interventions could increase access to evidence-based interventions and tools by supporting standard provider-delivered behavioral health care (e.g., treatment companion apps) or even supplanting the need for such care (e.g., self-guided or human-supported digital interventions). For example, digital interventions could be offered to veterans who are waiting for specialty behavioral health care within the VHA, service members who are referred to the TRICARE network, or individuals who are actively engaged in treatment but unable to see their provider at an effective frequency. In this way, digital interventions could help bridge the gaps in access to standard provider-delivered care and potentially reduce the number of provider-delivered sessions needed to achieve a good clinical outcome, thereby freeing provider time to deliver care to patients who are not interested in digital interventions for PTSD or for whom such interventions would not be clinically indicated.

Artificial intelligence

Research on mental health applications of artificial intelligence (AI) has advanced rapidly in the past few years, particularly with the release of large language models (LLMs) such as ChatGPT. LLMs, which are trained on

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vast amounts of text data, can "understand" and generate human-like language. Although estimates suggest up to one in four adults already use LLMs for mental health care (Stade et al., 2025), existing platforms are not explicitly designed for clinical purposes and, therefore, may provide clinically inappropriate responses and guidance. However, emerging evidence indicates that with appropriate safety testing and monitoring, LLMs that safely and effectively deliver mental health interventions can be developed. A recent randomized controlled trial found that a 4-week LLM-based cognitive behavioral intervention (i.e., Therabot) significantly reduced symptoms of major depressive disorder, generalized anxiety disorder, and feeding and eating disorders without serious adverse events (Heinz et al., 2025). Similarly, Socrates 2.0, an AI tool designed to engage patients in Socratic dialogue outside of therapy sessions, was deemed safe and showed effectiveness in reducing PTSD, depression, and anxiety symptoms in preliminary research with 61 users (Held et al., 2024). Despite these promising findings, clinically focused LLMs are in the early stages and carry risks, such as providing unhelpful information (De Freitas et al., 2024). For this reason, experts in the use of LLMs for addressing PTSD advocate for a conservative, phased model of development in which humans remain involved at varying degrees until safety and effectiveness are firmly established (Stade et al., 2024).

Once established, AI could be used to deliver or support the delivery of EBPs, improving system capacity to deliver care without additional staffing. In turn, this could improve access to care and facilitate the efficiency of care delivery. Another advantage of using technology to deliver trauma-focused interventions is that it can be used to outsource specific therapy tasks, such as exposure, which, in our experience, can be difficult to implement when delivered by providers (e.g., Becker et al., 2004; Cook et al., 2014). Training in EBPs for PTSD typically requires a multiday workshop and resource-intensive case consultation (e.g., McLean & Foa, 2013). This process needs to be repeated whenever there is turnover and new staff members are hired. In addition, providers may be reluctant to deliver trauma-focused treatments for a variety of reasons, including (a) discomfort with hearing details of traumatic events, (b) discomfort with witnessing the temporary distress that typically occurs as patients approach and process difficult memories and emotions, or (c) beliefs that trauma-focused treatment is harmful or poorly tolerated (e.g., Becker et al., 2004). Using digital interventions to implement trauma-focused interventions could delegate a critical component of care while still involving humans to oversee care coordination and risk assessment as needed.

CONCLUSION

Despite the benefits of EBP in the treatment of PTSD, capacity challenges in both public and private health care systems limit access and engagement with these treatments. The MHS and VHA represent two large health care systems for which data are available to study the downstream impacts of these capacity challenges and begin to develop solutions. It is important to reiterate that these challenges are not unique to these systems; in fact, in many cases, VHA and MHS settings are better resourced than the private sector, where most patients receive mental health care globally.

We assert that the most promising solutions to increasing access to EBPs for PTSD are those that acknowledge existing policies and staffing constraints and rethink the most effective ways to deploy recommended treatments. One such strategy is restructuring the length, timing, and content of EBPs for PTSD. Accelerated and centralized video telehealth delivery hubs are two such approaches that have somewhat widespread implementation. Efforts to continue to streamline the delivery of EBPs for PTSD to their most essential components (e.g., CPT multiphase optimization strategy [CPT-MOST]; Sripada et al., 2023) and expand the settings that serve as an intercept for care engagement (e.g., criminal-legal or homelessness programming) have promise in maximizing existing clinical resources. Task-sharing models, where nonexperts (e.g., peer coaches, behavioral health technicians) deliver EBPs for PTSD, provide opportunities to directly increase capacity by leveraging additional staffing. Finally, technology provides opportunities to supplement or offload clinical tasks through web-based interventions or artificial intelligence. Although companion mobile apps (e.g., CPT and PE Coach; VA Mobile, n.d.) have been available for some time, tests of self-guided and asynchronous technology-facilitated treatment have started to show promise. Critically, these approaches are not intended to replace clinicians but rather to provide additional, stepped-care options that increase access to effective treatment.

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OPEN PRACTICES STATEMENT

No new data were generated or analyzed during this study. Data sharing is not applicable to this article.

AUTHOR CONTRIBUTIONS

Carmen P. McLean: conceptualization, writing—original draft. **Nicholas Holder**: conceptualization, writing—original draft. **Ryan Holliday**: conceptualization; writing—original draft. **Craig Rosen**: conceptualization; writing—original draft.

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REFERENCES

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, *42*(3), 277–292. https://doi.org/10.1016/S0005-7967(03)00138-4

Cook, J. M., Dinnen, S., Simiola, V., Thompson, R., & Schnurr, P. P. (2014). VA residential provider perceptions of dissuading factors to the use of two evidence-based PTSD treatments. *Professional Psychology: Research and Practice*, *45*(2), 136–142. https://doi.org/10.1037/a0036183

De Freitas, J., Uğuralp, A. K., Oğuz-Uğuralp, Z., & Puntoni, S. (2024). Chatbots and mental health: Insights into the safety of generative AI. *Journal of Consumer Psychology*, *34*(3), 481–491. https://doi.org/10.1002/jcpy.1393

Defense Health Agency. (2024). *Fiscal Year 2024 Tricare Program evaluation report*. https://www.health.mil/Reference-Center/Reports/2024/09/23/Annual-Evaluation-of-the-TRICARE-Program-FY24

Department of Veterans Affairs, Homeless Programs. (n.d.) *Domiciliary care for homeless veterans*. https://department.va.gov/homeless/dchv/

Foa, E. B., Hembree, E. A., Rothbaum, B. O., & Rauch, S. A. M. (2019). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide* (2nd ed). Oxford University Press.

Foa, E. B., McLean, C. P., Zang, Y., Rosenfield, D., Yadin, E., Yarvis, J. S., Mintz, J., Young-McCaughan, S., Borah, E. V., Dondanville, K. A., Fina, B. A., Hall-Clark, B. N., Lichner, T., Litz, B. T., Roache, J., Wright, E. C., Peterson, A. L., & for the STRONG STAR Consortium. (2018). Effect of prolonged exposure therapy delivered over 2 weeks vs 8 weeks vs present-centered therapy on PTSD symptom severity in military personnel: A randomized clinical trial. *JAMA*, *319*(4), 354–364. https://doi.org/10.1001/jama.2017.21242

Fortney, J. C., Kaysen, D. L., Engel, C. C., Cerimele, J. M., Nolan, J. P., Jr., Chase, E., Blanchard, B. E., Hauge, S., Bechtel, J., Taylor, A., Acierno, R., Nagel, N., Sripada, R. K., Painter, J. T., DeBeer, B. B., Zimberoff, A., Bluett, E. J., Teo, A. R., Morland, L. A., … Heagerty, P. J. (2025). Pragmatic comparative effectiveness of primary care treatments for posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry*, *82*(12), 1203–1215. (189857924). https://doi.org/10.1001/jamapsychiatry.2025.2962

Franklin, C. L., Raines, A. M., Ennis, C. R., Boffa, J. W., Bender, A. M., Ferrie, M. L., Nocera, T. R., Dornbach-Bender, A., Seidler, D. A., Slaton, K. D., O'Malley, L., Shapiro, M. O., & Laborde, G. (2026). Evaluating coordination and quality of care among veterans receiving posttraumatic stress disorder care in the community. *Journal of Traumatic Stress*, *39*(1), 15–22. https://doi.org/10.1002/jts.70012

Gao, N., & Olfson, M. (2026). Trends in adult outpatient psychotherapy use in the United States, 2019–2023. *Psychiatric Services*, *77*(2), 175–178. https://doi.org/10.1176/appi.ps.20250377

Heinz, M. V., Mackin, D. M., Trudeau, B. M., Bhattacharya, S., Wang, Y., Banta, H. A., Jewett, A. D., Salzhauer, A. J., Griffin, T. Z., & Jacobson, N. C. (2025). Randomized trial of a generative AI chatbot for mental health treatment. *NEJM AI*, *2*(4), Article AIoa2400802. https://doi.org/10.1056/AIoa2400802

Held, P., Kovacevic, M., Petrey, K., Meade, E. A., Pridgen, S., Montes, M., Werner, B., Miller, M. L., Smith, D. L., Kaysen, D., & Karnik, N. S. (2022). Treating posttraumatic stress disorder at home in a single week using 1-week virtual massed cognitive processing therapy. *Journal of Traumatic Stress*, *35*(4), 1215–1225. https://doi.org/10.1002/jts.22831

Held, P., Pridgen, S. A., Chen, Y., Akhtar, Z., Amin, D., & Pohorence, S. (2024). A novel cognitive behavioral therapy-based generative AI Tool (Socrates 2.0) to facilitate Socratic dialogue: Protocol for a mixed-methods feasibility study. *JMIR Research Protocols*, *13*, Article e58195. https://doi.org/10.2196/58195

Hepner, K. A., Holliday, S. B., Gittens, A. D., Cabreros, I., Montemayor, C. K., & Pincus, H. A. (2022). Optimizing the role of military behavioral health technicians: A survey of behavioral health technicians and mental health providers. *Rand Health Quarterly*, *9*(4), Article 21.

Hepner, K. A., Roth, C. P., Sloss, E. M., Paddock, S. M., Iyiewuare, P. O., Timmer, M. J., & Pincus, H. A. (2018). Quality of care for PTSD and depression in the military health system. *Rand Health Quarterly*, *7*(3), Article 4.

Hernandez-Tejada, M. A., Bruce, M. J., Muzzy, W., Birks, A., Macedo E Cordeiro, G., Hart, S. M., Hamski, S., & Acierno, R. (2025). Peer support during in vivo exposure homework increases the likelihood of prolonged exposure therapy completion. *Military Psychology*, *37*(4), 259–268. https://doi.org/10.1080/08995605.2024.2352601

Hodge, A. S., Rogers, T. E., Esche, A. M., Tubman, D. S., Overpeck, A., Savage, B., & Tannahill, H. (2023, August 3–5). *Military behavioral health technicians: A systematic review of the empirical literature* [Poster session]. American Psychological Association, 131st Annual Convention, Washington, D.C., United States.

Holder, N., Batten, A., Shiner, B., & Maguen, S. (2025). Associations between delivery modality and treatment dose and density of trauma-focused evidence-based psychotherapy for posttraumatic

15736598, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jts.70090 by DARTMOUTH COLLEGE, Wiley Online Library on [15/06/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

stress disorder. *General Hospital Psychiatry*, *96*, 315–321. https://doi.org/10.1016/j.genhosppsych.2025.08.008

Holder, N., Batten, A., Shiner, B., & Maguen, S. (2026). Trauma-focused evidence-based psychotherapy for post-traumatic stress disorder delivered via video telehealth in the Veterans Health Administration. *Journal of Telemedicine and Telecare*, *32*(1), 3–11. https://doi.org/10.1177/1357633X241304072

Holder, N., Shiner, B., Li, Y., Madden, E., Neylan, T. C., Seal, K. H., Lujan, C., Patterson, O. V., DuVall, S. L., & Maguen, S. (2020). Timing of evidence-based psychotherapy for posttraumatic stress disorder initiation among Iraq and Afghanistan war veterans in the Veterans Health Administration. *Psychological Trauma: Theory, Research, Practice and Policy*, *12*(3), 260–271. https://doi.org/10.1037/tra0000496

Holliday, R., Holder, N., Yamokoski, C., Burden, J., Sippel, L. M., Harpaz-Rotem, I., & Smith, N. B. (2025). A preliminary evaluation of the effectiveness of massed delivery of PTSD psychotherapy in VA residential treatment. *General Hospital Psychiatry*, *97*, 126–129. https://doi.org/10.1016/j.genhosppsych.2025.10.004

Holliday, S. B., Hepner, K. A., Tanielian, T., Meyer, A., & Pincus, H. A. (2019). *Understanding behavioral health technicians within the military: A review of training, practice, and professional development*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR2649.html

Hoppen, T. H., Kip, A., & Morina, N. (2023). Are psychological interventions for adult PTSD more efficacious and acceptable when treatment is delivered in higher frequency? A meta-analysis of randomized controlled trials. *Journal of Anxiety Disorders*, *95*, Article 102684. https://doi.org/10.1016/j.janxdis.2023.102684

Kakuma, R., Minas, H., Ginneken, N.van, Poz, M. R. D., Desiraju, K., Morris, J. E., Saxena, S., & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *The Lancet*, *378*(9803), 1654–1663. https://doi.org/10.1016/S0140-6736(11)61093-3

Maguen, S., Madden, E., Patterson, O. V., DuVall, S. L., Goldstein, L. A., Burkman, K., & Shiner, B. (2018). Measuring use of evidence-based psychotherapy for posttraumatic stress disorder in a large national healthcare system. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(4), 519–529. https://doi.org/10.1007/s10488-018-0850-5

McGowan, M., Rose, D., Bonilla, A., Chawla, N., & Stockdale, S. (2026). Mental health leadership perspectives on the value of a national virtual contingency staffing program in the Veterans Health Administration. *Administration and Policy in Mental Health and Mental Health Services Research*, *53*(1), 107–114. https://doi.org/10.1007/s10488-025-01480-9

McLean, C. P., Bell, M. M., Haddock, C. K., LoSavio, S. T., Mann, J., McCaslin, S., Rahman, N., Rodden, L., Rogers, T., Rosen, C. S., Woodworth, C., & Cook, J. (2026). Behavioral health technician delivered written exposure therapy for posttraumatic stress disorder in the military: Design of a hybrid implementation effectiveness trial. *Contemporary Clinical Trials Communications*, *49*, Article 101598. https://doi.org/10.1016/j.conctc.2026.101598

McLean, C. P., Cook, J., Riggs, D. S., Peterson, A. L., Young-McCaughan, S., Borah, E. V., Comtois, K. A., Dondanville, K. A., Frick, E., Haddock, C. K., Mann, J., Reynolds, D., Mistretta, M., Neitzer, A., Brzuchalski, A., Clayton, S. P., Conforte, A. M., DuMars, T. D., Ekundayo, K., … Rosen, C. S. (2024). Barriers and potential solutions to implementing evidence-based PTSD treatment in military treatment facilities. *Military Medicine*, *189*(3–4), 721–731. https://doi.org/10.1093/milmed/usac240

McLean, C. P., & Foa, E. B. (2013). Dissemination and implementation of prolonged exposure therapy for posttraumatic stress disorder. *Journal of Anxiety Disorders*, *27*(8), 788–792. https://doi.org/10.1016/j.janxdis.2013.03.004

McLean, C. P., Foa, E. B., Dondanville, K. A., Haddock, C. K., Miller, M. L., Rauch, S. A. M., Yarvis, J. S., Wright, E. C., Hall-Clark, B. N., Fina, B. A., Litz, B. T., Mintz, J., Young-McCaughan, S., Peterson, A. L., & STRONG STAR Consortium. (2021). The effects of web-prolonged exposure among military personnel and veterans with posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(6), 621–631. https://doi.org/10.1037/tra0000978

McLean, C. P., Fong, C., Haddock, C. K., Cook, J., Peterson, A. L., Riggs, D. S., Young-McCaughan, S., Conforte, A. M., Flores, A., Jinkerson, J., Jones, Z. K., Kim, H. J., Link, J. S., Nofziger, D., Ringdahl, E. N., Woodworth, C., McCullen, J., Ho, E., Rosen, C. S., & for the TACTICS Research Group. (2025). Clinic-level predictors of psychotherapy dosage in the military health system. *Psychiatric Services*, *76*(3), 233–240. https://doi.org/10.1176/appi.ps.20240180

McLean, C. P., Haddock, C. K., Fong, C., Cook, J., Peterson, A. L., Riggs, D. S., Young-McCaughan, S., Conforte, A. M., Flores, A., Jinkerson, J., Jones, Z. K., Kim, H. J., Link, J. S., Nofziger, D., Paine, C., Ringdahl, E. N., Waggoner, J. W., Woodworth, C., McCullen, J., …Rosen, C. S. (2026). *Treatment of PTSD in the military health system: Which patients receive evidence based psychotherapy?* [Manuscript under review].

McLean, C. P., Malek, N., & Straud, C. L. (2024). A pilot randomized controlled trial of online written exposure therapy delivered by peer coaches to veterans with posttraumatic stress disorder. *Journal of Traumatic Stress*, *37*(3), 471–482. https://doi.org/10.1002/jts.23020

Miller, M., Davis, C. A., & McLean, C. (2024). Perceptions and experiences of renew: An exposure-based mobile app for posttraumatic stress. *Journal of Technology in Behavioral Science*, *9*(4), 615–627. https://doi.org/10.1007/s41347-023-00358-7

Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological treatments: Lessons from developing countries. *Behaviour Research and Therapy*, *49*(9), 523–528. https://doi.org/10.1016/j.brat.2011.06.012

Peipert, A., Krendl, A. C., & Lorenzo-Luaces, L. (2022). Waiting lists for psychotherapy and provider attitudes toward low-intensity treatments as potential interventions: Survey study. *JMIR Formative Research*, *6*(9), Article e39787. https://doi.org/10.2196/39787

Psychological Health Center of Excellence Behavioral Health Technician Work Group. (2019). *Healthcare provider's practice guide for the utilization of behavioral health technicians (BHTs)*. https://www.health.mil/Reference-Center/Publications/2021/05/10/PHCoE-Providers-Practice-Guide-5-10-2021-508

Ranney, R. M., Cordova, M. J., & Maguen, S. (2022). A review of the referral process for evidence-based psychotherapies for PTSD among veterans. *Professional Psychology: Research and Practice*, *53*(3), 276–285. https://doi.org/10.1037/pro0000463

Rauch, S. A. M., Cigrang, J., Austern, D., & Evans, A. (2017). Expanding the reach of effective PTSD treatment into primary care: Prolonged exposure for primary care. *Focus*, *15*(4), 406–410. https://doi.org/10.1176/appi.focus.20170021

15736598, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jts.70090 by DARTMOUTH COLLEGE, Wiley Online Library on [15/06/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Resick, P. A., Monson, C. M., & Chard, K. M. (2024). *Cognitive processing therapy for PTSD: A comprehensive therapist manual* (2nd ed.). The Guilford Press.

Roberge, E. M., Bennett, D. C., & Weinstein, H. R. (2025). Qualitative examination of the feasibility, acceptability, and considerations for implementation of massed evidence-based psychotherapies for PTSD into outpatient clinics. Cognitive and Behavioral Practice. Advance online publication. https://doi.org/10.1016/j.cbpra.2025.09.004

Rosen, C. S., Davis, C. A., Riggs, D., Cook, J., Peterson, A. L., Young-McCaughan, S., Comtois, K. A., Haddock, C. K., Borah, E. V., Dondanville, K. A., Finley, E. P., Jahnke, S. A., Poston, W. S. C., Wiltsey-Stirman, S., Neitzer, A., Broussard, C. R., Brzuchalski, M. A., Clayton, M. S. P., Conforte, L. A. M., … McLean, C. P. (2020). Targeted assessment and context-tailored implementation of change strategies (TACTICS) to increase evidence-based psychotherapy in military behavioral health clinics: Design of a cluster-randomized stepped-wedge implementation study. *Contemporary Clinical Trials*, *93*, Article 106008. https://doi.org/10.1016/j.cct.2020.106008

Rosenfeld, E. A., Malek, N., Thompson, S. M., Straud, C. L., Rosen, C., & McLean, C. P. (2026). *Examining veteran preferences and attitudes across intervention modalities for posttraumatic stress disorder* [Manuscript under review].

Rossouw, J., Yadin, E., Alexander, D., & Seedat, S. (2018). Prolonged exposure therapy and supportive counselling for post-traumatic stress disorder in adolescents: Task-shifting randomised controlled trial. *British Journal of Psychiatry*, *213*(4), 587–594. https://doi.org/10.1192/bjp.2018.130

Sayer, N. A., Rosen, C. S., Bernardy, N. C., Cook, J. M., Orazem, R. J., Chard, K. M., Mohr, D. C., Kehle-Forbes, S. M., Eftekhari, A., Crowley, J., Ruzek, J. I., Smith, B. N., & Schnurr, P. P. (2017). Context matters: Team and organizational factors associated with reach of evidence-based psychotherapies for PTSD in the Veterans Health Administration. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(6), 904–918. https://doi.org/10.1007/s10488-017-0809-y

Sayer, N. A., Wiltsey Stirman, S., Rosen, C. S., Kehle-Forbes, S., Spoont, M. R., Eftekhari, A., Chard, K. M., Kaplan, A., & Nelson, D. B. (2023). The role of therapy delivery and clinic organizational factors in explaining therapist effects for trauma-focused psychotherapies in the Veterans Health Administration. *Journal of Consulting and Clinical Psychology*, *91*(11), 665–679. https://doi.org/10.1037/ccp0000832

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures* (3rd ed.). The Guilford Press.

Sloan, D. M., & Marx, B. P. (2025). *Written exposure therapy for PTSD: A brief treatment approach for mental health professionals* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000441-000

Sripada, R. K., Peterson, C. L., Dziak, J. J., Nahum-Shani, I., Roberge, E. M., Martinson, A. A., Porter, K., Grau, P., Curtis, D., McElroy, S., Bryant, S., Gracy, I., Pryor, C., Walters, H. M., Austin, K., Ehlinger, C., Sayer, N., Wiltsey-Stirman, S., & Chard, K. (2023). Using the multiphase optimization strategy to adapt cognitive processing therapy (CPT MOST): Study protocol for a randomized controlled factorial experiment. *Trials*, *24*(1), Article 676. https://doi.org/10.1186/s13063-023-07669-3

Stade, E. C., Stirman, S. W., Ungar, L. H., Boland, C. L., Schwartz, H. A., Yaden, D. B., Sedoc, J., DeRubeis, R. J., Willer, R., & Eichstaedt, J. C. (2024). Large language models could change the future of behavioral healthcare: A proposal for responsible development and evaluation. *NPJ Mental Health Research*, *3*(1), Article 12. https://doi.org/10.1038/s44184-024-00056-z

Stade, E., Tait, Z., Campione, S., Stirman, S., & Eichstaedt, J. (2025). Current real-world use of large language models for mental health [Preprint]. Open Science Framework. https://doi.org/10.31219/osf.io/ygx5q_v1

Tanielian, T., Farris, C., Epley, C., Farmer, C. M., Robinson, E., Engel, C. C., & Jaycox, L. H. (2014). *Ready to serve. Community-based provider capacity to deliver culturally competent, quality mental health care to veterans and their families*. RAND Corporation. https://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR806/RAND_RR806.pdf

U.S. Department of Veterans Affairs/U.S. Department of Defense. (2023). *VA/DoD clinical practice guideline for management of posttraumatic stress disorder and acute stress disorder*. https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DoD-CPG-PTSD-Full-CPGAug242023.pdf

VA Mobile. (n.d.). *Mental health and behavioral therapy apps*. https://mobile.va.gov/mental-health-and-behavioral-therapy-apps

Vanneman, M. E., Rosen, A. K., Wagner, T. H., Shwartz, M., Gordon, S. H., Greenberg, G., Zheng, T., Cook, J., Beilstein-Wedel, E., Greene, T., & Kelley, A. T. (2023). Differences between VHA-delivered and VHA-purchased behavioral health care in service and patient characteristics. *Psychiatric Services*, *74*(2), 148–157. https://doi.org/10.1176/appi.ps.202100730

Wiltsey Stirman, S., Song, J., Hull, T. D., & Resick, P. A. (2021). Open trial of an adaptation of cognitive processing therapy for message-based delivery. *Technology, Mind, and Behavior*, *2*(1), 81–91. https://doi.org/10.1037/tmb0000016

Zhu, J. M., Huntington, A., Haeder, S., Wolk, C., & McConnell, K. J. (2024). Insurance acceptance and cash pay rates for psychotherapy in the US. *Health Affairs Scholar*, *2*(9), Article qxae110. https://doi.org/10.1093/haschl/qxae110

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