

# Evidence-Based Practices in VA: What do we know and what do we not yet know?

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“To know that one knows what one knows,  
and to know that one doesn't know  
what one doesn't know--  
there lies true wisdom.”

Confucius

# Goals

1. To identify current themes in the research literature on EBPs.
2. To explore how EBPS are differently defined by various entities.
3. To explore examples of EBPs that could be formally recognized as evidence-based treatments to conduct in VA.

# Context

- Proliferation of EBPs in past several decades
- Greater acceptance of the need for EBPs
- Better scientific testing for EBPs
- Yet we remain at a very early stage of understanding of EBPs

# 1. There are various valid lists of EBPs

- Substance Abuse Mental Health Service Administration National Registry of Evidence-Based Programs and Practices Programs ([www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov))
- American Psychological Association Division 12 (Psychotherapy) list of EBPs ([www.psychologicaltreatments.org](http://www.psychologicaltreatments.org))
- California Evidence-Based Clearinghouse ([www.cebc4cw.org](http://www.cebc4cw.org))

## 2. There are various valid criteria sets that define EBPs

- Chambless & Hollon, 1998 (used by Division 12 of APA)
- National Registry of Evidence-Based Practices and Programs (NREPP)
- Institute of Medicine
- Cochrane Reports
- Practice guidelines (e.g., VA/DoD; ISTSS)

*VA does not have a definition of "EBP"*

# Clinical Practice Guidelines for PTSD

1. VA/DoD Management of Post-Traumatic Stress Working Group, 2004
2. American Psychiatric Association. Practice Guideline for the Treatment of Patients with ASD and PTSD. APA, 2004
3. UK National Institute for Health and Clinical Excellence (NICE) Guidelines, 2005
4. Australian National Health and Medical Research Council (NHMRC) Guidelines Australian Centre for Posttraumatic Mental Health, 2007
5. The International Society for Traumatic Stress Studies (ISTSS) Guidelines, 2008
6. American Academy of Child and Adolescent Psychiatry (AACAP)
7. Amer. Acad. of Child and Adolescent Psychiatry; Cohen et al., 2010
8. Institute of Medicine. (2007). Treatment of PTSD. The National Academies Press, Washington, DC  
*Forbes et al., 2010*

### 3. EBPs for mental health disorders do not differ from each other in outcomes

Consistent findings in EBP research:

1. Manualized models consistently outperform TAU
2. Manualized models consistently produce positive outcomes
3. Manualized models rarely outperform each other (“distinctions without a difference”)
  1. For SUD see Imel et al., 2008
  2. For PTSD see Benish et al., 2007; VA/DoD practice guidelines for PTSD, 2010, pg. 114; Powers et al., 2010 meta-analysis on PE
  3. See also Garfield & Bergin, 2004; Bradley et al., 2005; Morganstern & McKay, 2007

VA/DoD PTSD CPG: “Among the A-level evidence-based psychotherapy treatments, the research suggests that they are much more equivalent in their effectiveness than many clinicians may realize.” Page 114

## 4. Clinicians differ in their liking and adoption of different EBPs

- EBPs are not perceived equally even if their evidence may be comparable.
- Clinicians clearly have preferences for some models over others, and this can impact how much they adopt a model, the fidelity they bring to it, and sustainability of the models in clinical practice.
- Two models may have comparable efficacy (ability to reduce patient symptoms), yet have quite different levels of adoption (use of the model by clinicians). Simply establishing a model as effective is no guarantee that clinicians and programs will adopt it, and there are various reports in the literature on such adoption gaps for particular models (e.g., PE, Behavioral Couples Therapy)
- "The wisdom of clinicians"
- "Research plays catch-up to clinicians": EMDR, DBT
- Studies in VA: Cook et al. (2009); Najavits, Kosten & Kivlahan (2010)

# Case Example: PTSD and SUD

40-50% of PTSD patients treated in VA  
have current substance use problems

*VA/DoD Clinical Practice Guidelines*

# Studies

Bradley et al. (2005) meta-analysis of PTSD literature.  
*62% of PTSD RCTs excluded substance abuse or dependence. 46% excluded for suicide risk.*

Schnurr et al. (2003): VA study (PE), men veterans.  
*Excluded: "Alcohol or substance dependence; unwillingness to refrain from substance use at treatment or work"*

Schnurr et al. (2007): VA study (PE), women veterans.  
*Excluded: "Substance dependence in remission for less than 3 months...prominent suicidal or homicidal ideation... self-mutilation within the previous 6 months."*

Nacasch et al. (2010): PE for combat-PTSD.  
*Excluded: "Substance dependence...risk for suicidal behavior."*



## UNDERSTANDING CO-OCCURRING PTSD AND SUD

### What is PTSD? What is SUD?

**Posttraumatic Stress Disorder (PTSD)** can occur after someone goes through combat, physical or sexual assault, terrorist attack, serious accident or a natural disaster. Symptoms of PTSD can include feeling keyed up, having flashbacks of the event, or feeling numb to things you used to enjoy. Some people try to cope with their PTSD symptoms by drinking heavily, using drugs, or smoking too much. Eventually, the overuse of these substances can develop into **Substance Use Disorder (SUD)**, and treatment should be given for both PTSD and SUD to lead to successful recovery. The good news is that *treatment of co-occurring (happening at the same time) PTSD and SUD works.*

"I entered treatment in 2009, after maybe 2 really bad years of PTSD and alcoholism. The treatment was amazing. The VA staff was amazing. It's a whole new day for me." -- Joe, Iraq Veteran



### How common is co-occurring PTSD and SUD?

Almost 1/3 of Veterans seeking treatment for SUD also have PTSD and more than 2 of 10 Veterans with PTSD also have SUD. As the wars have continued, about 1 in 10 returning soldiers seen in VA have a problem with alcohol or other drugs and many have PTSD. VA has made it easier to get help. It is important to know that **treatment works and you are not alone.**

"It was a big deal for me to enter treatment. I was so close to hitting bottom. I wasn't sure I'd last. But I'd learned to tough it out, and that was helpful." - Steve, OEF Veteran



### THE VA WANTS YOU TO HAVE THE BEST POSSIBLE CARE FOR CO-OCCURRING PTSD AND SUD.

Each VA medical center has a SUD-PTSD Specialist trained in treating both conditions in order to promote the best health outcomes. If there are signals you are at risk for both disorders, you will be encouraged to talk with a provider about how to best support your recovery. There are treatment resources at every VA medical center.

## WHAT TREATMENTS ARE OFFERED FOR CO-OCCURRING PTSD AND SUD?

Evidence shows that in general people have improved PTSD and SUD symptoms when they are provided treatment that addresses both conditions. This can involve: individual or group Cognitive Behavioral Treatments; specific psychological treatments for PTSD such as Cognitive Processing Therapy or Prolonged Exposure; Behavioral Couples Therapy with your spouse or significant other; and/or medications that may help you manage the PTSD or SUD symptoms. Treatment for specific symptoms such as pain, anger, or sleep disturbance should also be discussed with your provider.

# Topics

- Is it scientifically valid for the VA / DoD Clinical Practice Guidelines (PTSD, SUD, each separate) to be recommended for patients with comorbid PTSD/SUD?
- The two PTSD roll-out treatments are both Stage 2 models
  - Herman et al. (1992): safety (present), mourning (past), and reconnection (future)
- No criteria nor evidence-base on patient nor clinician readiness
- Cost (e.g., trainings, supervision, level of degree required for clinicians, group versus individual format)
- Useful to provide a list of any treatments that are acceptable to use? Not just Category A...

# Seeking Safety

[www.seekingsafety.org](http://www.seekingsafety.org) (click Outcomes)

- Pilots, controlled trials, randomized controlled trials, and multisite trials (15 published studies)
- All studies had positive outcomes in various areas
  - All showed reduction in PTSD or trauma-related symptoms by end of treatment
  - All but one showed reduction in substance use by end of treatment
  - Other areas of improvement included suicidality, problem solving, social skills, cognitions, overall functioning, and HIV risk behavior
- In five of six comparisons to treatment-as-usual (TAU) controls, SS stronger on various domains
- Compared to active controls, SS did as well as gold- standard SUD treatment (Relapse Prevention); outperformed Women's Health Education in some areas (greater therapeutic alliance, more rapid PTSD improvement, greater HIV risk reduction, more sustained gains during followup, worked better for severe substance users)
- Recent VA RCT versus TAU, 96 men veterans (Boden et al., under review): SS had significantly greater reduction (31%) in drug use; and greater attendance, coping, and active coping. Both conditions significantly reduced alcohol use.

## 5. The next generation of research needs to focus beyond just efficacy

- How and why some EBPs are adopted over others
  - Explore factors such as level of flexibility, difficulty to learn it, cost, training required, prerequisites, how the model converges with existing practices, basic appeal (e.g., readability).
- How much clinicians sustain use of EBPs (especially when extrinsic influences are withdrawn such as pressure from a supervisor or roll-out effort)? (O'Farrell et al.)
- How clinicians modify EBPs in positive ways to actually work in practice settings

*Rogers. 1995; Morganstern & McKay, 2007; Najavits, Kosten, & Kivlahan, 2010*

## 6. There are real-world challenges in the use of EBPs

- How do EBPs really work in VA? (most research done outside of VA)
- How do EBPs work with comorbid populations, suicidal patients, etc. (most research excludes these)
- Readiness factors
- Clinician training, experience (most research uses only top-level clinicians/training/supervision)

## 7. Needed for healthy scientific use of EBPs – a “Wish List”

- Clear definition of the term “EBP” in VA
- Rationale for why one EBP is selected over another
- A central resource for clinicians to learn about different EBPs
  - Including a grid comparison of models (e.g., number of days of training / supervision required, who can conduct it, exclusionary criteria, etc.)
- A VA website for VA clinicians to be able to report on real-world challenges and iatrogenesis in use of EBPs (two-way dialogue, not just top-down rollouts)
- A VA website for researchers and others to identify errors in representation of research results
- Open access to datasets that EBPs are based on
- Ability to update on EBPs
- Avoid “calcification” of EBP progress

“Absence of evidence is not  
evidence of absence.”

Carl Sagan

20<sup>th</sup> century American astronomer

*From: “The Fine Art of Baloney Detection”*

# Interesting questions

- Whether rigid adherence to manual outperforms a flexible adaptation of model
- How clinicians adapt / change models in positive ways because they don't work well "as written"
- What clinicians/clients are best suited to which models
- How to help clinicians make choices

# Themes

1. Efficacy era– but effectiveness is key too
2. How is “efficacy” defined?
3. How much fidelity is needed?
4. It’s not just the model, but also the clinicians; thus selection is key
5. Training shows limited impact, so why is training so prominent?
6. Premature conclusions and “headlines” on models
7. The need to standardize designs and measurement
8. Iatrogenesis and obstacles in implementation
9. Unclear: mechanisms of action of models and what parts of models are really needed
10. The politics and money of evidence-based practices

"...the clinician is required to make many decisions around the intricacies of implementation... Intervention[s], of course, [are] embedded in broader clinical care that includes, among other things, building a therapeutic alliance, comprehensive assessment, case formulation, and treatment planning. With our current state of knowledge it is unrealistic to assume that every aspect of care will be guided by Level I empirical data. Documents such as the IOM review, though an empirically rigorous document, is of limited benefit to practicing clinicians (and, of course, it was never intended to guide clinical care) because so many important questions are left unanswered."

*Forbes et al., 2010*

# The “fine print”

- What is the dosage (e.g., some PTSD studies assume 1.5 hour sessions)
- Paying patients to attend treatment sessions
- When is substance use assessed (e.g., in 1 study “baseline” was any time in past)

# Conclusions

- There are many highly effective EBPs that are not currently endorsed as first line treatments in the VA
- Rolled-out training on these models is not necessary, as that is beyond the VAs budget
- However, EBPs don't need to be disseminated in order to be effectively practiced
- Endorsement of a broad array of EBPs has many advantages:
  - Takes advantage of clinicians' existing expertise with EBPs not disseminated
  - Gives clinicians more options and flexibility in treating veterans, particularly:
    - those with co-morbidities
    - those whose presenting problems and individual characteristics (culture, learning style, past treatment experiences, etc.) recommend an alternative EBP to the ones rolled out

# Recommendations

- Provide explicit definition and criteria for what is considered an EBP in the VA
  - This is what all other scientific and professional organizations do
  - VA already defined EBPs in the Clinical Practice Guidelines, so these would be the logical criteria
- Explicitly endorse not only disseminated treatments, but current and future treatments that meet the above criteria
  - Do this in the VA Handbook, policy documents

# Example of a study

- Eleven models relevant to PTSD/SUD: Twelve-Step, Motivational Interviewing, Contingency Management, Relapse Prevention, Seeking Safety, Eye Movement Desensitization and Reprocessing (EMDR), Exposure Therapy for PTSD, Cognitive Processing Therapy, General Cognitive-Behavioral Therapy, Supportive Therapy, and Dialectical Behavior Therapy.
- For each model, staff rated four key areas: level of implementation, helpfulness overall, helpfulness for PTSD/SUD, and desire for training on it, all scaled 1-5 (with 1 "not at all" and 5 "greatly").
- N=202, VA wide "snowball method" anonymous survey

*Najavits, Kosten & Kivlahan, 2010*

# Results

- Most respondents were already using one or more models
- They reported significantly different preference ratings for the models in each of the four key areas addressed.
- Some models quite consistently appeared at the top or bottom. For example, Relapse Prevention and Seeking Safety were consistently at the top whereas EMDR and Contingency Management were at the bottom.
- The more clinicians had implemented a particular model, the more helpful they found it.
- A factor analysis of the models revealed four factors that related to their content, rather than to how much they were liked.
- Qualitative comments emphasized a desire for more training on SUD/PTSD topics and models, a broader array of psychotherapies to be implemented in VA, and more guidance on the use of PTSD models in the context of SUD.

# Studies of EBP adoption

- Overall, positive views of manuals (Barry et al., 2008; Godley, White, Diamond, Passetti, & Titus, 2001; Haug et al., 2008; Najavits et al., 2004; Najavits, Weiss, Shaw, & Dierberger, 2000), but two studies found mixed results (Addis & Krasnow, 2000; Lucock, Hall, & Noble, 2006).
- Some manuals, and specific elements of manuals, are perceived more favorably than others (Barry et al., 2008; Haug et al., 2008; McGovern, Fox, Xie, & Drake, 2004; Najavits et al., 2004; Najavits et al., 2000).
- Clinician factors play a role:
  - Those in academic settings value evidence base more than community clinicians (Addis & Krasnow; Barry et al., 2008)
  - CBT clinicians more positive about manuals than psychodynamic clinicians (Addis & Krasnow, 2000; Lucock et al., 2006; Najavits et al., 2004)
  - Less experienced clinicians are more positive about manuals than experienced therapists (Addis & Krasnow, 2000).
- Organizational factors play a role:
  - Private sector organizations are more favorable toward EBP than those in the public

- Other influences too:

- A study of over 2000 mental health practitioners by Cook et al. (2009b, 2009c); the most common positive influences were mentors, books, graduate training, informal collegial discussions, goodness-of-fit with existing practices, clients liking the treatment, and enjoyment conducting it. The most common negative influences (barriers) were insufficient time and cost for training, lack of confidence in mastering the technique, and lack of opportunities for refining skills.