VACO Update:
Psychotherapy and Psychogeriatrics

Bradley Karlin, Ph.D.
Associate Chief Consultant for Psychotherapy
and Psychogeriatrics

Office of Mental Health Services
VA Central Office

Evidence-Based Psychotherapy: Current Practice

- Low rates of evidence-based psychotherapy (EBP) across service sectors

  (Goisman, Warshaw, & Keller, 1999; Rosen et al., 2004)

  – Key factors:
    - limited training
    - lack of organizational support

    (Weissman et al. 2006; Willenbring et al., 2004)

- EBP often delivered with low fidelity

  (Madson & Campbell, 2006)

Over the years, research has yielded important advances in our knowledge of the brain, behavior, and effective treatments and service delivery strategies for many mental disorders. An array of evidence-based medications and psychosocial interventions - typically used together - now allows successful treatment of most mental disorders. Despite these advances in science, many Americans are not benefiting from these investments.

Far too often, treatments and services based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity. According to the Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about 15 to 20 years.

Even when these discoveries become routinely available at the community level, too often the clinical practice is highly uneven and inconsistent with the original treatment model that was shown to be effective.

New Freedom Commission on Mental Health, 2003

Bridging the Science to Practice Gap

- Requirement for access and capacity for:
    - CPT or PE for PTSD
    - CBT, ACT, or IPT for depression
    - SST for SMI
    - Other provisions (e.g., Family Psychoeducation, Motivational Enhancement, EB psychosocial treatments in RRTPs)
    - Evidence-based somatic treatments for mental and substance use disorders

Uniform MH Services Handbook

"All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy (PE) as designed and shown to be effective. Medical Centers and very large CBOCs must provide adequate staff to allow the delivery of evidence-based psychotherapy when it is clinically indicated for their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary."

Evidence-Based Psychotherapy Dissemination

- National initiatives to train VA MH clinicians in the delivery of EBPs for:
  - PTSD
    - Cognitive Processing Therapy
    - Prolonged Exposure Therapy
  - Depression
    - Cognitive Behavioral Therapy
    - Acceptance and Commitment Therapy
  - Serious Mental Illness
    - Social Skills Training

Training Model

- In-person, experientially-based **workshop**

- Ongoing, weekly **consultation** to build mastery and facilitate implementation

- Informal consultation opportunities over the longer-term

Training Figures

	Rollout	Non-Rollout	
	VA	VA/Community	DoD
CPT	1000	687	741
PE	291	162	120

Figures are as of March 31, 2009

Plans developed to provide expanded training opportunities to RCS staff

Initial Monitoring of Capacity

- Memo from 10N sent to field on February 19, 2009, inquiring about current provision of and plans for providing CPT and/or PE
  - 94% of facilities providing CPT or PE
  - 6% of facilities not providing CPT or PE
    - 2 sites lacked a specific plan for clear development toward a plan
- Technical assistance planned for sites not currently providing CPT or PE and without a specific plan for doing so
- Ongoing evaluation of capacity and delivery planned

Implementation Strategies

- Top down + bottom up approaches critical to promote adoption <u>and</u> sustainability
- EBP clinician rosters
- Computerized medical record templates for evidence-based psychotherapies
  - Report EBP delivery
  - Reminds staff of important therapy steps
  - Facilitate data recovery on delivery and fidelity
- Local Evidence-Based Psychotherapy Coordinator placed at each medical center

Local Evidence-Based Psychotherapy Coordinators

- Local EBP Coordinator placed at each medical center (.30 FTE position)
- Serves as a champion for EBP, providing clinical and administrative support
  - Provide information and education to leadership, other clinical staff and referral sources, and patients
  - Provide ongoing clinical consultation to promote local implementation, fidelity, and sustainability
  - Work with facility leadership, program managers, IT staff, and providers to ensure clinics and administrative supports in place
  - Track local utilization and delivery of EBPs and identify potential local obstacles to EBP utilization
  - Serve as local POC for information dissemination, recruitment

Local Evidence-Based Psychotherapy Coordinators

- Careful review and confirmation process of facility selections completed
- Extensive training resources being developed
  - EBP Coordinator Toolkit
  - In-person conferences: Summer FY09
  - Monthly conference calls
  - Listserv and other communication to create network

Promoting the Potential of Bibliotherapy

- VA Bibliotherapy Resource Guide developed
- Designed to promote the use of bibliotherapy as a supplement to treatment
- Guide covers wide range of mental health and behavioral health conditions
  - Application in mental health and primary care settings
- Memo from 10N sent on April 10, 2009, releasing the Resource Guide and authorizing use of MH lag funds to purchase items listed

Coming Soon

- VA-CBT and VA-ACT Therapy Manuals being finalized
- Decentralized training processes being developed (T3 arms) to broaden dissemination and promote sustainability
- Supplemental EBP training
- Dissemination of Motivational Interviewing, other EBPs

Integration of MH Providers in Geriatrics Settings

- New care models and roles for Psychologists to meet the MH needs of older veterans

- Integration of Mental Health care in:
  - Home-Based Primary Care
  - Community Living Center
  - Palliative Care Consult Teams
  - SCI
  - Blind Rehab

- Capacity for:
  - Cognitive screening
  - Capacity assessment
  - Education and support for family caregivers

Suicide Prevention Activities

- VA Safety Planning Intervention
  - Manual
  - Pocket Card

Step 6: MAKING THE ENVIRONMENT SAFE

◊   Ask veterans which means they would consider using during a suicidal crisis.

◊   Ask *"Do you own a firearm, such as a gun or rifle?"* and *"What other means do you have access to and may use to attempt to kill yourself?"*

◊   Collaboratively identify ways to secure or limit access to lethal means: Ask "How can we go about developing a plan to limit your access to these means?"

◊   For methods with low lethality, clinicians may ask veterans to remove or restrict their access to these methods themselves.

◊   Restricting the veteran's access to a highly lethal method, such as a firearm, should be done by a designated, responsible person-usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

Assess the likelihood that the overall safety plan will be used and problem solve with the veteran to identify barriers or obstacles to using the plan.

Discuss where the veteran will keep the safety plan and how it will be located during a crisis.

Evaluate if the format is appropriate for the veterans' capacity and circumstances.

Review the plan periodically when veteran's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE VETERAN AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

Department of Veterans Affairs

Safety Plan
QUICK GUIDE
for Clinicians

WHAT IS A SAFETY PLAN?
A Safety Plan is a prioritized written list of coping strategies and sources of support veterans can use who have been deemed to be at high risk for suicide. Veterans can use these strategies before or during a suicidal crisis. The plan is brief, is in the veteran's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?
Any veteran who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the veteran on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the veteran in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN
There are 6 Steps involved in the development of a Safety Plan.

Clinicians are strongly advised to read the manual, " *VA Safety Plan Treatment Manual to Reduce Suicide Risk,* " and review associated video training materials at the following link:

http://vaww.mentalhealth.va.gov/files/suicide prevention/VA_Safety_planning_manual_8 -19-08revisons.doc

Employee Education System

IMPLEMENTING THE SAFETY PLAN:
6 STEP PROCESS

Step 1: Warning Signs

- ☐ Ask *"How will you know when the safety plan should be used?"*

- ☐ Ask*" What do you experience when you start to think about suicide or feel extremely distressed?"*

- ☐ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the veteran's <u>own words</u>.

Step 2: Internal Coping Strategies

- ☐ Ask *"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"*

- ☐ Assess likelihood of use: Ask *"How likely do you think you would be able to do this step during a time of crisis?"*

- ☐ If doubt about use is expressed, ask *"What might stand in the way of you thinking of these activities or doing them if you think of them?*

- ☐ Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- ☐ Instruct veterans to use Step 3 if Step 2 does not resolve the crisis or lower risk.

- ☐ Ask *"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"*

- ☐ Ask for safe places they can go to be around people (i.e. coffee shop).

Step 3 cont'd

- ☐ Ask veteran to list several people and social settings, in case the first option is unavailable.

- ☐ Remember, in this step, the goal is distraction from suicidal thoughts and feelings.

- ☐ Assess likelihood that veteran will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- ☐ Instruct veterans to use Step 4 if Step 3 does not resolve crisis or lower risk.

- ☐ Ask *"Among your family or friends, who do you think you could contact for help during a crisis?"* or *"Who is supportive of you and who do you feel that you can talk with when you're under stress?"*

- ☐ Ask veterans to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.

- ☐ Assess likelihood veteran will engage in this step; ID potential obstacles, and problem solve.

- ☐ Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- ☐ Instruct the veterans to use Step 5 if Step 4 does not resolve the crisis or lower risk

- ☐ Ask, *"Who are the mental health professionals that we should identify to be on your safety plan?"* and *Are there other health care providers?"*

- ☐ List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255)).

- ☐ Assess likelihood veteran will engage in this step; ID potential obstacles, and problem solve.

Suicide Prevention Activities

- Family Resource Guide

Under Development
- Family ACE Pocket Cards
- Resources for Children

VA Mental Health Design Guide

- The environment of care has a significant psychological impact on patients and staff
- VA MH Design Guide designed to promote healing and welcoming environments in inpatient psychiatry and other MH settings
  - Architectural level (external and internal)
  - Interior design
  - Ambient features
  - Social features
- Critical to align the environment with services
- Intended to be a transformational document

Source: HDR