A VA Clinician's Guide to Optimizing the Treatment of Depression Utilizing Evidence-Based Psychotherapy for Depression

VA

U.S. Department of Veterans Affairs
Veterans Health Administration

PBM Academic Detailing Service
Office of Mental Health and Suicide Prevention

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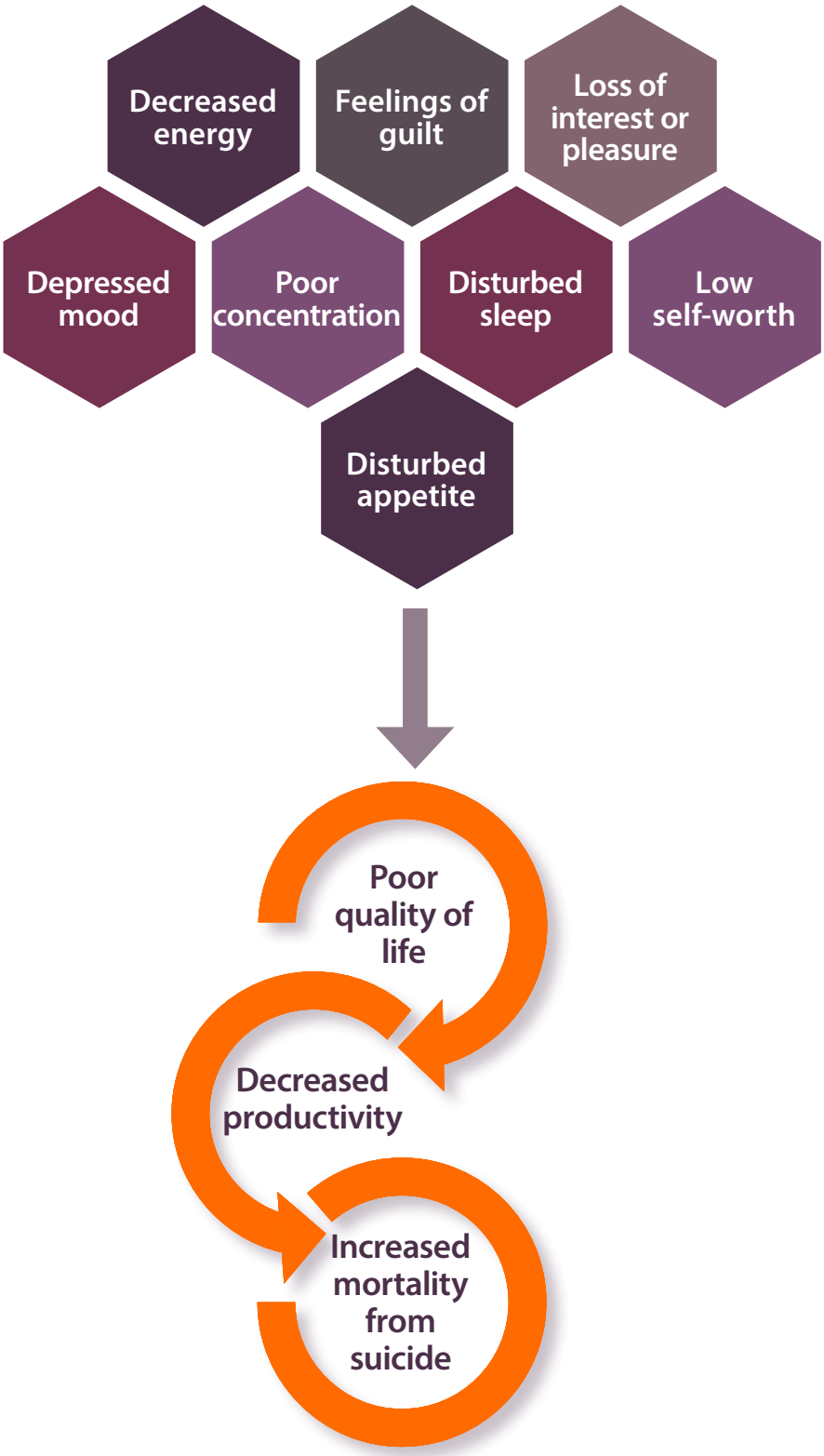
Background

Major depressive disorder (MDD) is the most prevalent and disabling form of depression. In addition to the immediate symptoms of depression, MDD results in poor quality of life overall, decreased productivity, and increased mortality from suicide. Social difficulties including stigma, loss of employment, and marital conflict can also occur because of depression.[1]

Figure 1. Immediate Symptoms and Results of MDD[1]

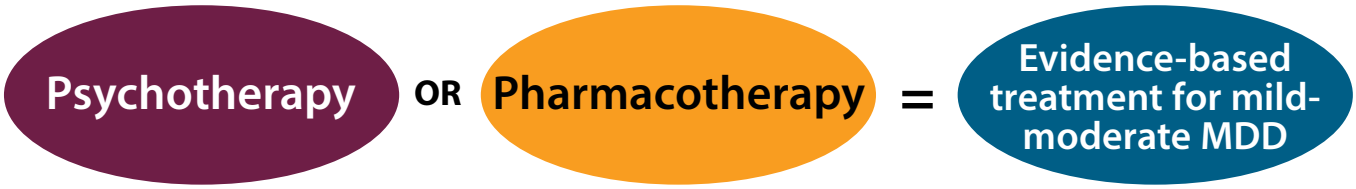


Treatment of Major Depressive Disorder

Treatment planning with the Veteran should follow the principles of shared decision-making and include patient education about depression as well as a discussion about available treatment options.[1] According to Clinical Practice Guidelines for The Department of Veterans Affairs and the Department of Defense (**https://www.healthquality.va.gov/guidelines/MH/mdd/**), there are two paths, linked to depression severity, when considering an evidence-based treatment*:

Uncomplicated mild-moderate MDD[1]

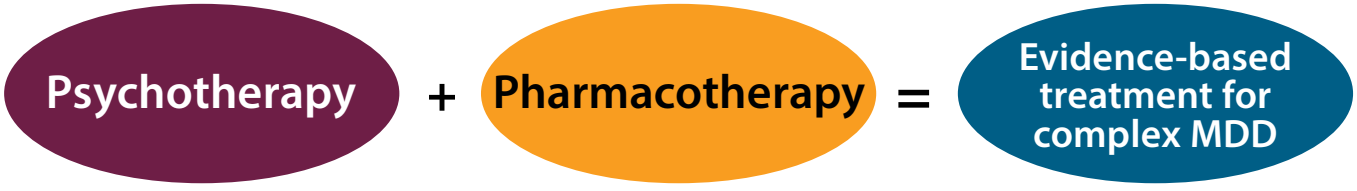
First-line treatment is either evidence-based psychotherapy or evidence-based pharmacotherapy. When well-informed about treatment options, patients with depression often choose psychotherapy over pharmacotherapy.[2,3]



Severe, chronic or recurrent MDD (complex)[1]

First-line treatment includes a combination of pharmacotherapy and evidence-based psychotherapy during a new episode of care when the MDD is characterized as:

- Severe [i.e., Patient Health Questionnaire (PHQ)-9 score >20]
- Chronic (duration greater than two years)
- Recurrent (with three or more episodes)

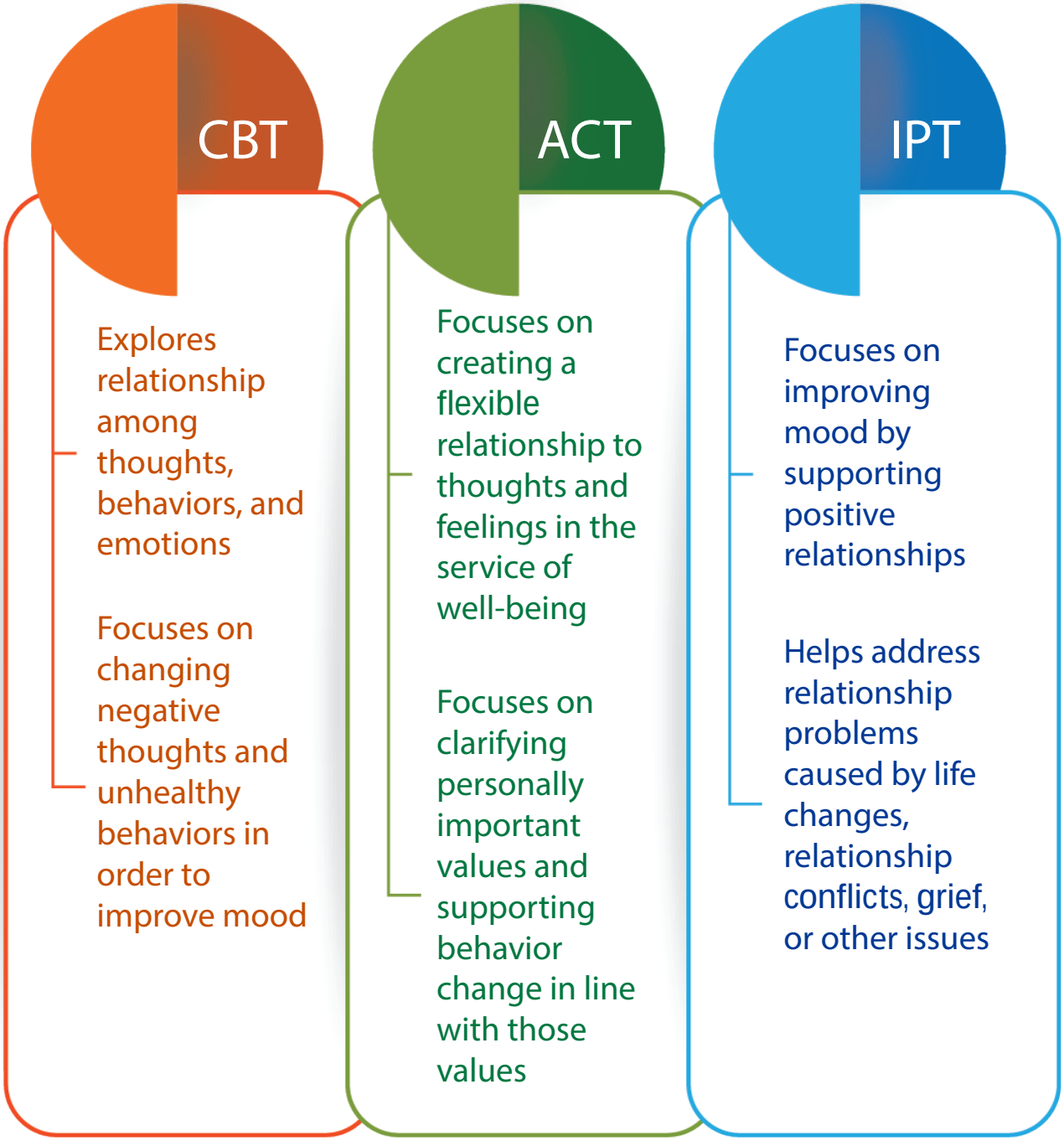


*Treatment selection should be based on patient preference, safety and side effect profile, personal or family history of response to a specific medication, concurrent medical illnesses, concurrently prescribed medications, cost of medication and provider training and competence.

Evidence-Based Psychotherapies (EBPs) are recovery-oriented with Veterans and therapists working together to identify and reach personal goals. They are also time-limited in that symptom reductions can be achieved for some in just a few sessions (average of 12 sessions for complete benefit), and have been shown to maintain their effectiveness after formal treatment ends.

Figure 2. Evidence-Based Psychotherapies[1]

Figure 3. Evidence-Based Psychotherapies for Treatment of Depression*



*EBPs for depression currently disseminated by the VA National EBP Training Program: CBT = Cognitive Behavioral Therapy; ACT = Acceptance and Commitment Therapy; IPT = Interpersonal Psychotherapy

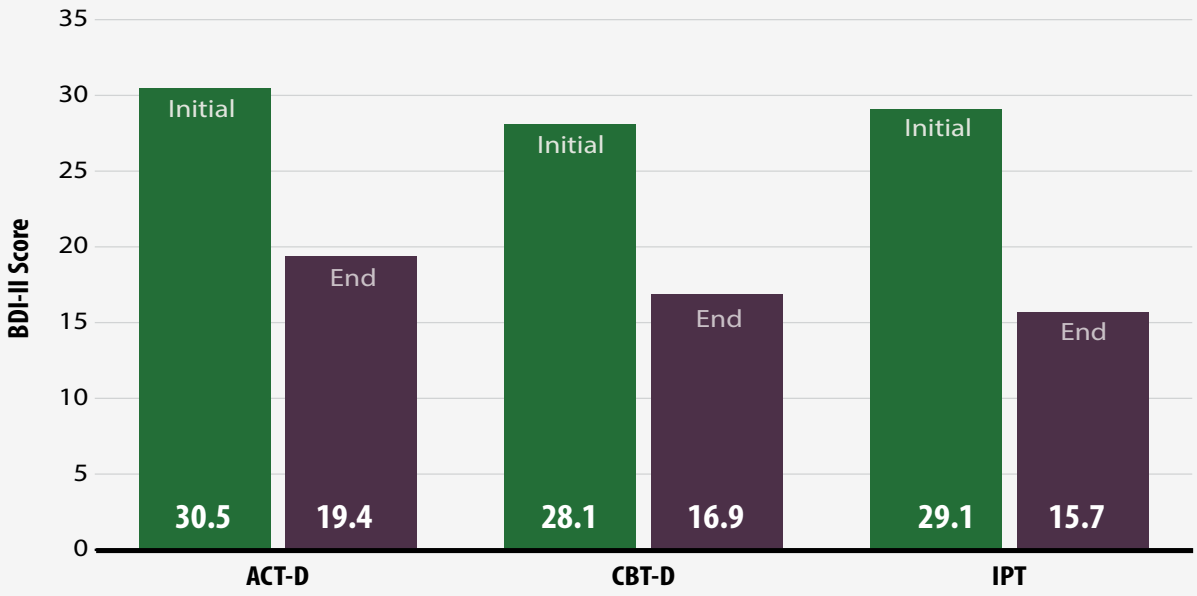
Provide or refer Veterans to EBPs for depression.

Effectiveness of EBPs for Depression

Studies show that Evidence-Based Psychotherapies (EBPs) are effective for:

- Reducing symptoms
- Decreasing suicidal ideation
- Improving quality of life
- Promoting recovery

Figure 4. Change in Depression Severity[4,5,6] (Intent-to-Treat Analysis)



ACT-D = Acceptance and Commitment Therapy for Depression
CBT-D = Cognitive Behavioral Therapy for Depression
IPT = Interpersonal Therapy

Table 1. BDI-II Scores and Depression Severity

Raw Scores	Depression Severity
0–13	Indicates minimal depression
14–19	Indicates mild depression
20–28	Indicates moderate depression
29–63	Indicates severe depression

Veterans participating in EBP for depression experience a

41%

average reduction in depression severity

Figure 5. Key Statistics[7]

56%

Veterans whose thoughts of suicide* are **reduced** after completion of an EBP for depression

78%

Veterans with more severe suicidal ideation** whose thoughts of suicide are **reduced** after completion of an EBP for depression

52%

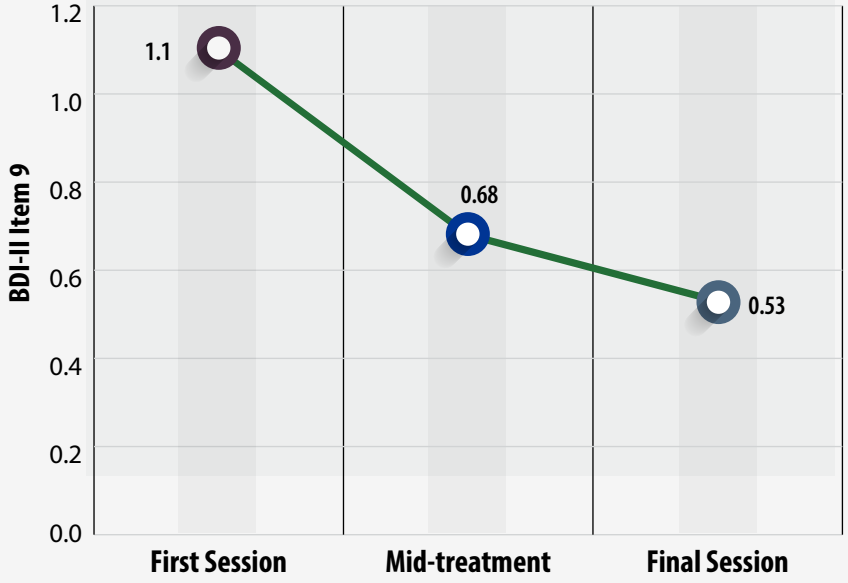
Veterans whose thoughts of suicide are **eliminated***** after completion of an EBP for depression

*Suicidal ideation as measured by item 9 of the BDI-II

**More severe suicidal ideation is indicated by a score of 2 or 3 on BDI-II item 9

***Veterans whose suicidal ideation was eliminated are also included in the statistics citing rates of reduced suicidal ideation, as the groups overlap and are not mutually exclusive

Figure 6. Change in Suicidal Ideation Severity[7]
(Intent-to-treat Analysis)



Severity of suicidal ideation decreases by

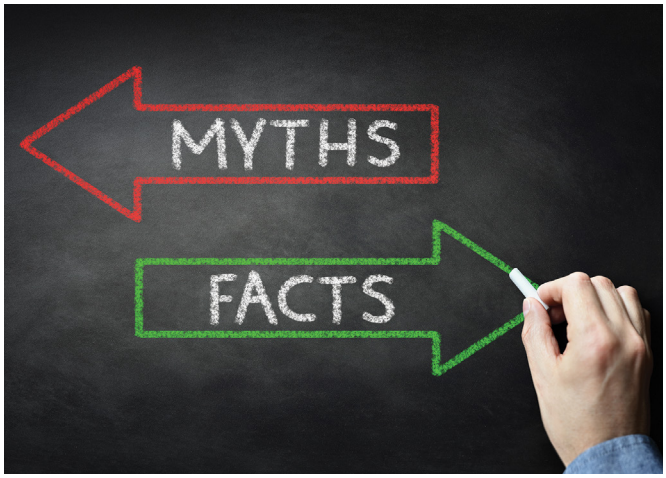
57.4%

over the course of EBP for Depression

Discussing Evidence-Based Options with Veterans

When I offer an EBP to Veterans, they don't want to go.

They just want medication.



While both psychotherapy and pharmacotherapy are considered first-line treatments, psychotherapy is not associated with side effects or drug interactions, which is one reason to consider psychotherapy options.

When discussing EBP options with Veterans, use a shared decision-making process to determine which type of therapy fits best. Veterans and providers can work together to explore treatment options and set goals. Linking the treatment rationale/explanation (as shown in Figure 3) to the Veteran's personal aims for therapy is an important part of shared decision-making. Educating Veterans about the effectiveness of each treatment option ensures that they are well-informed before consenting to treatment.

- Rather than establishing a traditional "doctor" and "patient" relationship, collaborate with the Veteran as equal partners. Explain the concept of "two experts in the room," and ask for Veteran input.

Figure 7. Benefits of Shared Decision-Making[8]

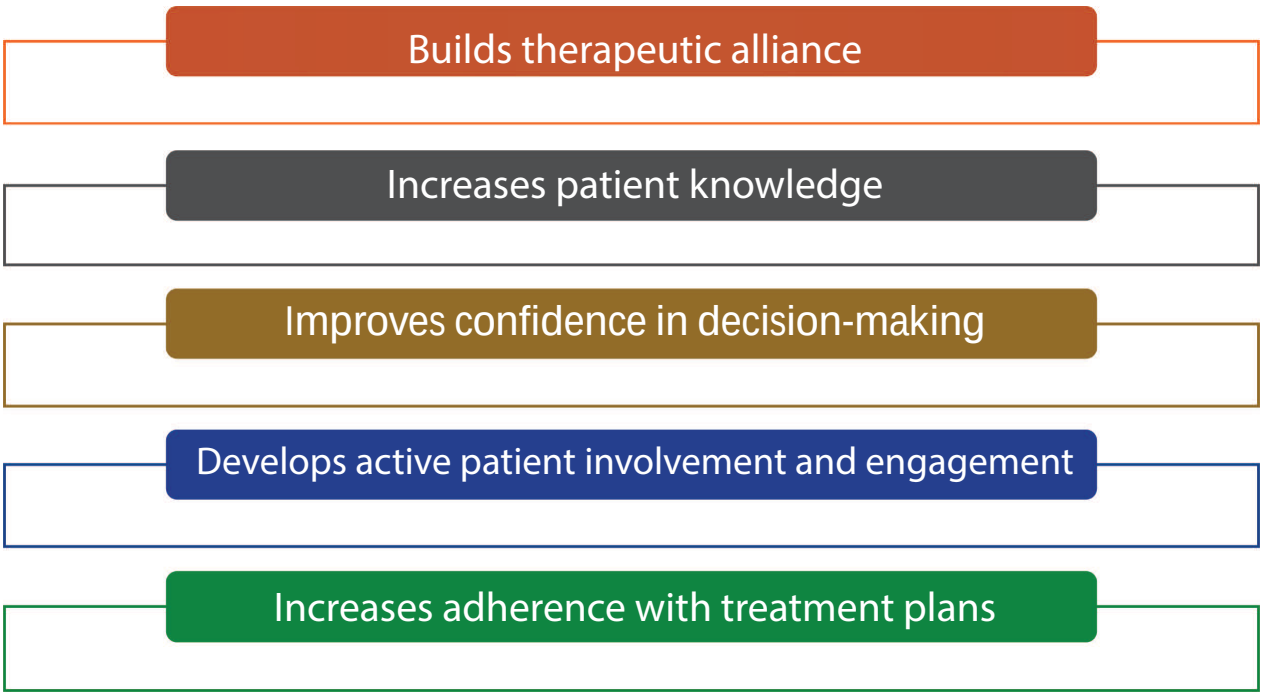
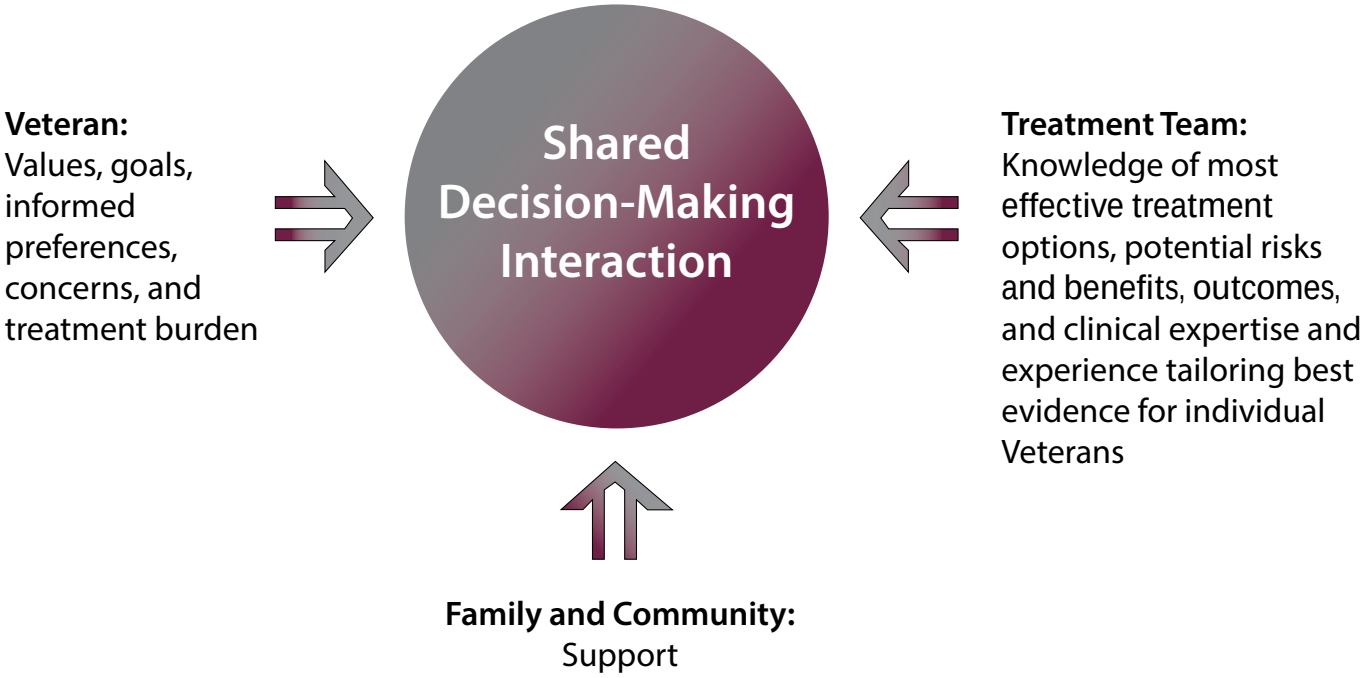


Figure 8. Shared Decision-Making Interaction

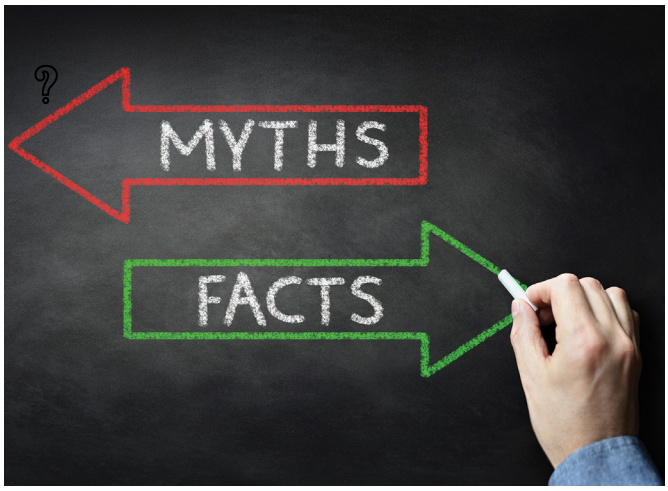


Ask the following of yourself:

- How is the Veteran involved in making decisions about care?
- Has the Veteran been offered choices among different treatments or options for care?
- Has the Veteran been given information on the likely effectiveness of different treatment options?
- Can the Veteran include other family members or supports in their care?
- Is treatment approached as a partnership that encourages the Veteran's participation in decision-making?
- Am I fostering a sense of hope?

Will Evidence-Based Psychotherapy Meet My Patient's Needs?

EBPs are too structured and impersonal and don't emphasize the therapeutic relationship.



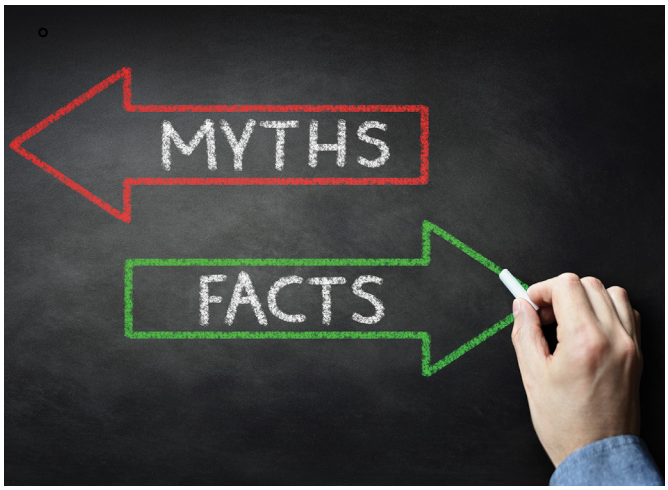
Research has shown that EBPs are effective for treating depression and for enhancing the therapeutic alliance.

Many clinicians have concerns that EBPs are too structured to meet the needs of their patients and, as a result, they may decide to adapt treatments or use specific strategies of the therapy that seem most appropriate. Depression EBPs have flexibility built into the treatments to accommodate individual needs. Evidence shows that treatment outcomes are best when the treatments are delivered as designed[9,10], and research supports the use of EBPs even with complex patients and co-morbid conditions.

Each Veteran's EBP treatment is tailored to the Veteran's needs by developing a specific, individualized case conceptualization and corresponding treatment goals that guide the implementation of the treatment.

What is the Time Commitment?

The Veterans I see don't want to come to the VA every week for therapy.



When informed about the benefits of evidence-based psychotherapy and its time-limited nature, many Veterans are willing to attend weekly sessions. In addition, using available technology, evidence-based psychotherapy can now be provided via VA Video Connect or Home Telehealth.

EBP Coaching Tools and Documentation Resources

Use coaching tools and patient resources to assist your discussion with the Veteran:

- Contact your facility's Local EBP Coordinator for guidance on local referral processes to available EBPs
- The EBP Training Program has several clinician and patient resources available at **http://vaww.mentalhealth.va.gov/ebp/programs_protocols.asp**
- **TreatmentWorksforVets.org** is a resource to support Veteran engagement in EBPs for depression

In recognition of the important role that EBP documentation plays in ongoing quality of care, EBP templates have been available throughout the VA system since 2014.[11] If you are not familiar with these templates, please contact your Local EBP Coordinator for assistance.

Figure 9. Purposes and Benefits of EBP Documentation Templates[12,13]

Valuable clinician resource that facilitates documentation of EBP delivery

Promotes fidelity in delivery of EBP

Reduces protocol drift over time

Allows for accurate reporting of information on use of EBPs

Use EBP standardized templates to ensure quality EBP is provided and recorded

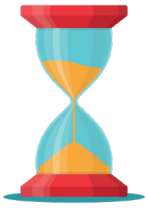
Integrating Measurement-Based Tools

Collect, Share, Act[14]

Collect from the Veteran, at regular intervals during therapy, self-report measures of depression that are reliable and validated, such as the PHQ-9.

Collect from the Veteran, at regular intervals during therapy, self-report measures of depression that are reliable and validated, such as the PHQ-9.

Share and discuss the results immediately with the Veteran and other providers involved in the Veteran's care.



Act together by utilizing outcome measures and shared decision-making to inform the development of a treatment plan, consider changes to the treatment plan, and assess progress over time.

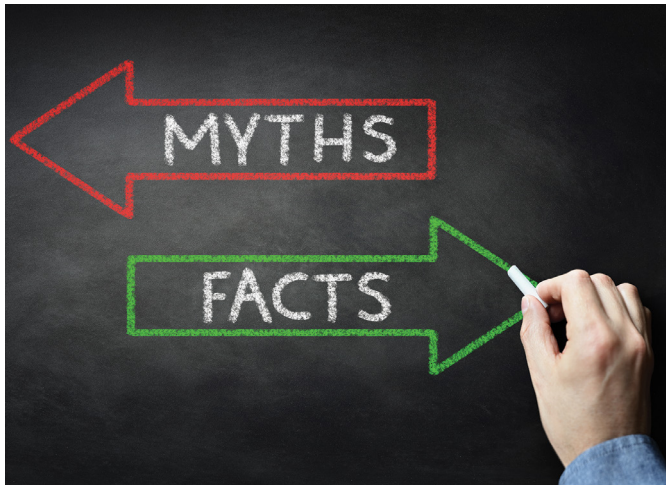
It is important to remember that measurement-based care can enhance the treatment process and is an essential component of providing EBPs. Measurement-based care can be used to:

- Inform treatment decisions
- Facilitate shared decision-making
- Prioritize Veteran-provider discussions
- Track outcomes over time
- Assess symptom severity and the Veteran's experience of symptoms
- Enhance engagement

Use measurement-based tools such as the PHQ-9 to assess and monitor Veteran symptoms

Discussing Treatment Completion

EBPs require too many resources, and scheduling weekly sessions limits access.



Helping Veterans recover from the mental health problems that interfere with their lives reduces the need for ongoing mental health care and thereby increases access for all. Psychotherapies with a strong evidence base are most likely to result in efficient recovery.

Evidence-based psychotherapy has been shown to reduce mental health treatment utilization and inpatient hospitalizations as well as costs. When routinely implemented, they improve access to care for all Veterans.[15,16]

Figure 10. Discuss Treatment Completion with Veterans

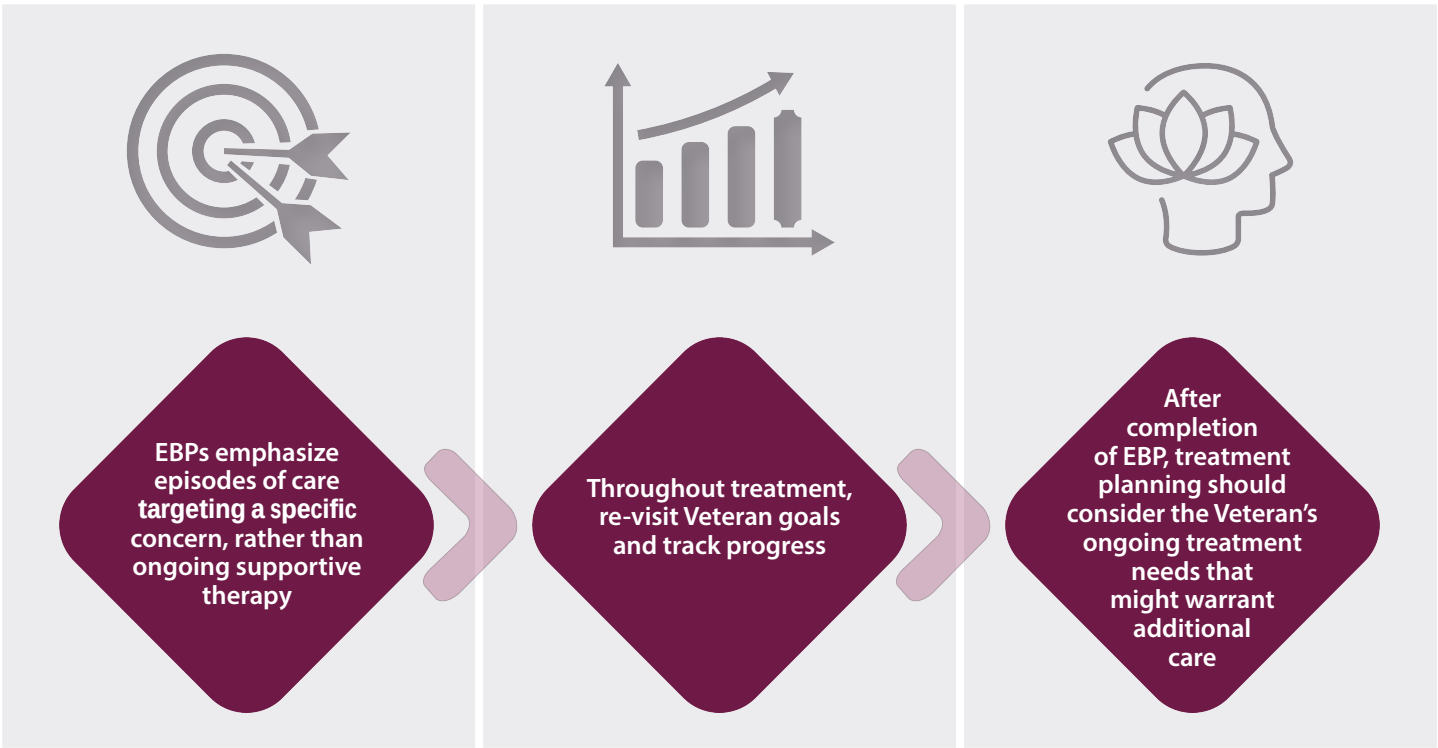
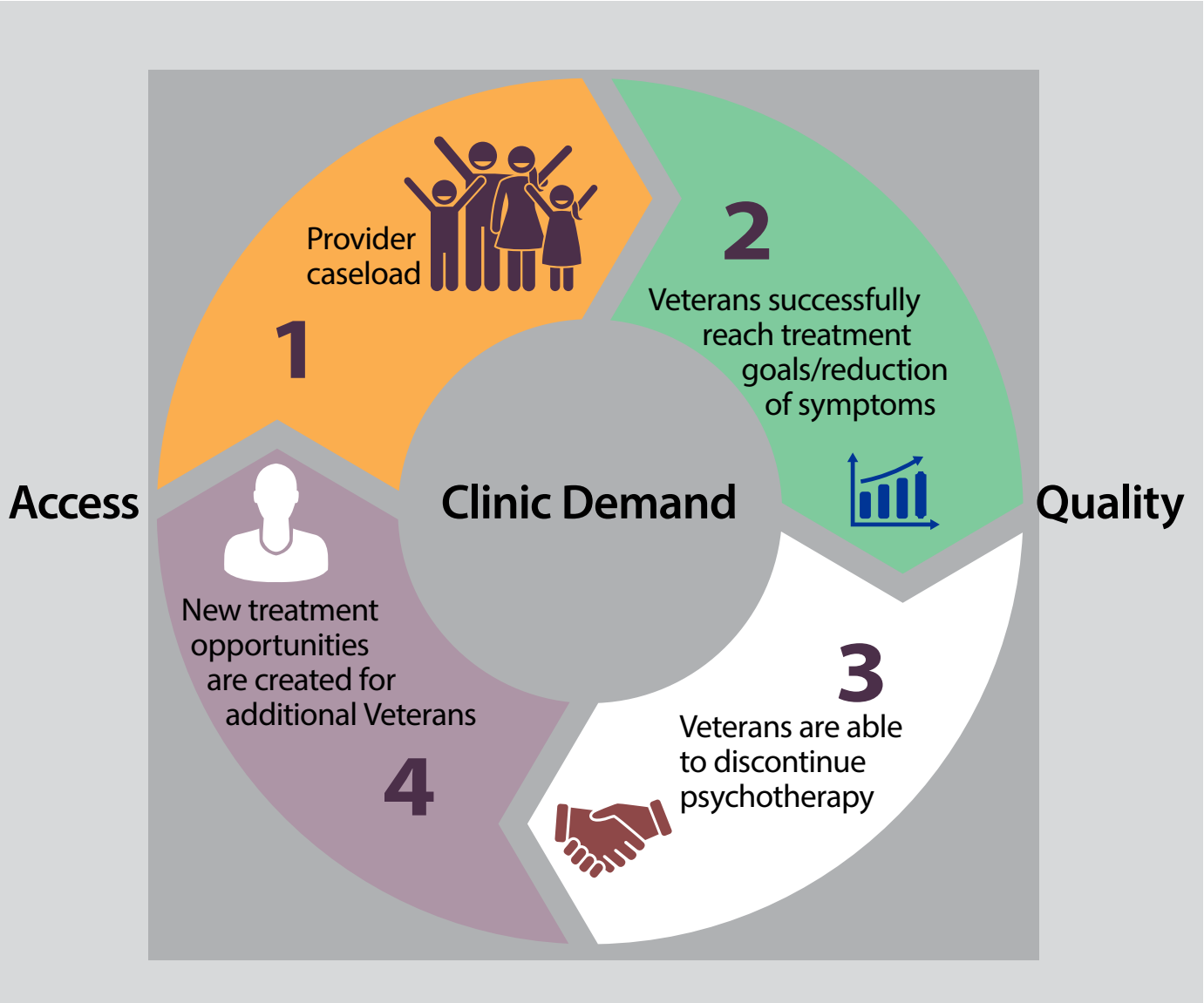


Figure 11. EBP and Access to Care



When an EBP comes to an end, it is time to evaluate and celebrate the work accomplished, talk about progress toward treatment goals, identify any additional treatment needs, and develop an aftercare or post-therapy plan. Remember that goals for therapy and conditions for ending therapy should be discussed at the outset of treatment and throughout the course of therapy. When Veterans achieve symptom reduction and other functional goals, they are able to discontinue formal psychotherapy and new treatment opportunities are created for additional Veterans.

Use EBPs to create new access opportunities.

Summary

EBPs are first-line treatments for depression and are effective for reducing depressive symptoms, including suicidality, and improving quality of life. Significant symptom reductions can be achieved with a small number of sessions and maintained after treatment ends.

- **Provide or refer Veterans to EBPs for Depression**
  - When discussing EBP options, use a shared-decision making process to determine which therapy approach is most appropriate/preferred.
  - Each Veteran's EBP treatment is tailored to the Veteran's specific needs.

- **Use EBP Templates to Ensure Quality EBP is Provided and Recorded**
  - Templates facilitate documentation of EBP delivery, provide reminders for essential treatment elements each session, and allow for accurate reporting on use of EBPs.
  - Local EBP Coordinators are a helpful EBP resource and can provide training on template use.

- **Use Measurement-based Tools such as the PHQ-9 to Assess and Monitor Veteran Symptoms**
  - Measurement based care enhances the treatment process and is an essential component of providing EBPs.
  - Clinicians should collect measures from the Veteran, at regular intervals during therapy, and share results with the Veteran and other providers to inform treatment decisions.

- **Use EBPs to Create New Access Opportunities**
  - EBPs target specific concerns and emphasize time-limited episodes of care rather than ongoing supportive care.
  - EBPs help Veterans to recover, reduce the need for ongoing mental health care, and increase access to care for all Veterans.
  - After completion of an EBP, treatment planning should consider whether the Veteran has ongoing treatment needs with emphasis on step-down care and/or self-maintenance strategies.

Resources

For additional information, see **Proven Treatments** and **EBP factsheets**

These are general recommendations only. For specific recommendations on policies and procedures, please identify and contact the facility point of contact for additional information.

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References

1. *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, D.o.D. Department of Veterans Affairs, Editor.
2. van Schaik, D. J. F., Klijn, A. F. J., van Hout, H. P. J., van Marwijk, H. W. J., Beekman, A. T. F., de Haan, M., van Dyck, R. (2004). Patient's preferences in the treatment of depressive disorder in primary care. *General Hospital Psychiatry, 26,* 184–189.
3. Dobscha, S. K., Corson, K, & Gerrity, M. A. (2007). Depression Treatment Preferences of VA Primary Care Patients. *Psychosomatics, 48,* 482–488.
4. Karlin, B. E., Brown, G. K., Trockel, M., Cunning, D., Zeiss, A. M., & Taylor, C. B. (2012). National dissemination of cognitive behavioral therapy for depression in the Department of Veteran Affairs health care system: Therapist and patient-level outcomes. Journal of Consulting and Clinical Psychology, 80, 707-718. doi: 10.1037/a0029328.

5. Stewart, M. O., Raffa, S. D., Steele, J. L., Miller, S. A., Clougherty, K. F., Hinrichsen, G. A., & Karlin, B. E. (2014). National dissemination of Interpersonal Psychotherapy for depression in Veterans: Therapist and patient-level outcomes. Journal of Consulting and Clinical Psychology, 2014, Vol. 82, No. 6, 1201–1206.
6. Walser, R. D., Karlin, B. E., Trockel, M., Mazina, V., & Taylor, C. B. (2013). Training in and implementation of Acceptance and Commitment Therapy for depression in the Veterans Health Administration: Therapist and patient outcomes. Behaviour Research and Therapy, 51, 555-563. doi: 10.1016/j.brat.2013.05.009.
7. Kimbrel, N.A., Kumpula, M.J., Lester Williams, K., Day, K., Crowe, C., & Wagner, H.R. (2018). Impact of Participation in Evidence-Based Psychotherapy for Depression on Suicidal Ideation among Veterans. Paper presented at the annual meeting of the American Association of Suicidology, Washington, D.C.
8. Slade, M. (2017). Implementing shared decision making in routine mental health care. World Psychiatry 2017;16:146–153.
9. Sasso, K. E., Strunk, D. R., Braun, J. D., DeRubeis, R. J., & Brotman, M. A. (2016). A re-examination of process-outcome relations in cognitive therapy for depression. *Psychotherapy Research, 26,* 387–398. doi: 10.1080/10503307.2015.1026423.
10. Strunk, D. R., Brotman, M. A., DeRubeis, R. J., & Hollon, S. D. (2010). Therapist Competence in Cognitive Therapy for Depression: Predicting Subsequent Symptom Change. *Journal of Consulting and Clinical Psychology, 78*, 429–437. doi:10.1037/a0019631.
11. VA. (2014). Memorandum on implementation of the evidence-based psychotherapy (EBP) documentation templates. October 9, 2014.
12. Stirman, S. W., Gutner, C. A., Langdon, K., & Graham, J. R. (2015). Bridging the gap between research and practice in mental health service settings: An overview of developments in implementation theory and research. *Behavior Therapy, 47*, 920–936.
13. Brown, J., Scholle, S. H., & Azur, M. (2014). Strategies for measuring the quality of psychotherapy: A white paper to inform measure development and implementation. report submitted to the assistant secretary for planning and evaluation. Washington, DC: U.S. Department of Health and Human Services.
14. VA Office of Mental Health and Suicide Prevention, Measurement-Based Care Initiative. **https://vaww.portal.va.gov/sites/OMHS/omhostrongpractices/MBC/default.aspx**
15. Teurk, P. W., Wangelin, B., Rauch, S. A. M., Dismuke, C. E., Yoder, M., Myrick, H., Eftekhari, A., & Acierno, R. (2013). Health service utilization before and after evidence-based treatment for PTSD. *Psychological Services, 10,* 401–409.
16. Worley, M. J., Trim, R. S., Tate, S. R., Hall, J. E., & Brown, S. A. (2010). Service utilization during and after outpatient treatment for comorbid substance use disorder and depression. *Journal of Substance Abuse Treatment, 39,* 124–131.

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This reference guide was created as a tool for VA providers and is available from the Academic Detailing Service SharePoint.

These are general recommendations only. The treating provider should make clinical decisions based on an individual patient's clinical condition.

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