Overcoming Challenges and Embracing Opportunities for Implementing EBP at the Local Facility Level

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Implementing EBP at the Local Facility Level

- A small sampling of Psychology Services was questioned regarding their experience with implementing EBP at the local level
- Results were combined from the 11 facilities that supplied feedback
- Given the small sample size, results will be utilized to share successes, challenges and generate discussion during this break-out session

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1. Training
   A. Access to VACO-funded training opportunities
      - 0% 1) No access granted
      - 18% 2) Limited access granted
      - 82% 3) Full access granted for all training opportunities

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Comments/Observations

- Available slots are limited relative to the number of psychologists within the service

- Each roll-out asked for specific numbers of staff to attend from each facility – the numbers were limited

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B. Access to other training (non-EBP)

0% 1) No access granted (no funding/no AA)

9% 2) Limited access granted (no local funding &/or AA granted)

64% 3) Access granted with significant justification (local funding/AA approved)

27% 4) No change from previous practice

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Comments/Observations

- Funding is limited, AA granted
- AA approved but funding is limited due to budgetary constraints

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2. Post-training Implementation
   A. Support for setting aside time for clinical supervision calls

9% 1) No time carved out for supervision

64% 2) Time carved out but clinic scheduling capacity stays the same

27% 3) Time carved out and clinic schedule adjusted

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B. Access to the "right patients" for completing the clinical supervision component of the training.

17% 1) Difficult to identify the "right patient," unable to complete training

50% 2) Patients identified but not representative of actual caseload

33% 3) Patients identified and representative of actual caseload

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Comments/Observations

- More of a problem with Vets not following through with scheduled sessions than a failure to identify potential patients
- Caseloads/demand for all forms of MH treatment has pushed the 'next available' months away
- Pts recommended for training supervision were not representative of actual caseload (PTSD recommended vs PTSD/SUD – actual caseload)
- Concern with ability to find the 'right'/cooperative/available patients in OPT settings
- The follow-up supervision commitment is burdensome – 90 minute weekly call for six months to complete the PE supervisory requirements (36 hours beyond the training hours)

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3. Implementation - Establishing specific EBP clinics

19% 1) Not able to set-up specific EBP clinics

19% 2) 60 minute clinics not an issue – 90 minute clinics are an issue

19% 3) Concern with no-shows for 90-minute clinics

33% 4) Full support for implementation/start-up of EBP clinics

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10% 5) Other + Comments/Observations

- 60 & 90 min slots available but limited due to volume, interest and readiness for treatment
- Clinics are set-up by clinician not by type of treatment provided - group EBP are set-up by EBP type
- 90 min slots impact CUSS data – seems to require 30-min slots
- Resources needed to insure 1st time access and case management competes with time needed to provide therapy
- No-shows are problematic for 90-minute slots
- Rigid scheduling for 90-minute slots not patient centered
- Restructuring clinics to allow for implementation of EBPs takes some work

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4. Local Perceptions/Issues

15% A. "One and done" – perception that vet receives one course of treatment and should not need further care

20% B. Only EBPs should be utilized

20% C. Special scheduling consideration given to EBP's while other treatment approaches are not supported

25% D. Caseloads not adjusted to accommodate EBP caseloads

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20% E. Other + Comments/Observations

- Both EBP and general therapy are well supported
- 60 and 90 minute slots available but limited due to large volume
- EBP sessions forced into existing slots
- Difficulty assessing need for EBP versus long term
- General case management activities seen as more "important" (i.e. mandated and monitored) than EBP availability

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5. Impact of EBPs on other empirically supported therapies (EMDR, Seeking Safety, etc.)

18% A. No impact

36% B. Minimal impact

18% C. Moderate impact

27% D. Significant impact

0% E. EST and other therapies not supported

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Comments/Observations

- Staff are tending to focus on training that is funded by VA at the expense of others
- Seeking Safety, which had been a first line treatment for co-occurring SUD/PTSD is no longer first line
- Greater justification needed for non-EBP training
- Disagree with the suggestion that no other treatment initiatives or services are effective
- Concern over the forcing of EBPs in areas not supported by research (SUD/PTSD) while other therapies that do have research support (Seeking Safety) are not even mentioned
- Positive impact in terms of more selective therapies that are proven to address certain dx/disorders

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6. EBPs - formal training has been completed and are now available within your service.

   PTSD: CPT (100%), PE (100%)

   Depression: CBT-D (82%), ACT-D (73%)

   SMI: SST (64%)

   Insomnia: CBT-I (64%)

   Family/Couples: BFT (45%), MFGT (9%), IBCT (45%)

   Other: MI (73%), Seeking Safety (73%), Contingency Mgt (18%), EMDR/DBT (9% each)

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7. For staff completing VA-sponsored EBP training, were there any issues with the quality of the post-training supervision?

50% YES

50% NO

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Comments/Observations

- The quality of supervision and the interest among supervisors has been uneven – some has been poor – this has negatively impacted on interest in further training
- CBT-D, PE and CPT were excellent, there was concern with ACT
- Follow-up requirements for PE experienced as too rigid
- Staff thought it was very good
- Insufficient access to post-training supervision and expertise
- Very limited answers regarding the comorbidity between PTSD & SUD when engaged in PE or CPT

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General Comments/Observations

- It is understood that EBP launch is an effort to (appropriately) reinvent MH treatment, however, the goal many veterans have of SC disability conflicts with the goal of treatment
- Staff limitations due to funding & concerns in participation in EBP trainings due to post-training certification demands
- Need to figure out how to measure flow of patients through an outpatient treatment program/EBP
- Struggle in outpatient with how to terminate care and have the patients re-enter as needed (for chronic conditions that do not meet the criteria for a MHICM or PRRC)
- Expectations are too high for EBP to the point of being unrealistic at times

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General Comments/Observations (Cont.)

- Would really like to see a movement toward regional training (bring the trainers to the VISN's) – more economical in the long run
- Develop Train-the-Trainer initiatives with strong fidelity checks
- Strong preference has been given to some EBT's and not others – Why?
- ACT has received very little rollout money while interest is high
- MI is a major pre-therapy intervention that has received almost no notice from the dissemination groups, & yet is one of the foundations of SA, PACT, and PC-MH Integration
- The labor intensiveness of the EBP's that competes with the high demand for fast initial access and the lack of compensation in VERA makes it difficult to "sell" increasing access to EBP's

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General Comments/Observations (Cont.)

- Most therapists are now just offering PE/CPT/EMDR - any combination of these for treatment of PTSD
- Veterans with PTSD not willing to engage in an EBP are not being seen in the PTSD clinic
- Staff are limiting their treatments to manualized therapies and losing their ability to "think"/to engage in the "art" of therapy
- Implementation approach and required training in Contingency Management have raised significant concerns that have not been adequately addressed
- Need to work on Administration buy-in when reducing clinic capacity to accommodate EBP
- Need accommodation from other staff (not offering EBP) when they absorb the added clinic time
- It would be helpful if the training was APA Approved for CE