Evidence Based MH Treatments in VHA –
Critiques, Responses and Future Directions

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A Critical Examination of the Movement toward Evidence-Based Mental Health Treatments in the U.S. Department of Veterans Affairs (2013)

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Summary of Critique

• Unknown standards to determine whether a treatment is “evidence-based”
  – Lacked transparency
  – Variety of types of evidence in addition to randomized trials
• Failure to account for differential response within diagnostic groups
  – Question relevance of evidence to Veterans
  – Moderator effects
  – Failure of VA guidelines to sanction “evidence informed practice”
• Absence of cross-cutting treatments the work
  – Implementation guidelines ignore importance of “tailoring” to the individual
• Unknown influences on the training of psychologists
  – VA as largest trainer with far-reaching impact on training and trainees
Suggestions

• Provide real-time client feedback (e.g., Lambert et al)
• Preserve therapist flexibility
• Establish guiding principles that apply across treatment types and diagnostic groups
• Common factors
  – Participant factors
  – Relationship factors
  – Technique factors
• Widen the scope of empirically-based guidelines
• Systematically adapt treatments and relationships to client factors
“We have several good treatment options to choose from. On average, they have about the same chance of success. But you are not an average; you are an individual. At this time, there is no scientific way to predict which treatment will work best for you. Together, we will look at your options and decide what treatment to start with. But it is important to remember that there are other options. If the first treatment we pick does not work out for you, some other treatment might work well. Regular follow-up over the next several weeks will tell us whether to stay with our first choice or try something else”
Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders

Type: Consensus Study
Topics: Quality and Patient Safety, Substance Abuse and Mental Health
Board: Board on Health Sciences Policy

http://www.iom.edu/Activities/MentalHealth/PsychosocialInterventions.aspx
An IOM committee will develop a framework to establish efficacy standards for psychosocial interventions used to treat mental disorders. The committee will explore strategies that different stakeholders might take to help establish these standards for psychosocial treatments.
IOM Committee Members

- Mary Jane England, Chair
- Patricia Arean* 
- John Brekke
- Michelle Craske*
- Kermit Crawford*
- Patricia Deegan
- Frank deGruy, III
- Jonathan Delman
- Constance Horgan
- Haiden Huskamp
- Harold Pincus
- Enola Proctor
- Rhonda Robinson-Beale**
- Sarah Scholle
- John Walkup
- Myrna Weissman

* Members of APA Guideline Advisory Steering Committee
** Member of APA Guideline Development Panel for Depression
Mission of APA Guideline Development

Improve mental, behavioral, and physical health by promoting clinical practices based on the best available evidence. Identify interventions that are effective and can be implemented in the community. Develop treatment guidelines that are scientifically sound, clinically useful, and informative for psychologists, other health professionals, training programs, policy makers, and the public.

Vision

• Improve mental, behavioral and physical health.
• Improve patient experiences of care.
• Improve the effectiveness, quality, and value of health care services.
• Inform shared decision making between patients and health professionals.
• Improve practice by health professionals.
• Enhance training of psychologists and other health professionals.
• Enhance competency of psychologists and other health professionals.
• Educate professionals, consumers, and policy makers about effective interventions.
• Identify gaps in the evidence base to be addressed by future research.
Operational Principles

• Focus on treatment efficacy and clinical utility for specific problems or disorders.

• Utilize transparent rationale and procedures for guidelines development.

• Solicit input from professionals, consumers, educators, payers, and policy makers.

• Focus on prevention, treatment, or management.

• Address common factors and relational issues associated with effective interventions.

• Consider the full range of research evidence.
Operational Principles

• Evaluate the quality of the evidence and identify areas where it is lacking.

• Identify potential harms and benefits.

• Consider outcomes across multiple domains.

• Consider setting, sociodemographics, multicultural issues, and patient preferences.

• Acknowledge the clinician’s responsibility for individualized clinical care decisions.

• Provide recommendations that are advisory rather than compulsory.

• Update guidelines periodically to reflect developments in research and practice.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Explanation/Comments</th>
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<tbody>
<tr>
<td>I. Aggregate/Global Strength of Evidence (SOE)</td>
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<tr>
<td>Evidence Statements</td>
<td></td>
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<td>II. Treatment Outcomes/Consequences</td>
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<tr>
<td>• Benefits of the Treatment</td>
<td></td>
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<td>• Harms of the Treatment</td>
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<tr>
<td>• Burdens of Treatment (Note: do not include financial cost)</td>
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<tr>
<td>Balance of Benefits and Harms/Burdens of Treatment</td>
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<tr>
<td>III. Patient Values and Preferences</td>
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<tr>
<td>IV. Applicability of Evidence</td>
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<tr>
<td>☐ Recommendation Direction Based on the net benefit and other factors, what is the treatment decision?</td>
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<tr>
<td>☐ Strength of Recommendation</td>
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<tr>
<td>☐ Recommendation (text)</td>
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<tr>
<td>☐ Justification (for recommendation)</td>
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Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Potential Applicability Issues</th>
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<tbody>
<tr>
<td>Patients / Populations</td>
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<td>Interventions</td>
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<td>Comparators</td>
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<td>Outcomes</td>
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<td>Timing or Time frame</td>
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<tr>
<td>Settings</td>
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Notes/Comments:
Updates from the Psychotherapy and Psychogeriatric Section

- The position for the National Mental Health Director for Psychotherapy and Psychogeriatric Section was recently posted and closed on May 9th
- We have selected someone to assist with “decentralizing” the EBP training programs
  - We don’t think there is a one size fits all model for all the MHS-sponsored EBP training programs
  - This person will be reaching out to key stakeholders in leadership and the field to elicit ideas about decentralizing the EBP training process
    - I’d like to talk with any of you who have ideas about how we can improve EBP training in particular and therapist training in general
  - Key to this will be determining what aspects of training are crucial to retain since the goal is to provide VA MH staff excellent training that leads to improved Veteran outcomes
    - Also key is how do field staff get protected time to train, consult, and learn in a decentralized model
PTSD Consultation Program
FOR VA PROVIDERS

(866) 948-7880
PTSDconsult@va.gov
Learn more at
vaww.ptsd.va.gov

Speak directly with staff psychologists, social workers, and physicians about:
TREATMENT • CLINICAL MANAGEMENT • RESOURCES • ASSESSMENT
REFERRALS • PROGRAMATIC ISSUES • IMPROVING CARE
Consultation Topics

• Education (34%)
• Treatments or therapy (27%)
• Program development (18%)
• Diagnosis/screening/assessment (15%)
• Program referrals (12%)
• Medications (3%)
Who Is Seeking Consultation?

- Psychologists
- Social workers
- Trainees
- Pharmacist
- Patient advocates
- Recreational and addiction therapists
- Peer support specialists
- Primary care providers
Comorbidities

- SUD (5%)
- Depression/MDD (2%)
- Sleep Disorder (2%)
- Chronic Pain (<1%)
- TBI (<1%)
- Aggression (<1%)
- Anxiety (<1%)
- Medical conditions (heart condition, migraines)
PTSD Consultation Program
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(866) 948-7880 or PTSDconsult@va.gov

Upcoming Topics in Our Monthly Lecture Series

*Third Wednesday of the Month – 2-3PM (ET)*

**May 21**

*PTSD Apps and Clinical Practice*

Josef I. Ruzek, PhD

**June 18**

*PTSD and Sleep Problems: An Update on Medical Management*

Bruce Capehart, MD

**July 16**

*Pain and PTSD: Behavioral Mechanisms and Interventions*

Niloo Afari, PhD and Matthew Jakupcak, PhD
(866) 948-7880
PTSDconsult@va.gov

Learn more at
va.gov/ptsd

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Implications for our PTSD Specialty Clinics

- Large part of the PTSD Mentoring Program is to offer advice on clinic redesign issues
- We want to ensure that our clinics can offer Cognitive Processing Therapy or Prolonged Exposure to every Veteran who wants these first-line treatments as outlined in the Uniform Services Handbook
- But not every Veteran is willing to engage in a trauma-focused treatment
- Sometimes clinicians do not think they are ready to engage in these treatments
How Can We Encourage New Treatments?

- We want to encourage clinicians to test new treatments in their clinics, to be flexible in their presentations.
- For example, present-centered therapy (PCT) has been recommended by the APA, stress inoculation therapy (SIT) is recommended in the PTSD Clinical Practice Guideline, new briefer intensive cognitive or exposure therapies are being tested with good results.
- But it can be difficult to figure out how to implement these in the context of other clinic requirements.
How Can We Encourage New Treatments?

- Can contradict performance measure when you are testing a briefer treatment (5-6 sessions)
- Hard to know if they are effective without outcomes measures
- What do we need to do to get our clinics to use outcome measures more effectively?
- Is it just a matter of not having adequate program support to collect the data?
Who Determines What Can Be Tested?

- We at the NCPTSD often get questions about treatments with little evidence such as the use of hyperbaric oxygen therapy, emotional freedom therapy, integrative treatments, or the use of dogs, fly fishing, horses, etc for treatment.
- Who should say what treatment can or should be tested in our clinics?
- How then do we determine if these other treatments can be helpful while still maintaining our availability of evidence-based MH treatments?
Clinical Practice Guidelines

• How can we improve this process to allow for treatment to be tailored to an individual?
• How can we better disseminate them in a way that is easy for clinicians to find the information they need and to use?
• We need to find an easy way to update the recommendations. For example, CPT group treatment? Should this now be updated? New medication findings? Family treatment (Conjoint CBT)?
• Should more clinicians be part of the process?
Step 4: Refer
PTSD and co-occurring conditions should be treated concurrently through an integrated treatment approach, which considers patient preferences, provider experience, severity of conditions and the availability of resources.

Provider Actions for Referral:
Primary care providers can use the following checklist when considering a referral to specialty care.
- Identify patient preferences.
- Identify potential barriers and facilitators (e.g., travel vouchers to overcome geographical barriers).
- Engage with family, caregivers and/or significant others.
- Perform a “warm handoff” (e.g., in-person or telephone clinical transfer of patient from one provider to the next, ideally involving patient).
- Assess need for telemental health options.
- Assess need for community and web-based referrals (e.g., Military OneSource, vet center, afterdeployment.org).

Barriers to Seeking Behavioral Health Treatment

- **Hopelessness or Cynicism**
  Patients may be skeptical about the effectiveness of behavioral health treatment and may believe that problems will resolve on their own

  **EMPHASIZE** the success of evidence-based treatments

- **Avoidance**
  Patients may want to avoid reminders of the event or may have had a negative experience in behavioral health treatment in the past

  **REMIND** patients that their safety and comfort will always come first

- **Shame**
  Patients may feel shame about the trauma, their role in the trauma or their reaction

  **COMFORT** and **NORMALIZE** the patient’s feelings

- **Denial**
  Patients may be in denial that symptoms are problematic

  **EDUCATE** about the negative results of leaving PTSD untreated
So What Can We Do?

• First and fundamentally, we need more research to show the efficacy of the EBPs we recommend.
• We need clinic outcomes data – particularly when a clinic is offering alternative first-line treatments to better understand what works with whom.
• We need to do a better job of disseminating new research that supports the recommended treatments.
• Finally, we need to think about how we can move to a shared decision making model of care and give you the tools to support that.
Bottom Line

• Sometimes in discussions of performance measures, meeting mandates, improving access, the original aim of dissemination of the EBPs gets lost: to improve our patients’ outcomes.

• We want our clinicians to take advantage of these incredible training opportunities the VA offers and to use these techniques to produce the most successful outcomes in the largest number of Veterans possible.
After a trauma, it's common to have troubling symptoms like nightmares, anger, feeling numb, or avoiding reminders of the traumatic event.

When these symptoms don't go away over time, and interfere with daily life, it may be PTSD – posttraumatic stress disorder.

A 17-minute video dramatizing three Veterans’ experiences in a busy VA waiting room.
QUESTIONS?

- Nancy Bernardy at nancy.bernardy@va.gov
- Dan Kivlahan at daniel.kivlahan@va.gov
- Sonya Norma at sonya.norman@va.gov
- Tracey Smith at tracey.smith2@va.gov
#6 My HealtheVet Power Tool: Patient Generated Data

Veterans can self-enter personal health information (e.g., medications, weight, blood pressure, pain) in their Personal Health Record.

Three things to know:
1. Patient Generated Data complements clinical data
2. Use the VA Blue Button to create a summary and send using Secure Messaging
3. Tracking information may also increase patient engagement and participation
Activity Description

The Affordable Care Act calls for health care delivery system reforms and innovations that rely heavily on putting more health services under budgeted systems. These include accountable care organizations, health homes, bundled payment systems, coordinated care entities, and other forms of managed care. In these systems, accountability will increasingly take the form of linking performance and quality measures to economic rewards. The behavioral health field should further its progress in the development of measures to allow one to track whether the content of psychosocial treatment is consistent with evidence-based treatment.

The process by which psychosocial therapies are currently validated, and coverage determinations are made, is highly variable. There are a wide range of disciplines and levels of training that claim to provide effective psychosocial treatments. Variation exists in the levels of scientific evidence as well as types of studies and outcome measures that are used to determine what constitutes an effective treatment, the necessary dose and duration of a treatment, and coverage for a treatment. Further, there are no standards in place to ensure that treatment fidelity is based, for example, on providers' training or performance metrics for providers. As a result, it is difficult for consumers and payers to understand what they are buying. This uncertainty creates skepticism among purchases regarding the value of the average psychosocial service. Developing evidence-based standards will help ensure quality care for patients.

An IOM committee will develop a framework to establish efficacy standards for psychosocial interventions used to treat mental disorders. The committee will explore strategies that different stakeholders might take to help establish these standards for psychosocial treatments.

For more information