

**LOCAL IMPLEMENTATION OF EVIDENCE-BASED PSYCHOTHERAPIES FOR
MENTAL AND BEHAVIORAL HEALTH CONDITIONS**

- 1. REASON FOR ISSUE.** This Veteran Health Administration (VHA) Handbook specifies the expectations and procedures for implementing evidence-based psychotherapies (EBP) for specific mental and behavioral health conditions locally. **AUTHORITY:** Title 38 United States Code 1706.
- 2. SUMMARY OF CHANGES.** This is a new VHA Handbook which provides the procedures for implementing VHA Handbook 1160.01, which requires that facilities make available and provide EBPs for specific mental and behavioral health conditions.
- 3. RELATED ISSUES.** VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.
- 4. RESPONSIBLE OFFICE.** Mental Health Services (10P4M) in the Office of Patient Care Services (10P4) is responsible for the contents of this Handbook. Questions may be directed to the National Mental Health Director for Psychotherapy and Psychogeriatrics, Mental Health Services, VA Central Office, at 202-461-7304.
- 5. RECISSIONS.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled to be recertified on or before the last working day of October 31, 2017.

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LOCAL IMPLEMENTATION OF EVIDENCE-BASED PSYCHOTHERAPIES FOR MENTAL AND BEHAVIORAL HEALTH CONDITIONS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook specifies the expectations and procedures for locally implementing evidence-based psychotherapies (EBP), which must be made available to Veterans with specific mental and behavioral health conditions (see subpar. 15a and 15b). **AUTHORITY:** Title 38 United States Code 1706.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) is strongly committed to making EBPs widely-available to Veterans with mental and behavioral health conditions. VHA Handbook 1160.01 requires that Veterans have full access to EBP services as designed and shown to be effective, and that facilities have full-staff capacity to provide these therapies. **NOTE:** *Additional requirements for ensuring local capacity to deliver EBPs are specified in the VHA Mental Health Initiative Operating Plan (see subpar. 15b).*

b. VHA has developed and implemented competency-based EBP staff training programs. As of August 31, 2012, VHA has provided EBP training to over 6,000 VA mental health staff. VHA has also developed other mechanisms to promote the dissemination and implementation of these therapies, including designation of a Local EBP Coordinator at each facility.

c. Initial program evaluation results associated with the dissemination of EBPs in VHA reveal that VHA, as a system, has significantly increased its capacity to provide these treatments and that training in, and implementation of, EBPs has yielded significant, positive therapist and patient outcomes (see subpar. 15c).

d. Beginning in Fiscal Year 2012, VHA developed and implemented a performance measure requiring the delivery of at least eight psychotherapy sessions within a 14-week therapy period for Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans with Post-Traumatic Stress Disorder (PTSD). Several additional metrics, for information purposes, have been developed that measure the extent to which Veterans of all eras with PTSD, depression, and other conditions are receiving similar doses of psychotherapy within a 14-week therapy period. These additional metrics are part of a larger set of mental health metrics related to the requirements of VHA Handbook 1160.01. Addressing the needs for the local implementation of EBPs outlined in this Handbook assists facilities and Veterans Integrated Service Networks (VISN) to meet the OEF/OIF/OND Psychotherapy for PTSD performance measure and additional psychotherapy metrics.

3. DEFINITION OF EVIDENCE-BASED PSYCHOTHERAPIES

EBPs are specific psychological treatments that have been consistently shown in controlled clinical research to be effective for one or more mental or behavioral health conditions. The

specific EBPs being nationally disseminated in VHA and identified in this Handbook do not represent all EBPs or potentially-appropriate treatment options for Veterans.

4. SCOPE

Consistent with VHA Handbook 1160.01 and the VHA Mental Health Initiative Operating Plan, all medical centers and very large community-based outpatient clinics (CBOC); i.e., those that serve more than 10,000 unique Veterans each year must provide adequate staff to allow the delivery of specific EBPs when they are clinically indicated for their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary.

5. MISSION

VHA is committed to making EBPs widely available to Veterans for whom they are clinically indicated. EBPs are highly recommended in the VA/Department of Defense Clinical Practice Guidelines, and are considered as first-line treatments for many conditions in VHA. EBPs can promote significant improvement in symptoms and recovery for many Veterans with mental or behavioral health conditions.

6. VISION

All Veterans with PTSD, depression, and other mental and behavioral health conditions must have access to specific EBPs being nationally disseminated and implemented in VHA when these treatments are clinically appropriate. EBPs must be fully available to Veterans when clinically indicated, and that there must be sufficient staff capacity to provide these therapies, as they were designed and shown to be effective, in a timely fashion.

7. RESPONSIBILITIES OF VHA CENTRAL OFFICE MENTAL HEALTH SERVICES (MHS)

MHS in VHA Central Office is responsible for establishing, maintaining, and communicating policy regarding EBPs and for national VA EBP staff training programs.

8. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

Each VISN Director is responsible for ensuring that EBPs are accessible to all eligible Veterans, when clinically indicated, by providing adequate resources.

9. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The Facility Director is responsible for:

a. Providing and maintaining program oversight to ensure the full implementation of VHA policy and procedures related to EBP delivery, including staffing and administrative and logistical requirements.

- b. Ensuring that facility staff receives training and consultation in EBPs (see par. 14b).
- c. Providing appropriate support and resources to ensure that mental health programs providing EBPs accomplish their stated mission, goals, and objectives.
- d. Ensuring that the facility has a .3 full-time equivalent (FTE) Local EBP Coordinator.
- e. Ensuring the timely completion of all mandated reporting and monitoring requirements.

10. EVIDENCE-BASED PSYCHOTHERAPIES PROGRAM ELEMENTS

EBP Program elements are:

- a. Access and capacity requirements,
- b. Clinic and scheduling needs,
- c. Treatment planning and clinical implementation issues, and
- d. Training needs.

11. EVIDENCE-BASED PSYCHOTHERAPIES ACCESS AND CAPACITY REQUIREMENTS

a. Pursuant to VHA Handbook 1160.01, EBPs for PTSD (Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy (PE)), depression (Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, or Interpersonal Therapy), and serious mental illness (Social Skills Training) must be available, and needs to be offered when clinically appropriate, to all Veterans with a primary diagnosis of one of these conditions.

b. EBPs for PTSD, depression, and serious mental illness (identified in subpar.11a) need to be provided in a timely fashion to existing and new mental health patients who choose to receive these treatments. Initiation of a course of EBP should generally be within 30 days of when the provider and patient agree EBP should begin.

c. VHA is beginning to disseminate and implement EBPs for additional mental and behavioral health conditions, including substance use disorders, insomnia, pain, motivation or engagement, and relationship distress, as identified in the VHA Mental Health Initiative Operating Plan and in subparagraph 11c(2)(a) through 11c(2)(i). These efforts will continue to be an important focus within VHA and evolve over time.

(1) Medical facilities and their affiliated CBOCs need to work to: implement these therapies as they are disseminated in VHA; ensure that they are offered to patients with the target conditions; and ensure they are delivered in a timely fashion to those who choose to receive these treatments.

(2) These treatments are:

(a) Cognitive Behavioral Therapy for Insomnia,

(b) Integrated Behavioral Couples Therapy,

(c) Cognitive Behavioral Therapy for Pain Management,

(d) Interpersonal Psychotherapy for Depression,

(e) Motivational Interviewing,

(f) Motivational Enhancement Therapy (for Substance Use Disorder staff),

(g) Behavioral Couples Therapy for Substance Use Disorders,

(h) Contingency Management (for Substance Use Disorder Intensive Outpatient Program staff), and

(i) Cognitive Behavioral Therapy for Substance Use Disorders.

d. Sufficient levels of dedicated and appropriately-trained staff need to be maintained to deliver EBPs in a timely fashion, and do so with high fidelity to the research established model, which should include regular monitoring of patient outcomes. Staff capacity to deliver EBPs in a timely fashion needs to take into account current and projected patients with the target conditions found in subparagraphs 11c(2)(a) through 11c(2)(i).

e. Sufficient staff capacity needs to be maintained to regularly provide individual, as well as group, EBP sessions. Although the group modality can be appropriate and effective for many Veterans, clinical issues and other considerations may indicate that individual-based EBP sessions are most appropriate in certain circumstances. In addition, certain EBPs are typically designed to be delivered only in individual therapy sessions.

12. EVIDENCE-BASED PSYCHOTHERAPIES CLINIC AND SCHEDULING NEEDS

a. Clinic structures and processes need to be in place that align with and support widespread, regular use of specific EBPs, as well as support the use of other psychotherapy, psychosocial, and psychopharmacological treatment services, as clinically indicated. EBP protocols typically require nine to sixteen sessions, generally delivered on a weekly or more frequent basis; although, the specific length of treatment for a particular patient is based on the needs and circumstances of that patient.

(1) Guidelines based on research and clinical experience substantiates the treatment lengths of different EBPs and can be found in the treatment manuals for the different EBPs (see <http://vaww.mentalhealth.va.gov/ebp> for additional information about specific therapy manuals).

NOTE: This is an internal Web site and is not available to the public.

(a) EBPs delivered in individual format usually require weekly sessions from approximately 60 to 90 minutes in length, depending on the specific treatment.

(b) EBP sessions delivered in group modality typically require approximately 90 to 120 minutes.

(2) Clinic profiles can be modified to promote the maximal utilization of EBPs.

b. Careful attention to scheduling needs is critical to effectively implementing EBPs. It is essential that scheduling practices be appropriately flexible to enable clinicians to deliver full courses of EBP. **NOTE:** *Facility staff are encouraged to work closely with Local EBP Coordinators and PTSD Mentors to develop the set of scheduling requirements needed in specific programs at a particular site.*

(1) It is generally expected that individual and group-based EBP sessions be implemented on a weekly basis for the duration of the treatment. Of course, the exact length of treatment for a particular case is based on the specific aspects of that case and can be affected by patient and staff absences from sessions. Scheduling procedures need to include flexibility to account for such.

(2) A number of facilities have developed scheduling procedures that support EBPs that have included clinic profiles with a default time increment of 30 minutes. The 30-minute default increment allows the clinician to specify to the scheduler whether a 30-, 60-, 90-, or 120-minute session is required.

(3) Another useful scheduling strategy is to schedule an entire course of weekly EBP sessions (or a significant number of sessions for the therapy protocol) prior to the initiation of treatment (e.g., Cognitive Processing Therapy typically requires 12 weekly 60-minute sessions). **NOTE:** *This can be accomplished using the "multibook" (multiple appointment booking) function in the Veterans Health Information and Technology Architecture (VistA) scheduling package.* This practice of multibooking can help ensure that the weekly appointment time is not inadvertently scheduled with a different patient. The consistency of date and time from week to week increases the likelihood that the patient will remember the appointment, with fewer failures to show, and also supports the patient's commitment to completing the entire course of psychotherapy.

(a) Although the multibook function is one potential option that may work well at many instances, it is not required, and other options may be more appropriate based on local circumstances and in specific situations.

(b) Other scheduling procedures may be more appropriate in situations when there is an ongoing pattern of patient no-shows. Because the "mechanics" of implementing EBPs often require substantive changes to long-standing clinic practices, facility staff needs to work with their Local EBP Coordinator and PTSD Mentor when designing scheduling procedures and other administrative supports.

c. Scheduling needs to account for the fact that a course of EBP should typically be delivered by the same therapist (or therapists, when there are co-therapists delivering a group-based EBP) for the duration of the therapy protocol.

13. EVIDENCE-BASED PSYCHOTHERAPIES TREATMENT PLANNING AND CLINICAL IMPLEMENTATION ISSUES

a. Treatment planning needs to explicitly match client diagnoses and problem behaviors with the most effective treatments known for those conditions.

(1) The consideration of EBPs needs to be documented in the treatment plan, with indication made in the medical record whether an EBP was offered to the patient and whether the patient chose to engage in the treatment and a decision not to offer or implement an EBP, considered to be a standard of care for a particular condition, also needs to be documented in the medical record. Departures from the use of EBPs, identified as a standard of care, need to be based on the Veteran's preference or need to serve a defined clinical purpose based on evidence-based principles of care, such as coping skills training to prepare a patient with PTSD to participate more effectively in an EBP for PTSD.

(2) A number of facilities have established mental health orientation groups, EBP information sessions, or other similar mechanisms for offering and discussing one or more EBPs and other potential therapy options with Veterans. These processes typically include information about the length and process of the therapy (or therapies), effectiveness and potential utility of the therapy, other aspects of the therapy, and considerations of the patient(s). These groups have often included a family member which can help to facilitate the adherence of the Veteran to the protocol.

b. It is encouraged that medical facilities have other appropriate EBPs and other psychotherapies and psychosocial treatments available in addition to the EBPs identified. The availability of other psychotherapies and psychosocial treatments is particularly important for:

(1) Patients who may not be ready to complete a full course of EBP and may benefit from preparatory work focused on providing support, psychoeducation, and/or coping skills;

(2) Patients with conditions that do not have clearly established evidence-based treatments; and

(3) Patients who may not respond to, or may choose not to, receive certain EBPs.

c. The decision about what particular treatment needs to be provided to a specific patient is a clinical decision that needs to be made collaboratively between the provider and the patient.

NOTE: *It is expected that the capacity to provide the EBPs, identified in VHA Handbook 1160.01 and the VHA Mental Health Initiative Operating Plan, is available at each facility for each patient, with the target condition, who chooses to receive the therapy. Patients need to be informed regarding the availability and potential benefits of these therapies when making treatment decisions with their provider.*

d. A course of EBP needs to be delivered by the same therapist for the duration of the therapy protocol (or therapists, when there are co-therapists delivering a group-based EBP), except in rare instances where a transfer to a new therapist may be necessary due to unforeseen circumstances.

e. Broad education efforts to educate Veterans and referring staff about the availability, effectiveness, and utility of EBPs for various mental health and behavioral health conditions need to be implemented at each facility.

(1) This may be accomplished through the use of brochures, posters, videos, Internet sites, discussion groups, and individual face-to-face contacts.

(2) MHS in VA Central Office has developed a national EBP staff and public awareness campaign to support this effort. As part of this initiative, EBP posters for placement in primary care, mental health, and other clinical areas have been developed and are being disseminated to medical facilities and clinics. **NOTE:** *Facility and clinic staff are encouraged to work closely with the Local EBP Coordinators and PTSD Mentors in providing education to Veterans and staff on EBPs, as this is a key duty of these positions.*

14. EVIDENCE-BASED PSYCHOTHERAPIES TRAINING NEEDS

a. EBPs need to be delivered by clinicians who are qualified, trained, and competent to deliver EBPs, or by clinicians in the process of receiving EBP training, who are supervised by clinicians competent to deliver the EBPs. **NOTE:** *MHS in VA Central Office has established a national workgroup that is finalizing the development of criteria for recognizing staff who have received competency-based training in EBPs outside of VHA. These criteria will indicate competency-based training in EBPs outside of VHA is equivalent to the training provided in the VHA EBP training programs.*

b. Designated facility staff must be supported in order to fully participate in competency-based EBP training (including training provided in VA's EBP staff training programs), which is often not included in graduate clinical training (see subpar. 9b). Support for training needs to include sufficient time to participate in weekly EBP consultation that is typically part of competency-based EBP training, as well as time for informal consultation and preparation that may be needed.

c. Clinicians learning and implementing EBPs require access to supplies and equipment that allow them to deliver EBPs as designed and shown to be effective. Supplies and equipment that may be needed include, but are not limited to: audio recording equipment, copies of printed therapy materials, and clinical assessment materials.

d. When possible, staff members specifically trained in a particular EBP need to devote a significant amount of their clinical time to implementing that therapy and using their learned skills, rather than have staff members become formally trained in and implement a number of EBPs, which can be a less efficient use of EBP training and staff resources. In certain situations, however, it can be appropriate to have specialists (e.g., core PTSD providers) trained in more than one EBP for a particular condition (e.g., CPT and PE for PTSD) to promote patient choice

and EBP availability. This may be especially appropriate in smaller facilities and clinics with fewer EBP providers treating the condition.

15. REFERENCES

- a. VHA Handbook 1160.01. Uniform Mental Health Services in VA Medical Centers and Clinics.
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- d. Karlin, B. E., Brown, G. B., Trockel, M., Cuning, D., Zeiss, A. M., & Taylor, C. B. (2012). National dissemination of Cognitive Behavioral Therapy for depression in the Department of Veterans Affairs health care system: Therapist and patient-level outcomes. Journal of Consulting and Clinical Psychology. Advance online publication. doi: 10.1037/a0029328