

*Meeting the Needs of
Returning Veterans:*

Dissemination of Evidence-
Based PTSD Treatment

Josef I. Ruzek, PhD
National Center for PTSD
VA Palo Alto Health Care System
Josef.Ruzek@va.gov

Effective Dissemination

- Must address several component processes:
 - Identifying and prioritizing best practices
 - Assessing the context of dissemination to identify barriers/facilitators
 - Executing and monitoring an implementation pilot test
 - Expanding implementation to include PTSD settings throughout the VA system

Limitations of Published Guidelines

- Passive diffusion of guidelines (e.g., printing guidelines) is generally ineffective in changing practice
- Significant areas of disparity between current VA PTSD assessment/treatment practices and guideline recommendations
- Under-use of
 - Standardized PTSD assessment instruments
 - Evidence-based treatments

Identifying and Prioritizing Best Practices

- VA-DOD practice guideline itself describes a large range of practices
- Necessary to prioritize in terms of relative importance of dissemination
- Selected as change priorities: Evidence-based PTSD interventions
 - Prolonged Exposure Therapy (PE; Foa & Rothbaum, 1998)
 - “Strongly recommended” in PG
 - Cognitive-Processing Therapy (CPT; Resick & Schnicke, 1993)

Barriers to PE in Civilian Settings

- Common barriers to use among civilian psychologists include
 - Lack of training (60% of practitioners)
 - Resistance to manualized treatments (25%)
 - Fears of retraumatizing patients (22%)

Possible Barriers to PE in VHA

- Not currently widely used inside the VHA
- Possible barriers are related to
 - System obstacles
 - Provider factors
 - PE intervention itself
 - Patient barriers

Possible System Barriers

- Training costs
- Workload may impede delivery of individual treatment
- Workload may reduce willingness to experiment and capacity to explore new treatment options

Possible Provider Barriers

- Skills and training
 - Widespread skills deficit
 - Lack of previous professional training related to evidence-based treatments
 - Lack a cognitive-behavioral theoretical orientation
 - Advocacy for other kinds of (non-empirically-supported) interventions, based on training or interest

Possible Provider Barriers (cont)

- Attitudinal barriers
 - Resistance to perceived reduction of practitioner autonomy
 - Beliefs that impede use of PE
 - “Many veterans with PTSD are not ready for CBT” due to their lack of treatment motivation, lack of compliance with treatment, chronic problems, intense anger, suicidality
 - “PE will make patients worse”

Possible Provider Barriers (cont)

- Program philosophies sometimes not PE-compatible
 - Some programs eschew trauma-focused treatments and emphasize management of current-day problems
 - Some organized around alternative procedures (e.g., EMDR)
 - Managers may have non-evidence-based opinions or other management priorities

Possible Barriers Related to the PE Intervention

- PE is a 9-12 session individual treatment, may be difficult to deliver in context of heavy provider workload
- PE is an individual treatment while much PTSD care is delivered in groups
- PE requires significant preparation between sessions

Possible Patient Barriers

- Primary patient barrier is likely to be a desire to avoid trauma-related distress
- Significant “homework” on the part of patients

Addressing Barriers: Leadership Support

- MH leadership endorses PE and is funding a national dissemination/training initiative
- Trainees must have signed approval of facility/region directors

Addressing Barriers: Training

- Training/Supervision designed to remedy skills deficits and some attitudinal obstacles
 - Training will be adequate in intensity
 - Training will include effective change methods (e.g., modeling, role play, feedback, homework)
 - Trainees will see two cases under weekly supervision
 - Trainees will commit to use PE, supervise others

Addressing Barriers: Assessment to Understand Emerging Barriers

- Focus groups
- Questionnaires administered
 - Before training
 - After training
 - During and after supervision
 - After implementation period
- Ongoing monitoring of clinician experiences with implementation

Addressing Barriers: Building Practitioner Support

- Dissemination is unlikely to succeed if changes are only initiated “top down”
- Problems with previous efforts at dissemination may have been their unidirectional nature
 - Emphasis on changing practitioner behavior as decided by researchers or administrators
- Professional tasks are non-routine, their effective performance requires committed performance
- Clinicians and managers as partners

Traumatic Stress and Readjustment Website

- VHA intranet site designed to organize knowledge, foster sharing of information, support “communities of practice”
- PE training/dissemination section
 - Participant forums, online consultation
 - PE training materials
 - Powerpoints
 - Instructional videos
 - Manuals
 - Patient materials
 - Downloadable articles
 - Online surveys