Evidence-Based Case Conceptualization & Treatment Planning for Complex Presentations:

A QUICK GUIDE

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Evidence-Based Case Conceptualization & Treatment Planning for Complex Presentations: a Quick Guide

In mental health care, multiple clinical problems and diagnoses (aka comorbidity) experienced by the same individual are the norm, rather than the exception.[1] Taking a Veteran-centered, proactive and whole-person approach to caring for mental health is part of the VA's whole health initiative.[2] This quick guide illustrates some current best practices for evidence-based case conceptualization and treatment planning for Veterans with complex mental health presentations.

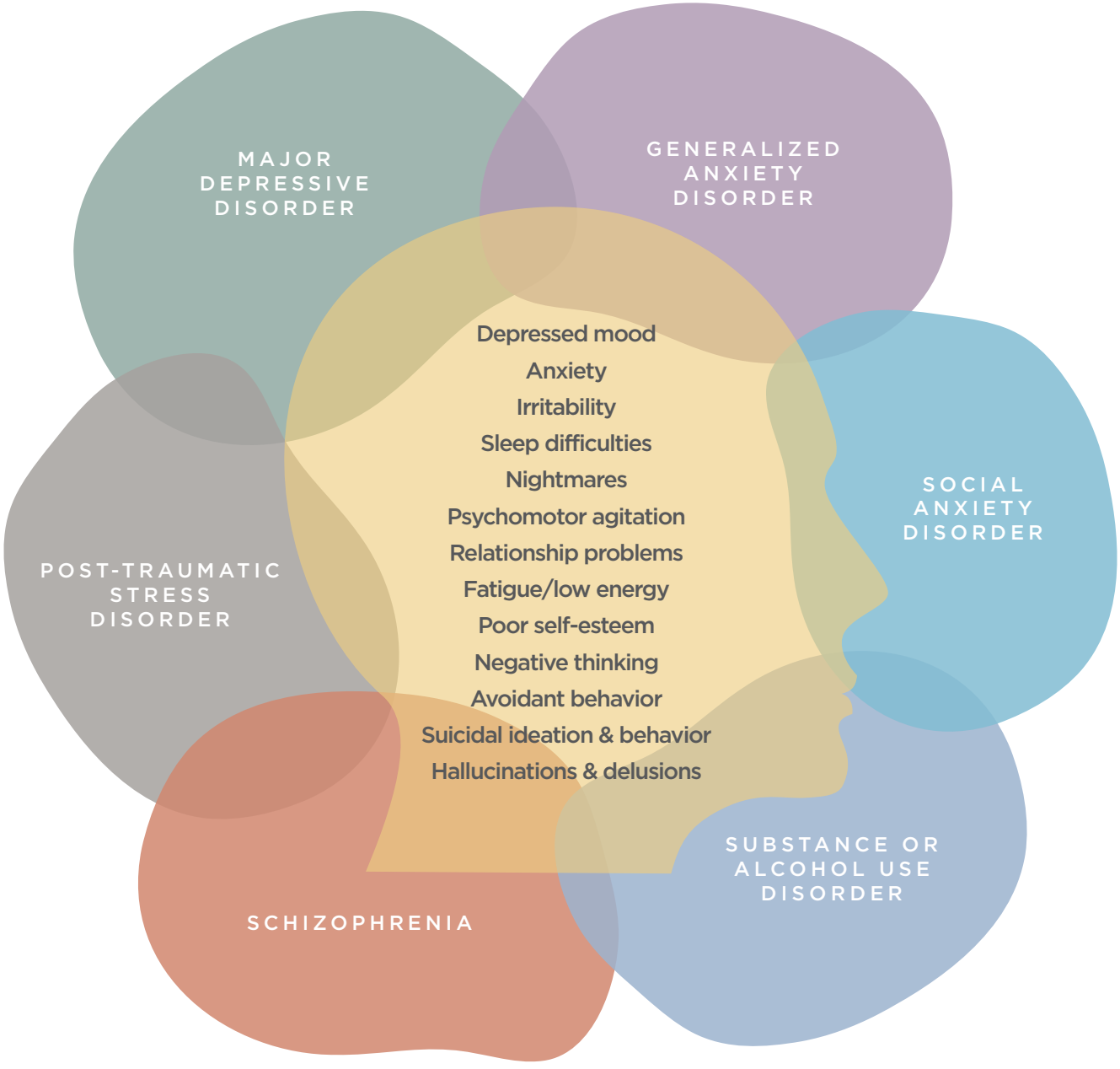

Figure 1. Example of some ways in which different mental health diagnoses can overlap and present with similar symptoms. There are many illnesses and circumstances to which this concept applies; not all are shown.

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The views expressed in this guide are those of the authors and do not necessarily reflect the position or policy of the Department of veterans Affairs or the United States government. This guide was supported by a clinical educator grant from the VA South Central Mental Illness Research, Education and Clinical Center (MIRECC). This manual can be downloaded at https://www.mirecc.va.gov/VISN16/evidence-based-case-conceptualization.asp . For a hardcopy of the manual, please contact VISN16SCMIRECCEducation@va.gov. Questions for the authors about the content in this manual may be directed to Elizabeth.Nosen@va.gov.

How to Use This Guide

What will I learn from this guide?

This guide will help you better understand and plan treatments to address co-occurring mental health conditions. You will learn how to use measurement-based care during case conceptualization and treatment planning. You will learn to take a flexible, Veteran-centered approach to planning care over time.

Who is this guide for?

Clinicians who want to facilitate access to effective and collaborative care for Veterans with complex mental health needs.

How should I use this guide?

Take time to read this guide and consider how you might apply these concepts in your own practice. Develop a working case conceptualization for all Veterans you treat. Use measurement-based care to help inform this case conceptualization and guide shared decision-making around treatment approach.

Case Conceptualization for Complex Presentations

Core Concepts & Definitions

Case conceptualization Case conceptualization, also known as "case formulation," is a clinical summary that provides a framework for understanding the development and maintenance of an individuals' mental health difficulties. It has been described as "the heart of evidence-based practice."[3(p53)] Case conceptualization is usually grounded in a specific theoretical orientation (e.g., Cognitive Behavioral, Interpersonal, Psychodynamic) and includes working hypotheses about the specific factors underpinning mental health difficulties (e.g., negative beliefs, behavioral inactivation, ineffective interpersonal behaviors).[4,5] Case conceptualizations guide selection of symptom measurement tools and treatment approaches, build shared understanding and expectations for progress between the clinician and the individual receiving services and are modified over time as needed, based on new information and insights.[6]

Psychiatric comorbidity The co-occurrence of two or more mental health difficulties within the same individual (e.g., a person experiencing symptoms of posttraumatic stress disorder (PTSD), depression, and substance use).[1,7]

Clinical practice guidelines (CPGs) Systematically developed recommendations for ways to diagnose and treat a medical or mental health condition that are intended to assist clinicians and Veterans with the shared decision-making process.[8] Current VA Clinical Practice Guidelines can be found here: www.healthquality.va.gov/

Evidence-based practice Integration of best available research evidence with clinician clinical expertise and Veteran preferences to inform and optimize Veteran outcomes.[9] Terms like evidence-based practices, treatments and interventions are used to refer to specific types of therapeutic protocols found efficacious in the research literature.

Measurement-based care (MBC) Use of standardized questionnaires or other quantitative measures to systematically evaluate symptoms to inform case conceptualization, shared decision-making and treatment planning.[10,11]

Shared Decision-Making (SDM) The collaborative process by which Veterans and their clinicians make healthcare decisions together, including identification of Veteran needs, goals, values and strengths, evidence-informed education about treatment options, and development of preferences, choices and treatment strategy.[12–14] More information is available on VA shared decision-making here: dvagov.sharepoint.com/sites/VACOMentalHealth/Psychotherapy/SitePages/Shared-Decision-Making.aspx

Treatment planning The iterative process of developing, monitoring, updating and modifying a plan for treating identified health needs.[15]

Recovery model A conceptual framework for treatment planning that recognizes all people are capable of building resilience and a meaningful life through empowerment, skill building and support, regardless of mental health diagnosis.[16,17]

Clinical Complexity & Comorbidity

Common features of complex cases can include severe or diffuse symptom presentation, comorbidity, safety concerns (e.g., suicidality or self-injurious behavior), medical concerns or chronic pain, psychosocial stressors (e.g., severe financial or housing instability), cognitive impairment, motivational concerns and previous treatment failures.[18] These features can complicate clinical decision-making and treatment planning. Comorbidity, in particular, can sometimes leave clinicians uncertain about which condition(s) to treat first.[18]

Spotlight on comorbidity in PTSD

Most individuals experiencing PTSD also experience other types of mental health conditions. According to the National Comorbidity Study:[1]

79% to 88% of individuals with PTSD meet diagnostic criteria for at least one other mental health diagnosis

44 to 59% meet diagnostic criteria for three or more other mental health diagnoses

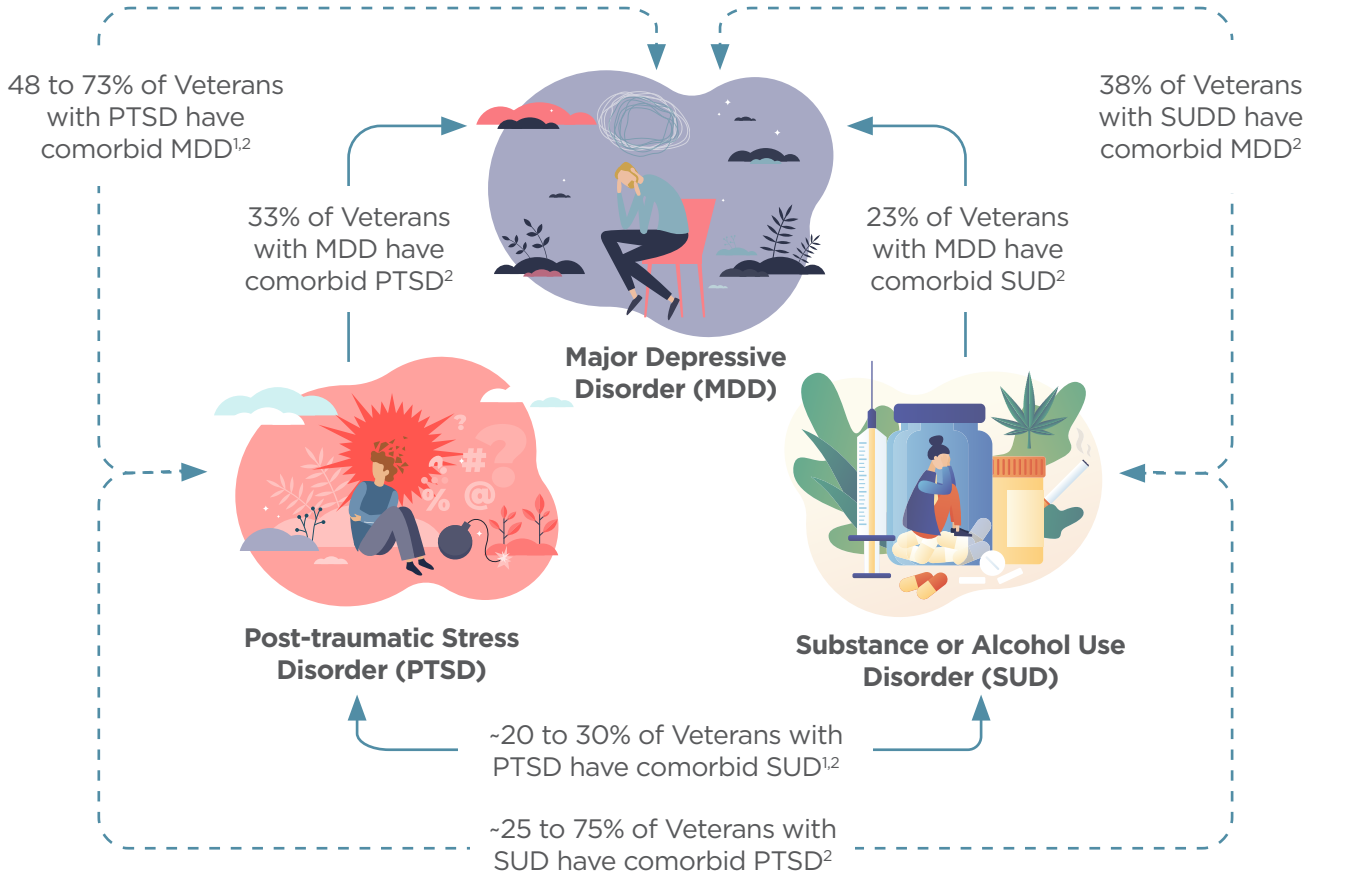


Figure 2. Comorbidity of PTSD in U.S. Veterans.[20]

FACT: Veterans with PTSD and Major Depressive Disorder (MDD) are twice as likely to have attempted suicide (vs PTSD only).[19]

Case Conceptualization

Effective case conceptualization can guide decisions around treatment selection in complex presentations.[6,21,22] A complete case conceptualization[6,23–25]:

- Describes all key problems or symptoms experienced
- Proposes hypotheses about the specific mechanisms maintaining distress or dysfunction, including both origins and more recent precipitants activating these mechanisms
- Is a parsimonious, coherent narrative that ties various information together as a whole
- Is grounded in a theoretical approach but is tailored and individualized to the Veteran
- Is developed collaboratively with shared understanding between the clinician and the Veteran
- Is flexible and is permitted to change or evolve over time as new information emerges and treatment progresses

Tips for Developing an Effective Case Conceptualization

Obtain a thorough biopsychosocial history as a part of the diagnostic evaluation.

- Learn what was going on in the Veteran's life when symptoms first began, the timeline/course of symptoms, and factors or situations that seem to increase/decrease symptoms as well as the physical/environmental/cultural context of the Veteran's experiences with an eye towards understanding the factors underlying the presenting problem.

Example: *Knowing that a someone's sleep problems began soon after an assault is a clue that the person may be experiencing trauma-related symptomatology. Conversely, knowing that a person's sleep problems began shortly after initiating a new medication should prompt exploration of alternative causation (e.g., pharmacological side-effects).*

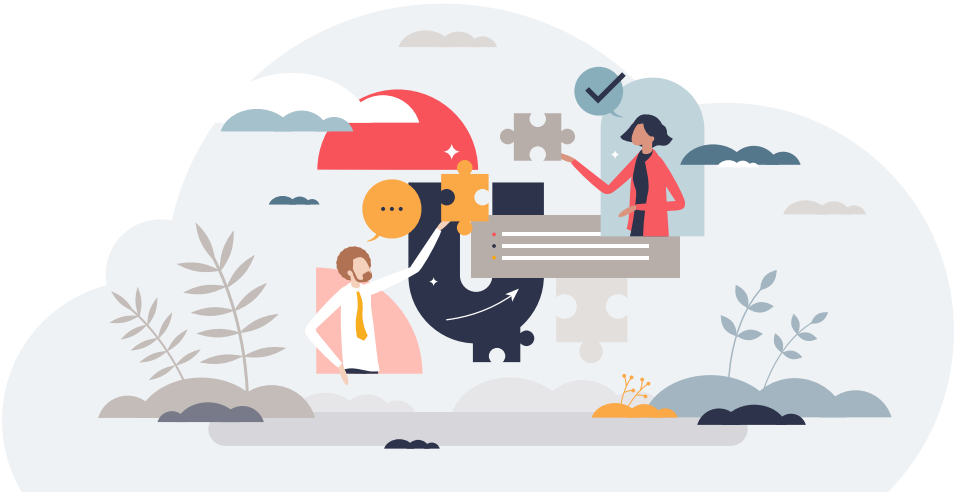
The "4 Ps" model encourages assessing the biological, social or psychological factors that may be functionally contributing to the presenting problems in the following ways:[26–30]

1. **Predisposing Factors** What makes the Veteran vulnerable to the presenting problem? Consider genetics and biology, early childhood experiences, social modeling, generational trauma, sociocultural factors, etc.
2. **Precipitating Factors** Why is this problem occurring now? Identify antecedent conditions, events or experiences that may be causal triggers (e.g., moving to a new city, relationship conflict, alcohol use) or current reasons for seeking treatment (e.g., escalation of adverse consequences, job or relationship loss).
3. **Perpetuating Factors** What factors are exacerbating or maintaining the presenting problem? Consider mechanisms that may become potential targets for intervention (e.g., poor coping skills, problematic ways of thinking, limited occupational prospects or training, isolation, avoidance, emotional or social reinforcers, pain).
4. **Protective Factors** Why isn't the presenting problem even worse than it is? Identify Veteran strengths and other conditions that ease severity or mitigate risks (e.g., good social support, stable employment or volunteerism, self-care, intelligence).

Collaborate and exchange ideas with the Veteran.

Provide a summary to the Veteran and ask for feedback, opinions, and thoughts. Ask the Veteran for thoughts as to why certain things are bothersome or how various problems relate. Be curious and further explore symptoms or issues that don't seem to fit with the current case conceptualization. Listen for information that may not have been initially offered and/or that was previously assumed to be unrelated.

Example: *Some Veterans may feel intense shame about certain feelings or experiences (e.g., sexual issues, trauma history, hallucinations, substance use), or may not realize when information may be relevant (e.g., "I thought that was normal; aren't everyone's parents like that?") so may not mention unless asked directly or invited to explore in additional depth. However, these details can be critical to an accurate case conceptualization.*



Treat your conceptualization as a hypothesis.

Be open to revising your case conceptualization and diagnoses, based on new information. If treatment does not appear to be working as well as anticipated, see this as an opportunity to review and revise your hypotheses. Track symptoms using measurement-based care to assess treatment progress and efficacy.

> ***Example:*** *A clinician initially conceptualized a Veteran's anxiety as being related to job stress and discomfort speaking up in meetings when her boss was present. The therapist taught the Veteran assertiveness skills to assist. However, this treatment did not seem to relieve the anxiety. The therapist and Veteran took the opportunity to review the case conceptualization and discussed information that may not have been known. This led to the discussion of a sexual assault that was not previously disclosed. The anxiety was reconceptualized as PTSD and treated accordingly, which brought the client needed relief.*

Know your blind spots.

Like all humans, mental health clinicians are subject to personal biases and tend to rely on heuristics when short on time. Blind spots can develop based on:

- **Background training:** Therapists may be more likely to conceptualize problems in a way that can be addressed by psychotherapy and focus on psychological or psychosocial contributing factors. Clinicians with prescribing privileges may be more likely to conceptualize a problem in a way that can be addressed by medications and focus on biological contributing factors.
- **Clinic area or specialty:** Clinicians working in a substance use disorder (SUD) clinic may be more likely to conceptualize a problem such as sleep difficulty as being a direct result of substance use, but clinicians working in a PTSD clinic may be more likely to attribute those same problems to PTSD.
- **Personal background and experience:** Clinicians are raised in households or cultures that vary in level of acknowledgment and support of certain diagnoses, mechanisms or treatment approaches. Clinicians may also have had personal or professional experiences that make certain diagnoses or explanations for symptoms seem more salient or probable.
- **Veteran characteristics:** Mental health conditions can be over- or under-diagnosed, depending on the Veteran's age, race, ethnicity, gender, socioeconomic status, sexual orientation, indigenous heritage, and national origin.[31–35] Vickers and colleagues,[36] for example, recently found that Black and Hispanic Veterans are more likely to be assigned an Alcohol Use Disorder (AUD) diagnosis than White Veterans, despite similar levels of alcohol consumption.

BLIND SPOTS can create serious missed opportunities and adversely impact treatment access. Reflect on your practice and take actions to help reduce the impact of blind spots and bias (e.g., seek consultation and additional training). Using an evidence-based approach to diagnosis, case conceptualization and treatment planning can also help offset the impact of biases.[37,38]

Measurement-Based Care in Case Conceptualization

Measurement-based care (MBC) is a pillar of evidence-based practice and involves systematic administration of questionnaires or other quantitative measures to inform case conceptualization, shared decision-making and course of treatment. As an adjunct to clinical interview, mental health measures offer a quick and easy objective benchmark for assessing symptom severity and other treatment-relevant characteristics.[39] Repeated assessment allows you to observe change over time and track treatment effectiveness.

In VA, MBC specifies three vital interconnected components: Collect (gather evidence-based measures at clinically appropriate intervals), Share (discuss the results with Veterans), and Act (inform treatment plans and goals for recovery).[40]

Learn more at dvagov.sharepoint.com/sites/VACOMentalHealth/MBC or contact MBCInformation@va.gov.

MBC improves case conceptualization and treatment planning in the following ways:

- Serves as a tool to start a discussion between a Veteran and a clinician
- Provides objective data that may improve accuracy of clinical decision-making
- Helps efficiently assess both presence and severity of symptoms across diagnoses and theoretical approaches
- Ensures that both the Veteran and clinician are aware of changes (if any), which in turn facilitates identification of treatments that are working as well as reduces time spent on ineffective treatment
- Facilitates effective team-based care when used across the clinic, service or organization
- Permits assessment of theorized mechanisms of change (e.g., negative beliefs or avoidance in depression or PTSD) and case conceptualization hypotheses

Example: Use of MBC for Case Conceptualization Hypothesis Testing

Veteran presented with cocaine use and depressed mood.

Veteran and clinician identified three different case conceptualization possibilities:

1

Veteran's cocaine use may be triggering depression symptoms (e.g., low self-esteem resulting from biopsychosocial consequences of cocaine use).

In this case, Cocaine Use Disorder diagnosis would be prioritized for treatment.

2

Veteran's depressed mood may be triggering cocaine use (i.e., substance use as a coping mechanism).

In this case, Major Depressive Disorder (MDD) diagnosis would be prioritized for treatment.

3

Both these possibilities may be occurring simultaneously.

In this case, concurrent or sequential treatment may be indicated.

They agreed to set up a test based on Veteran's preferences—treat the cocaine use first using best practices (Contingency Management) and measure both cocaine use (via BAM-C and UDS) and depression symptoms (via PHQ-9) during treatment1

If Option 1 is correct:
Effective treatment of cocaine use will be associated with reduced depression symptoms.

Measures over time:
BAM-C/UDS = negative
PHQ-9 = decreasing >5 pts and to minimal range

If Option 2 is correct:
Depression symptoms will persist even after effective treatment of cocaine use.

Measures over time:
BAM-C/UDS = negative and
PHQ-9 = same or increasing

If Option 3 is correct:
Effective treatment of cocaine use will partially lower depression symptoms.

Measures over time:
BAM-C/UDS = negative and
PHQ-9 = decreasing >5 pts but not to minimal range

BAM-C = Brief Addiction Monitor Consumption Items; PHQ-9 = Patient Health Questionnaire 9; UDS = Urine Drug Screen

Review of measure patterns over time revealed that Option 3 appeared most accurate: Veteran found his mood improved after stopping cocaine use but not 100%.

On the basis of this information, Veteran and his clinician agreed that prioritizing treatment of MDD would be a good next step. Veteran agreed to a referral to a course of Cognitive Behavioral Therapy.

Measurement-Based Care as a Transdiagnostic Tool

Because many medical and mental health conditions can present with similar features and symptoms, it is important to interpret Veteran-reported outcome measures alongside (not in place of) good diagnostic assessment practices. For example, the Patient Health Questionnaire (PHQ-9)[41] is conceptualized as a measure of depression symptom severity. However, Veterans can experience many of the symptoms assessed (and therefore self-report elevated PHQ-9 scores) without meeting diagnostic criteria for Major Depressive Disorder (MDD). This often occurs when symptoms are attributable to other diagnoses and conditions (e.g., untreated hypothyroidism, recent back injury, substance use). In these cases, you may still find it very useful to track symptoms using the PHQ-9. However, treatment selection should be guided by accurate diagnoses and case conceptualization (e.g., treat the hypothyroidism first and see if this resolves symptoms before moving on to considering a diagnosis and treatment of MDD).

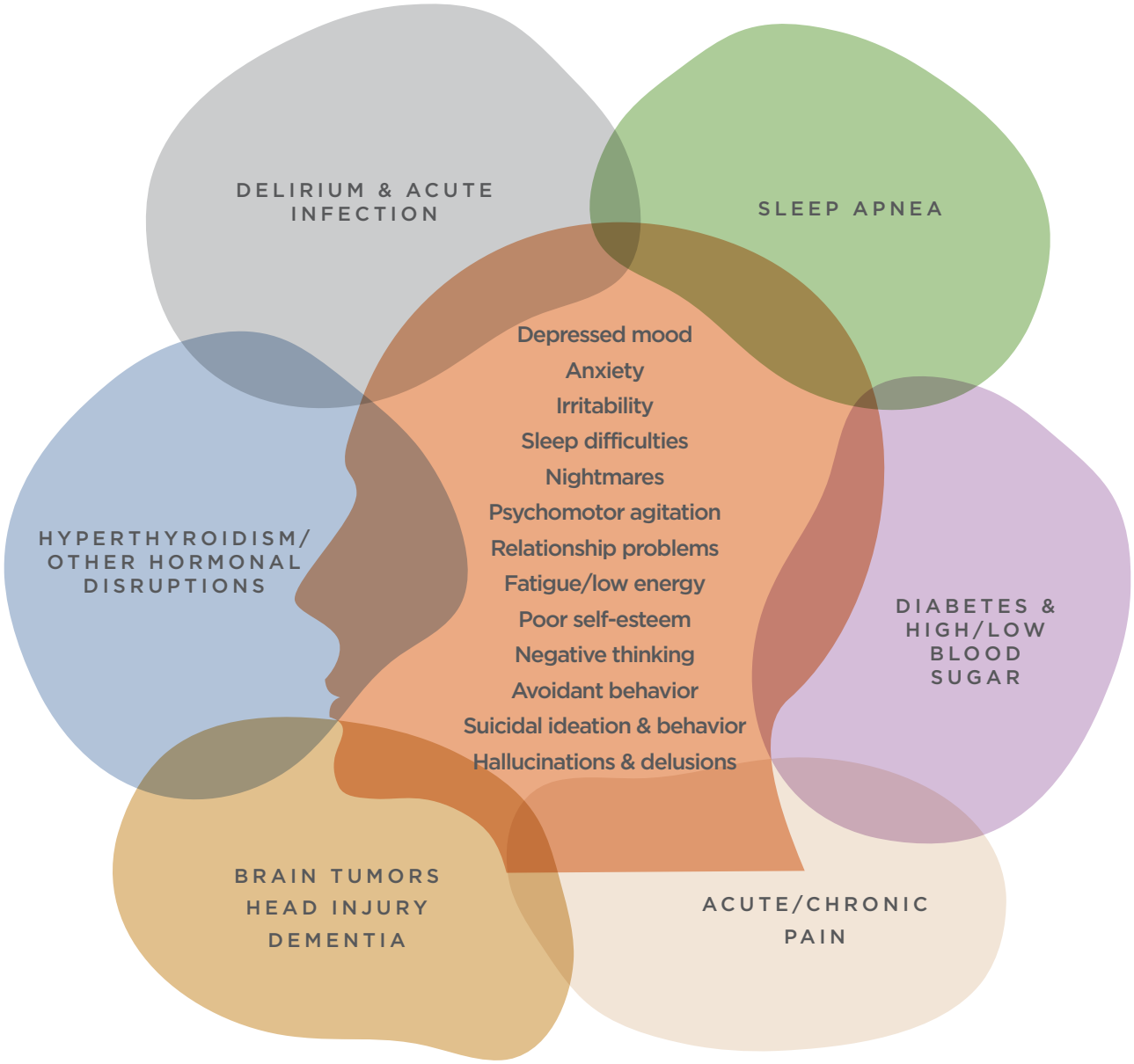


Figure 3. Many symptoms commonly attributed to mental health conditions can also stem from medical concerns.

Measurement-Based Care Quick Reference

The VA Measurement Based Care in Mental Health Initiative promotes the collection of patient-reported information (COLLECT), to inform shared decision-making (SHARE) and to individualize clinical care and treatment plans (ACT).[40]

The initial four measures in the initiative included:

- Patient Health Questionnaire (PHQ-9) for assessment of depression
- Generalized Anxiety Disorder (GAD-7) for assessment of anxiety
- Brief Addiction Monitor (BAM-R) for assessment of substance use, risk and recovery factors
- PTSD Symptom Checklist (PCL-5) for assessment of PTSD

These and additional measures are included below for quick reference:

Measure	Score	Interpretation	
Patient Health Questionnaire-9 (PHQ-9)[42]	1–4	No Depression (or remission)	Score ≥ 8–10 indicates probable depression. 5-pt change = clinically significant.
	5–14	Mild Depressive Symptoms	
	15–19	Moderate Depressive Symptoms	
	20–27	Severe Depressive Symptoms	
Generalized Anxiety Disorder-7 (GAD-7)[43]	0–5	Mild Anxiety	Score ≥ 10 indicates probable anxiety disorder. 5-pt change = clinically significant.
	6–10	Moderate Anxiety	
	11–15	Moderately Severe Anxiety	
	16–21	Severe Anxiety	
Brief Addiction Monitor (BAM-R)[44]	Substance Use composite Sum of items: 4, 5, 6	Range 0-90	No cutoffs for this measure; use to assess baseline and change over time. 10-pt change = clinically significant.
	Risk Factors composite Sum of items: 1, 2, 3, 8, 11, 15	Range 0-180	
	Protective Factors Sum of items: 9, 10, 12, 13, 14, & 16	Range 0-180	
Alcohol Use Disorders Identification Test (AUDIT)[45]	1–7	Low Risk Consumption	Score ≥ 8 indicates hazardous alcohol use.
	8–14	Hazardous or Harmful Alcohol Consumption	
	15 or more	Moderate-Severe AUD	
PTSD Checklist 5 (PCL-5)[46]	0–10	No or minimal symptoms reported	Score ≥ 31–33 indicates probable PTSD. 5-pt change = reliable change. 10-pt change = clinically meaningful.
	11–20	Mild Symptoms	
	21–40	Moderate	
	41–60	Severe	
	61–80	Very Severe	
Insomnia Severity Index (ISI)[47,48]	0–7	No Clinically Significant Insomnia	6-pt change = clinically meaningful.
	8–14	Subthreshold Insomnia	
	15–21	Clinical Insomnia (moderate)	
	22–28	Clinical Insomnia (severe)	

Talking Points: Tips for Integrating Measurements into Case Conceptualization

Share results and solicit feedback.

Your score on the PHQ-9 today is a 12. This is in the moderate range; it also appears a little bit higher than the last time we met (which was a 10). How does this fit with how you've been feeling?

That sounds pretty accurate, I guess. I have been feeling a little more stressed out about work lately. My sleep has been worse, that's for sure.

Seek clarification as needed.

I see your AUDIT score today is a 0. That's great! Oh wait, didn't you mention going out for drinks last weekend?

That's right! Sorry, I forgot about that when filling out the questionnaire; let me update that.

Keep an eye out for clinically relevant discrepancies between the measures, case conceptualization and symptoms.

I see you scored a 3 on the GAD-7 today, which is in the minimal range. So does that mean you've been feeling less anxious?

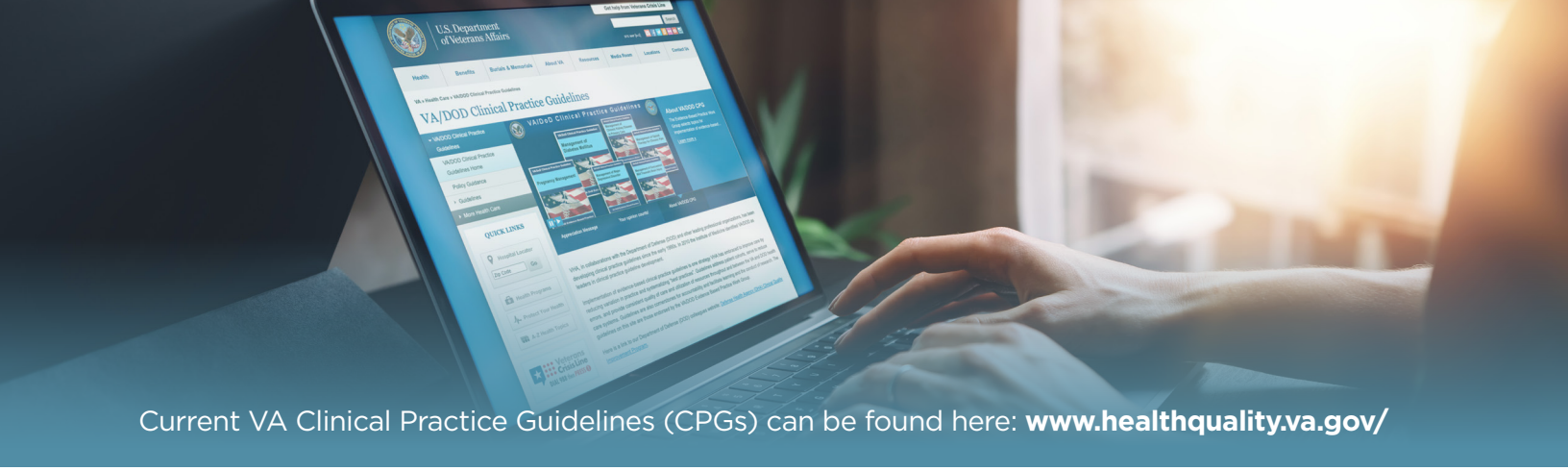
Well sort of...I have been feeling a lot less worried about work and school...but at the same time I've been having these new bouts of dizziness anytime I stand up. Could that be anxiety?

Hmm, hard to say. Can you share more about what you're experiencing? What it feels like? Any other triggers you're noticing? Since this is a new symptom for you, we might have your primary care doc check it out as well. That way we can make sure it's not related to a medical issue.

Treatment Planning for Comorbid Presentations

Once a working case conceptualization has been established, the next step is to complete shared decision-making[14] around treatment approach. Case conceptualization will ideally have identified the key mechanisms and targets for treatment. You are subsequently encouraged to consult clinical practice guidelines and the research literature to identify the most effective interventions to discuss with the client as a part of the shared-decision making process.

Ruscio & Holohan (2006)[18] argue that, in complex presentations, when in doubt the best approach to begin with is to offer the identified empirically supported treatment(s) for the target problem, delivered with the originally intended fidelity. This is simply because choosing a treatment option known to work effectively for a given problem has a better likelihood of success than choosing a treatment option or modifications with no known efficacy. Fortunately, a growing body of research is also offering support for sequential, concurrent and integrated approaches to delivering multiple evidence-based practices in comorbid populations. For example, evidence suggests that delivering Prolonged Exposure therapy alongside with other evidence-based practices has been shown to effectively reduce PTSD symptoms and improve functional outcomes among individuals with comorbid substance use[49,50] and Borderline Personality Disorder[51,52] more than delivery of single-focus protocols alone.



Current VA Clinical Practice Guidelines (CPGs) can be found here: **www.healthquality.va.gov/**

About the Clinical Practice Guidelines

The VA CPGs are a tool to facilitate evidence-based treatment planning. These are systematically developed, research-based recommendations for how to triage and treat medical and mental health conditions. CPGs are intended to assist clinicians and Veterans with the shared decision-making process by identifying the treatments most likely to be effective for a given condition.

Each CPG specifies which treatment options for a specific condition have "strong," "weak" or "insufficient" evidence. Note that these designations reflect the state of the scientific literature when the CPG was created, not efficacy per se. That is, treatments designated as having "weak" or '"insufficient" evidence could possibly be quite effective, but thus far they lack sufficient evidence to demonstrate this. In general, it's best practice to start with the treatments you're more confident are going to be helpful (aka "strong" evidence) before moving to the treatments you're less certain about (aka "weak" or "insufficient" evidence).

VA CPGs have currently been developed for a variety of mental health conditions, including Suicide Prevention, First-Episode Psychosis and Schizophrenia, PTSD, SUD, MDD, Bipolar Disorder and Insomnia. In addition to VA CPGs, you can also consult other resources to identify effective treatment options, including the CPGs from non-VA workgroups (e.g., American Psychological Association CPGs: www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines; ECRI Guidelines Trust: www.ecri.org/solutions/ecri-guidelines-trust), systematic reviews or other types of research articles and/or the expertise of colleagues.

Using VA Clinical Practice Guidelines in Context of Comorbidity

For a Veteran experiencing symptoms of multiple clinically relevant mental health diagnoses, it is ideal to review and discuss the CPGs for each mental health condition to develop an appropriate holistic treatment plan.

This does not mean that every condition is targeted with a disorder-specific first-line treatment at once. Rather, it means the CPGs are consulted and included as a part of the collaborative decision-making process that includes prioritization of urgent needs and treatments hypothesized to make the biggest impact based on integration of the case conceptualization, clinician judgment, Veteran preference, and best available research evidence. This also allows opportunities to look for

appropriate transdiagnostic or integrated options (e.g., therapies or medications that are likely to be helpful for more than one present condition) or opportunities for sequential or concurrent treatment planning approaches.

Effective treatment plans for concurrent conditions will include both an immediate focus as well as a projected order of operations over time that will be informed by measurement-based care (i.e., tracking what is working as well as where improvements still need to be made).

Tips for Using CPGs in Treatment Planning

The VA CPGs are formatted in a variety of ways to improve ease of use. For example, the clinician resources available as a part of the CPG for Bipolar Disorder include the full guideline (220 pages), provider summary (24 pages), quick reference (11 pages) and pocket card (2 pages). Clinicians may download and/or bookmark the CPG clinician resources to facilitate access and review as needed.

The VA CPGs also include tools suitable for sharing directly with Veterans and their families. For example, the CPG for Bipolar Disorder includes seven different Veteran-facing educational handouts and brochures. These documents can be particularly useful to have on hand during sessions to help facilitate shared decision-making conversations.

For complex presentations, multiple CPGs may be relevant. As such, you are encouraged to review the relevant VA CPGs prior to treatment planning sessions to help understand areas of overlap across conditions and identify priority recommendations.

Basic Steps to Treatment Planning for Psychiatric Comorbidities


Set expectations for recovery at onset.


Assess and address urgent health, safety and security needs first, including unmet needs for food, water, medical treatment, clothes and safe housing, as well as stabilization of mental health emergencies (e.g., suicidality, active psychosis, delirium).


Provide a complete mental health evaluation including measurement-based care, biopsychosocial history, and diagnostic assessment to inform and assist with development of a working case conceptualization.


Complete shared decision-making, including review of treatment options that are most likely to be effective for each mental health diagnosis and treatment goal as well as prioritization of interventions, given the time available.


Implement chosen treatment strategies and administer patient-reported outcome measures to help track progress.


Return to case conceptualization and shared decision-making following completion of an intervention and/or if progress is not being made.


Reinforce gains and provide closure once goals are met or upon transitions to other levels or types of care.

Shared Decision-Making: Initial Treatment Planning

Veteran presents with mental health symptoms

Assess and address any urgent health, safety and security needs.

Complete Mental Health Evaluation

Assess acute/chronic suicide risk & any safety concerns; complete safety planning.

Complete diagnostic/psychosocial interview to clarify problem list and diagnoses.

Assess severity of mental health problems using MBC

Consider PHQ-9, PCL, AUDIT-C, BAM-R, GAD-7, ISI or other measures as indicated.

Develop initial case conceptualization.

Assess and troubleshoot adherence, side-effects, safety, psychosocial barriers to treatment, diagnoses, case conceptualization and re-evaluate whether changes to treatment plan are indicated.

Complete Shared Decision-Making

Discuss case conceptualization and solicit feedback to develop shared understanding.

Share information with the Veteran about the treatments most likely to be helpful for each condition (i.e., per CPGs or other research).

Explore Veteran goals, values and preferences.

Collaboratively decide on an initial (and potentially longer-term) treatment plan.

Discuss measurement-based care plan, including how to tell if treatment is working and what next steps might be considered if treatment isn't effective.

Reassess symptoms, diagnostic status, functionality, quality of life, additional treatment and support needs, Veteran preferences, suicide risk or other urgent needs.

Is Veteran improving?

YES **NO**

Great! Develop maintenance and relapse prevention plan.

Shared Decision-Making: Initial Treatment Planning Case Example

Angela Garcia is a 53-year-old woman who was referred for "anxiety and depression." She noted that she has "dealt with these problems for a long time," and she was reluctant to even show up for the appointment. She reported that she "used to be a different person" before she joined the military, but an assault early on in her service "taught her to handle things herself and not rely on other people." She reported that she has been having "a few drinks" at night to help her sleep ever since then. She retired last year from the military after 30 years of service. Her only son moved out of the home two months ago, so she is currently living alone and does not get out of the house often. She has a history of high blood pressure, migraine, and hypothyroidism for which she sees primary care at the VHA.

Veteran's PCP introduced her to a mental health social worker to discuss depression symptoms.

Ms. Garcia reported that she and her PCP had discussed and planned to evaluate potential medical contributors to her mood, including a history of hypothyroidism and a potential impact of menopause on mental health symptoms.

Mental Health Evaluation

The clinician completed a full evaluation while prioritizing rapport and a recovery-oriented approach, given Ms. Garcia's hesitance to engage in care.

The clinician administered measures that yielded the following scores[1]:

- C-SRRS: Negative;
- PHQ-9: 22 (Severe);
- AUDIT-C: 4 (Positive);
- PCL-5: 65 (Positive)
- ISI: 18 (Moderate).

No emergent needs were identified.

Shared Decision-Making

The clinician provided personalized feedback and discussed Ms. Garcia's reaction to the information, how she felt it fit for her, and what her goals for treatment might be.

Ms. Garcia initially reported that she would like to focus on sleep difficulty.

The clinician and Ms. Garcia conceptualized that sleep problems may be stemming from a few areas of concern, including PTSD, alcohol use, and medical conditions.

The clinician provided education on how these conditions may be impacting sleep, as well as treatment options available for PTSD and alcohol use.

Ms. Garcia reported that she appreciated the information on PTSD and alcohol use but noted uncertainty about whether mental health treatment was right for her. She reported that she would like to initially prioritize medical evaluation of hormonal and other biological contributors to sleep difficulties. If this didn't sufficiently address her problems, she reported she would consider therapy for PTSD or depression as a next step.

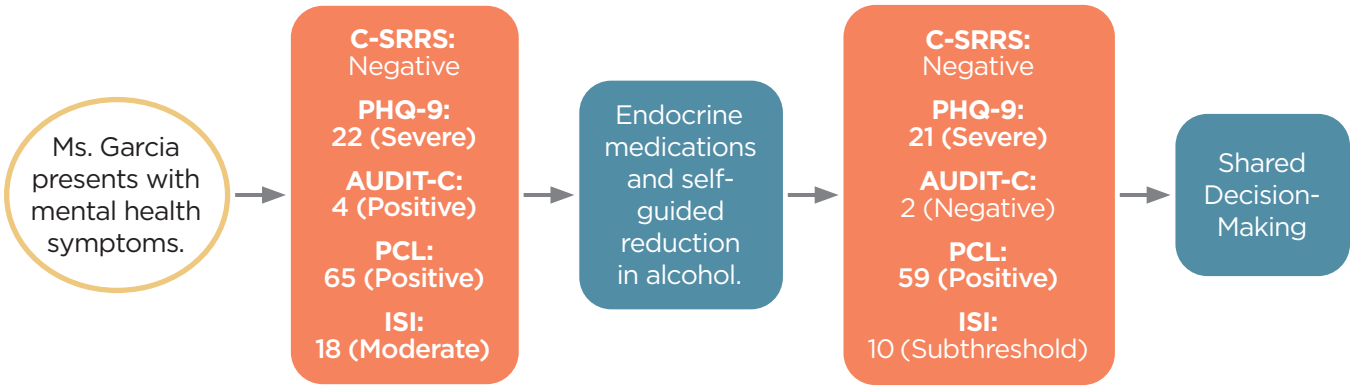
Ms. Garcia agreed to return in a month to report whether her symptoms were improving, using the same measures administered today.

1. C-SSRS= Columbia Suicide Severity Rating Scale; PHQ-9 = Patient Health Questionnaire 9; AUDIT-C = Alcohol Use Disorders Identification Test – consumption items; ISI = Insomnia Severity Index; PCL-5 = PTSD Checklist 5

Per the initial treatment plan, Ms. Garcia continued working with her PCP to address potential medical causes of sleep difficulties. Her PCP prescribed a medication to address identified thyroid hormone imbalances.

After a month of taking this medication, Ms. Garcia met with her mental health clinician for a follow-up visit. The clinician re-administered the measures, which yielded the following scores: C-SSRS: Negative; PHQ-9: 21 (Severe); AUDIT-C: 2 (negative); PCL: 59 (Positive) & ISI: 16 (Moderate).

Ms. Garcia and her clinician reviewed these scores together. She noted that she was feeling good about cutting back on alcohol use this month, which is reflected in the lower AUDIT-C score. Ms. Garcia also noted that she has been getting a few more hours of sleep overall. However, she reported continuing to feel sad most days and has even noticed a few more nightmares interrupting her sleep. Ms. Garcia agreed to more in-depth assessment and shared decision-making around mental health treatment options.



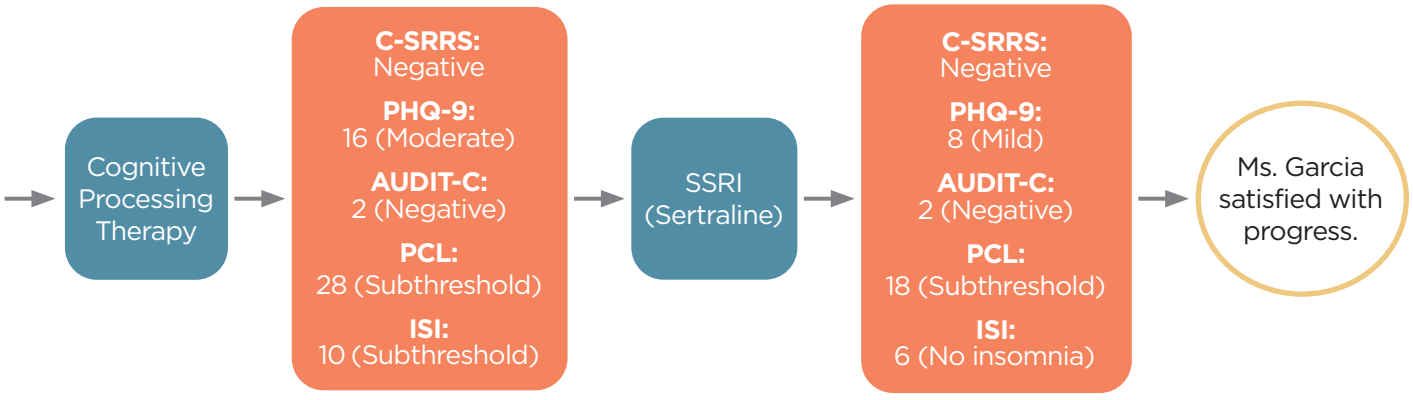
Ms. Garcia's clinician opted to use measurement-based care to guide a collaborative discussion of case conceptualization and shared decision-making. They also re-administered these measures periodically over the subsequent months to help assess progress and guide further treatment decisions.

Suicidality (CSSRS) Ms. Garcia denied any history of suicidal ideation, plans, intent or behavior and she reported strong cultural and religious beliefs that prohibit suicide. Ms. Garcia and her clinician agreed that suicidality was not an acute concern. They agreed to check in on suicidality using the C-SSRS. To strengthen protective factors, Ms. Garcia also reported plans to resume attending a prayer service she previously enjoyed because she considers her faith to be a great source of strength.

Alcohol use (AUDIT-C) Ms. Garcia did not meet diagnostic criteria for an AUD. She was provided education about potential adverse effects of alcohol on sleep and education on recommended safe drinking levels. She and her clinician hypothesized that alcohol may be contributing somewhat to her sleep problems. Ms. Garcia decided it may be a good idea for her to stop drinking entirely following this discussion. Ms. Garcia declined need for additional assistance with this effort but agreed to reach out if she experienced difficulties reducing use. She and her clinician agreed to check in on alcohol use at subsequent visits. They reviewed progress over time and noted that Ms. Garcia was indeed successful at reducing use on her own.

PTSD (PCL-5) Ms. Garcia initially reported that she did not want to talk about the assault she experienced in the military and was hesitant to engage in PTSD assessment and treatment. Her clinician normalized this concern and provided general education about trauma reactions and PTSD symptoms. The clinician informed Ms. Garcia about the impact PTSD could have on sleep. Following this discussion, Ms. Garcia agreed to complete the CAPS-5, which confirmed a diagnosis of PTSD. They agreed to conceptualize PTSD as a primary contributor to her mood, anxiety and sleep problems and reviewed best-practice treatment options for PTSD. Ms. Garcia agreed to a referral to a PTSD specialist for trauma-focused therapy as a next step, where she agreed to engage in weekly Cognitive Processing Therapy (CPT).

Depression (PHQ-9) Ms. Garcia and her therapist initially conceptualized PTSD as the primary contributor to her depressed mood, so they did not begin separate treatment options for depression. However, they agreed to continue monitoring depression symptoms to ensure mood improved satisfactorily with trauma treatment. Ms. Garcia completed a course of CPT with a PTSD specialist. She and her therapist tracked her PTSD and depressive symptoms using the PCL-5 Checklist and PHQ-9. Reviewing scores, Ms. Garcia reported she felt really good about work she completed processing her trauma, but she wished for additional improvement in depression symptoms.



She and her clinician discussed depression treatment guidelines and available options. Ms. Garcia reported she needed a break before jumping back into weekly psychotherapy. They decided to consider medication for treatment of depression. Given Ms. Garcia's residual PTSD symptoms, she and her PCP decided that sertraline may be a good since it's been found to be effective for both PTSD and depression. After three months of using a therapeutic dose of sertraline, Ms. Garcia reported continued improvements in both PTSD and depression symptoms.

Insomnia (ISI) Sleep problems were Ms. Garcia's primary presenting complaint. Throughout treatment, she and her clinician conceptualized PTSD, depression, thyroid hormone abnormalities, and alcohol use as contributing factors to her insomnia. They observed that, following PTSD therapy, treatment of thyroid hormone levels, initiation of depression medication and reduction in alcohol use, Ms. Garcia was now sleeping much better. ISI score posttreatment was a 6 (no clinically significant insomnia range). Ms. Garcia and her clinician agreed that additional treatment for insomnia was not needed at present.

Talking Points: Tips for Integrating MBC into Treatment Planning

Review scores over time.

This is our 10th session together. Let's take a moment to check in about what changes you've noticed in your depression symptoms since we started our work. Looking back...it looks like when we first started meeting about two months ago, your PHQ-9 depression score was a 23, which is in the severe range. Today, your score is a 15, which is in the moderate range. What do you think about that?

It's interesting seeing that the score has changed. To be honest, I wasn't sure if we were making any progress. In part, I think it's hard for me to see improvements from day-to-day, so looking back over two months helps put things in perspective. I'm still not where I want to be with the depression, though; it's still a struggle most days.

Yes, sometimes it's easier to see progress when we look back over time. I agree though— you still have depression symptoms that are affecting you. Let's talk about what small changes we may want to consider to help get you where you want to be.

Reflect on change (or lack thereof).

Let's have a look at your sleep scores on the ISI. It looks like your insomnia scores initially improved after we first started our work together, but recently your sleep has worsened. What do you make of that?

Yeah, when we first started the new medication, it seemed like it was working pretty well. But since I lost my job, I just haven't been able to stop worrying about how I'm going to pay my bills. I'm worried we might lose our house. I just can't relax enough to sleep.

That does sound incredibly stressful. Let's talk about what kinds of things may be helpful.

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