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The next issue of the *South Central MIRECC Communiqué* will be published September 2, 2011.

Deadline for submission of items to the September newsletter is August 26, 2011.

Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at Ashley.McDaniel@va.gov

South Central MIRECC Internet site: www.mirecc.va.gov/visn16

National MIRECC Internet site: www.mirecc.va.gov

IMPLEMENTING EVIDENCE-BASED PSYCHOTHERAPY WITHIN THE VA

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G.V. Sonny Montgomery VA Medical Center

Since the development of the Mental Health Strategic Plan in 2004, the VA has been transforming and improving its mental health care delivery system by increasing the number of mental health providers and promoting a shift to evidence-based practice. As part of this effort, the VA's Evidence-Based Psychotherapy (EBP) Initiative was created to help disseminate and implement EBPs into clinical practice. This article discusses policies supporting EBPs, the national EBP training program, and local EBP implementation efforts at the G.V. "Sonny" Montgomery VAMC.

Policies Supporting EBP within VA

VHA Handbook 11-6.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, outlines requirements for delivery of core EBPs. This policy builds capacity for EBPs and allows Veterans, wherever they obtain VA care, to have access to EBPs. According to this handbook:

- "All Veterans with PTSD must have access to cognitive processing therapy or prolonged exposure as designed and shown to be effective."
- "All Veterans with depression or anxiety disorders must have access to cognitive behavioral therapy, acceptance and commitment therapy, or interpersonal therapy."
- "Social skills training is an evidence-based psychosocial intervention that must be provided when clinically indicated at all medical centers and very large CBOCs."

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Implementing Evidence-Based Psychotherapy in the VA continued...

Each VA medical center is also required to have a local EBP coordinator who manages the local implementation of EBPs and serves as a liaison between the VA Office of Mental Health Services, which oversees the EBP implementation and dissemination efforts, and the local VA. The EBP coordinator's role includes educating providers and management about EBPs; providing information on EBP trainings; working with clinicians, team leaders, and mental health leadership to implement more EBPs within clinical care; and helping to identify and overcome system barriers to the implementation of EBPs.

In addition, the fiscal year 2011-2013 Mental Health Initiative Operating Plan recently proposed a quality measure to assess the number of OIF/OEF Veterans with PTSD who receive 8 sessions of an EBP within 14 weeks. The baseline rate is 9%. A short-term goal of 15% and long-term strategic goal of 60% have been set.

National EBP Training Programs

The VA's national Evidence-Based Psychotherapy Training Initiative provides training for identified evidence-based psychotherapy initiatives (See Table 1). Trainings have both didactic and competency-based components. Trainees attend a 3-4 day workshop to receive initial knowledge about EBPs and practice skills.

Afterwards, trainees receive at least 6 months of weekly telephone consultation while they practice delivering these psychotherapies to patients. For most training programs, sessions are recorded so consultants can provide feedback and assess adherence to treatment protocols and treatment fidelity. Trainees who complete the consultation process and meet criteria for illustrating competence in an EBP are identified as VA certified providers in that therapy.

Implementation of EBPs at the G. V. "Sonny" Montgomery VA Medical Center

Since 2008, 26 providers have attended EBP trainings. Eight are certified EBP providers in a single EBP; two are certified providers for two EBPs; and 11 are currently receiving consultation. These VA-trained EBP clinicians have provided 2,108 EBP encounters to 279 patients ($M = 7.55$ encounters per patient). From January to June 2011, there has been an average of 19 new EBP patients and 153 EBP encounters per month. Current EBPs offered include cognitive processing therapy, prolonged exposure, cognitive behavioral therapy, acceptance and commitment therapy, social skills training, integrative behavioral couple therapy, and behavioral family therapy.

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Table 1. *Current EBP Training Initiatives*

EBP	Targeted Condition or Population	Sessions	Length
Cognitive Behavioral Therapy	Depression	12-16	50 minutes; individual
Acceptance & Commitment Therapy	Depression & Anxiety	12-16	50 minutes; individual 90 minutes; group
Cognitive Processing Therapy	PTSD	12	60 minutes; individual 90 minutes; group
Prolonged Exposure	PTSD	8-15	90 minutes; individual
Social Skills Training	Severe Mental Illness	24	45-90 minutes; group
Behavioral Family Therapy	Severe Mental Illness	24	50 minutes; family
Multifamily Group Therapy	Severe Mental Illness	~24	90 minutes; group
Integrative Behavioral Couple Therapy	Couples with marital distress	~24	50 minutes; couples
CBT-Insomnia	Insomnia	4-6	50 minutes; individual
Problem-Solving Therapy	Depression	6	50 minutes; individual
Motivational Interviewing	Veterans considering treatment	1-4	15 minutes; individual

(continued from page 2)

Treatment Outcomes for Social Skills Training and Cognitive Processing Therapy at the G. V. “Sonny” Montgomery VA Medical Center

Social Skills Training (SST). The G. V. “Sonny” Montgomery VA Medical Center has three social workers trained in social skills training (two certified, one in consultation). Social skills training groups have been delivered primarily in the Mental Health Intensive Case Management program; however, sessions have also been conducted with patients receiving inpatient psychiatric hospitalization. Of the 56 patients in the Mental Health Intensive Case Management program, 13 (23.2%) attended more than three sessions. Three 6-month social skills training groups have been completed. Of the 417 encounters, 82% of enrolled Veterans attended the first group, 77% attended the second group, and 90% attended the third group. Improvements have been noted by providers. Case managers rated Veterans on social skills before and after participation in a 6-month SST group using a percent effectiveness scale. Table 2 shows improvements in participant outcomes before and after social skills training.

Table 2. Clinicians’ ratings of Veterans’ social skill effectiveness before and after participation in SST.

Social Skill	Pre	Post
Listening to Others	20%	80%
Making Requests	40%	80%
Positive Feelings	20%	80%
Negative Feelings	40%	60%
Conflict Resolution	20%	60%

Cognitive Processing Therapy (CPT). Sixteen providers have been trained in cognitive processing therapy (6 certified; 5 in consultation). Cognitive processing therapy is offered in the Trauma Recovery Program, Substance Use PTSD Treatment Clinic, Mental Health Outpatient Clinic, and Post-Deployment Clinic. A cognitive processing therapy group for women Veterans is also available. Of the 110 Veterans who started cognitive processing therapy, 64% attended at least 10 sessions. The PTSD checklist is a self-report assessment of PTSD symptoms with possible scores ranging from 17 to 85, with higher scores indicating greater symptom severity. In a sample of 51 Veterans who completed 10 sessions of cognitive processing therapy and had PTSD checklist scores at the beginning and end of treatment, PTSD checklist scores decreased an average of 11.41 points. Over half showed a clinically significant (10-point) decrease in PTSD symptoms. One-third of Veterans’ scores dropped below the PTSD cut-point of 50 following treatment. A recent cognitive processing therapy group completed a satisfaction questionnaire following treatment. Satisfaction was extremely high ($M = 3.9$ on 4-point scale). Table 3 shows individual response distribution on three items. ■

Table 3. Percentage of Veterans who endorsed each response to satisfaction items following CPT treatment

Have the services you received helped you to deal more effectively with your problems?	Yes, they helped a great deal	Yes, they helped somewhat	No they really didn't help	No they seemed to make things worse
	100%	0%	0%	0%
To what extent has the program met your needs?	All needs met	Most needs met	Only a few needs met	None of needs met
	20%	80%	0%	0%
If a friend were in need of similar help, would you recommend our program to him/her?	Yes, definitely	Yes, I think so	No, I don't think so	No, definitely not
	100%	0%	0%	0%

SC MIRECC Acknowledgements



The SC MIRECC would like to congratulate investigator Jeffrey Cully, Ph.D. for his appointment as the Assistant Director of Advanced Fellowships at the VA's Office of Academic Affiliations. Dr. Cully's primary responsibilities pertain to the administration and oversight of "non-accredited" specialty fellowship programs within VA. These specialty programs include MIRECC, Parkinson's Disease Research, Education and Clinical Center, and Health Services Research & Development advanced fellowship programs nationwide.

Congratulations to the SC MIRECC investigators selected to present talks and/or posters at the Improving Veterans Mental Health Care for the 21st Century National VA Mental Health Conference in Baltimore, MD, August 23-25, 2011.

Association between sexual dysfunction and mental health among young OEF/OIF Veterans (Poster)

Monawar Hosain, Ph.D., David Latini, PhD, LPC,
Michael Kauth, Ph.D.;
Heather Honore Goltz, Ph.D., LCSW
& Drew Helmer, M.D., M.S.

Choosing Between Prolonged Exposure and Cognitive Processing Therapy in the Treatment of Military Sexual Trauma Related PTSD: Can Predominant Trauma Affect be Helpful in Clinical Decision-Making? (Poster)

John A. Hunter, Ph.D.

Patient Perspectives on Group-Based Exposure Therapy for PTSD (Poster)

Juliette Mott, Ph.D.; John Sutherland, Ph.D.; Wright Williams, Ph.D.; Stacey Lanier, Ph.D.
& *Ellen Teng, Ph.D.*

Physical Health Status of U.S. Women Veterans: Contributions of Military Sexual Trauma, Sex Partnership, and Chronic Pain (Presentation)

Teri Davis, Ph.D., Brenda Booth, Ph.D.,
Michelle Mengeling, Ph.D., James Torner, Ph.D.
& Anne Sadler, RN, Ph.D.

Calculating Present Productivity: A Collaborative Venture Between Document Storage Systems and Mental Health Programs (Presentation)

J. Vincent Roca, Ph.D. & Gene Long, M.B.A.

Metabolic Monitoring of Antipsychotic Medications: Implementation Strategies, Tools, Barriers and Solutions (Workshop)

Noosha Niv, Ph.D., *Teresa Hudson, Pharm.D.,*
Melissa Christopher, Pharm.D.
& Amy Furman, Pharm.D.

Partners in Dementia Care (Presentation)

Mark Kunik, M.D., M.P.H.

The Couch vs. the Pew? Partnering with Clergy to Reduce Disparities in Mental Health Care for Veterans (Workshop)

Greer Sullivan, M.D., MSPH,
Steve Sullivan, M.Div., Th.M., Justin Hunt, M.D.
& *Tiffany Haynes, Ph.D.*

The REACH Program: Family Psychoeducation for Veterans Living with PTSD and Their Families (Workshop)

Michelle Sherman, Ph.D. & Alan Doerman, Psy.D.

Recent SC MIRECC Publications

PARTNERS IN DEMENTIA CARE: A CARE COORDINATION INTERVENTION FOR INDIVIDUALS WITH DEMENTIA AND THEIR FAMILY CAREGIVERS

Judge, K.S., Bass, D.M., Snow, A.L., Wilson, N.L.,
Morgan, R., Looman, W.J., McCarthy, C.,
& **Kunik, M.E.**

Gerontologist, 2011, 51(2), 261-272

This article provides a detailed description of a telephone-based care coordination intervention, Partners in Dementia Care (PDC), for Veterans with dementia and their family caregivers. Essential features of PDC included (a) formal partnerships between VA medical centers and Alzheimer's Association Chapters; (b) a multidimensional assessment and treatment approach; (c) ongoing monitoring and long-term relationships with families; and (d) a computerized information system to guide service delivery and fidelity monitoring. Data illustrating the use of the intervention were displayed for 93 Veterans and their caregivers after 12 months in PDC. Descriptive data were provided for each major component of the intervention protocol, including initial assessment, goals, action steps, and ongoing monitoring. Care coordinators completed a 12-item questionnaire ascertaining the acceptability and feasibility of implementing PDC.

Data from the assessments and goals indicating areas of need were not limited to any one issue or subset of issues, but were widely distributed across a variety of domains. Findings for action steps suggested a primary focus on getting/giving information and action-oriented tasks to access services and programs. Most action steps were assigned and completed by Veterans' spouses and the majority were successfully accomplished. On average, families had two contacts per month with care coordinators. Few barriers were indicated by care

coordinators in implementing PDC, highlighting the acceptability and feasibility of the PDC protocol. PDC addressed the diverse needs of individuals with dementia and their caregivers, including important non-medical care issues, such as understanding VA benefits, accessing community resources, and addressing caregiver strain. PDC proved to be a feasible model that was complementary to the existing programs of the two partnering organizations.

FACILITATING PRACTICE CHANGES IN MENTAL HEALTH CLINICS: A GUIDE FOR IMPLEMENTATION DEVELOPMENT IN HEALTH CARE SYSTEMS

Kauth, M., Sullivan, G., Cully, J.A., & Blevins, D.

Psychological Services, 2011, 8 (1), 36-47

For more than a decade, health care systems have attempted to implement evidence-based practices and guidelines. These efforts have demonstrated the difficulty in making practice changes in complex systems of care. Many health care systems, including the Department of Veterans Affairs and state community mental health systems, have made adoption of evidence-based treatments, especially psychotherapies, a priority. Psychologists, as behavioral change experts and clinical leaders, are positioned to aid local implementation efforts but may have limited knowledge of the "implementation science" literature. This article provides a brief introduction to the implementation literature and offers a guide for developing an implementation plan to adopt evidence-based psychotherapies in local health care settings illustrated by a hypothetical example. Challenges to implementation are discussed. ■

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SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.