Dialectical Behavior Therapy Training and Desired Resources for Implementation: Results From a National Program Evaluation in the Veterans Health Administration

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ABSTRACT  Context: Little is known about nonresearch training experiences of providers who implement evidence-based psychotherapies for suicidal behaviors among veterans. Evidence Acquisition: This national program evaluation identified the history of training, training needs, and desired resources of clinicians who work with at-risk veterans in a national health care system. This sequential mixed methods national program evaluation used a post-only survey design to obtain needs assessment data from clinical sites (N = 59) within Veterans Health Administration (VHA) facilities that implemented dialectical behavior therapy (DBT). Data were also collected on resources preferred to support ongoing use of DBT. Results: While only 33% of clinical sites within VHA facilities reported that staff attended a formal DBT intensive training workshop, nearly 97% of participating sites reported having staff who completed self-study using DBT manuals. Mobile apps for therapists and clients and templates for documentation in the electronic health records to support measurement-based care were desired clinical resources. Conclusion: Results indicate that less-intensive training models can aid staff in implementing DBT in real-world health care settings. While more training is requested, a number of VHA facilities have successfully implemented DBT into the continuum of care for veterans at risk for suicide.

INTRODUCTION
Suicide is a national public health concern representing the 10th leading cause of death, occurring at an age-adjusted rate of 12.57 per 100,000 individuals in the U.S. general population in 2013. Veterans are estimated to comprise 20% of the overall suicide rate in the United States, and the prevalence rate of suicide is estimated to be higher among veterans than in the general population. A recent Department of Veterans Affairs (VA) Suicide Data Report indicates that although there have been no clear changes in the number of veterans with suicidal behavior, there has been an increase in the number of younger male VA health care users with suicidal behavior. Given this, national efforts to prevent suicide among the general public and veterans seeking VA health care are of paramount concern.

There are a number of clinical and public health strategies to address conditions associated with suicide. Of these, means safety, promoting help seeking, access to care among those in distress (e.g., hotlines), depression screening, and care management are effective. Among clinical interventions, cognitive therapy, dialectical behavior therapy (DBT), medication management, continuity of aftercare, and follow-up contact (i.e., caring letters, safety planning) have some data to support reduction in suicide attempts and suicide.

To coalesce current national efforts in suicide prevention specific to veteran and military populations, joint VA/Department of Defense (DoD) Clinical Practice Guidelines (CPG) for the Assessment and Management of Patients at Risk for Suicide were released in June 2013. Given the state of science reviewed at the time, the CPG provides no recommendations with the Strength of Recommendation of strong [A] or recommendable [B], leaving the majority of practices lacking sufficient evidence among veteran and military populations. One treatment, DBT, is recommended; however, with “insufficient” evidence for treating an underlying disorder (i.e., borderline personality disorder [BPD] or other personality disorders characterized by emotional dysregulation and a history of suicide attempts and/or self-harm) in patients who have suicidal behavior.

According to other reviews of the evidence, DBT is considered as an evidence-based psychotherapy (EBP) for emotional dysregulation and suicidal behavior. The Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices independently rated DBT as a well-researched treatment effective at reducing suicide attempts, nonsuicidal self-injury, drug use, symptoms of eating disorders, and improving psychosocial

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adjustment and treatment retention among civilians. DBT has been examined in 11 randomized controlled trials and, in addition to the above, has been shown to be effective at reducing depression, hopelessness, anger, and impulsiveness (see summary in Landes and Linehan).

DBT has been shown to be effective in the Veterans Health Administration (VHA). Studies indicate that it was effective in reducing suicidal ideation, hopelessness, depression, and anger expression and helpful in reducing VA health care costs. VHA program evaluation has shown that DBT improves veterans’ clinical outcomes. Chiba and colleagues examined their DBT program and found a decrease in inpatient admissions, inpatient days, and cost (presentation at the 2009 VA/DoD Evolving Paradigms II OEF/OIF National Conference). Nappi and colleagues piloted a DBT skills group for depression and found improvement on depression, quality of life, and satisfaction (presentation at the 2012 Association of Behavioral and Cognitive Therapies Conference). Even though DBT has evidence of effectiveness in VHA settings, it has historically received little attention in comparison to other national EBP dissemination efforts, perhaps because of limited information available on providers’ history of training, adoption, and current use of DBT within this national health care system.

The “gold standard” of DBT training is the DBT Intensive Training Course, provided in two 5-day trainings, separated by 6 months of self-study. Studies on intensive training show that in a county-wide implementation, intensive training was correlated with improvement in therapists’ attitudes toward patients with BPD, greater confidence in DBT’s effectiveness, and increased self-reported use. Research on a statewide implementation using intensive training revealed that clinicians acquired mastery over the DBT model and theory. Brief training (i.e., 2-day workshop) has been found to only increase provider attitudes toward and knowledge about clients with BPD and improve opinions regarding treatment options for these clients. While intensive training is considered the gold standard to produce the expected system-level outcomes of adoption of DBT in health care settings for research purposes, community-based clinicians are propelling the adoption and use of DBT in nonresearch health care settings.

There is emerging evidence about DBT training experiences among community providers (e.g., duration, intensity, and modality of training). One study examined therapists’ use of DBT, including the amount and type of training received. This study, involving therapists (N = 129) trained by a commercially available DBT training company, found that 64% of therapists completed a 2-day workshop on skills training, 58% completed a 2-day workshop on individual therapy, and 39% had participated in intensive training.

To our knowledge, no other studies have examined therapist training in general health care or community settings, and even less is known about training and implementation of DBT in the national veterans’ health care system. To better understand the current uptake and spread of DBT in VA health care settings and identify the history of training and training needs for implementing DBT, a national program evaluation of VHA facilities that have implemented DBT was initiated in 2013 in collaboration with VA’s Office of Suicide Prevention. This article presents results of this national program evaluation.

METHODS

Study Design

The overall study design was a sequential mixed methods national program evaluation study consisting of a quantitative self-report survey and qualitative semi-structured interviews. The survey was administered first to sites within VHA facilities (N = 59). This quantitative results could directly inform design of the qualitative interview. The primary objective of the quantitative data was to attain clinic-based needs assessment data and, for the qualitative data, to attain in-depth information from key stakeholders knowledgeable about implementing DBT in VHA settings.

The data presented here are a subset of this larger study. This article focuses specifically on the training history and resource preference data. The rationale for selecting this subset of data is to inform national policy makers and VHA clinical managers on the design and development of a national DBT training and implementation plan. Ethical approval for this study was obtained from the appropriate VA institutional review boards.

Ascertainment and Sample Characteristics

The ascertainment of the sample used a national program evaluation approach. Considering the need to obtain data from all VHA sites identified with the use of DBT, the VA national health care system was our sampling area. We further limited our sampling frame to clinical sites that were identified on an internal VHA DBT resource Web site. The goal was to recruit at least 1 person per site to complete the survey on the site’s behalf or complete the survey as a team (either resulting in one submission per site). Characteristics of sites included VHA clinical sites implementing DBT. There were no exclusion criteria.

Sampling Strategy

Sites were identified using a two-step, purposive, snowball sampling process. First, the research team purposively identified providers who were their site’s point of contact on the VHA DBT resource Web site. The goal was to recruit at least 1 person per site to complete the survey on the site’s behalf or complete the survey as a team (either resulting in one submission per site). Characteristics of sites included VHA clinical sites implementing DBT. There were no exclusion criteria.
Dialectical Behavior Therapy Training and Desired Resources for Implementation

Dialectical Behavior Therapy (DBT) is a treatment approach designed to help people manage emotional distress and improve their quality of life. However, implementing DBT in healthcare settings can be challenging due to the need for specialized training and resources. This research aimed to understand the training needs and desired resources for implementing DBT in the Veterans Healthcare Administration (VHA) settings.

### Data Collection Procedures

The research team used the Checklist for Reporting Results of Internet E-Surveys (CRES) to guide the development and collection procedures of a Web-based survey. The survey was designed to be administered using a commercial Web-based platform, with the goal of pretesting before fielding. The survey was voluntary and did not require password protection or incentives.

The survey was structured into two main parts: Part 1 had 6 sections focusing on the history of DBT training among VHA clinical providers, while Part 2 consisted of 4 sections on training needs and desired resources.

### Measures

Surveys were collected between July 2013 and May 2014. The survey was designed to capture data on the types and amount of DBT training providers in their setting, as well as details about each component offered.

The first section of Part 1 allowed sites to describe their clinic setting, including type of treatment setting, number of DBT staff, and the context for delivering DBT. The second section addressed the context for delivering DBT, focusing on the components of DBT and clients’ presenting problems. The remainder gathered more details about each component offered.

Part 2 consisted of 4 sections. Section 1 focused on use of DBT strategies (e.g., diary cards) while section 2 focused on the types and amount of DBT training providers in their setting. Sections 3 and 4 were designed to capture data on the history of DBT training and the context for delivering DBT.

### RESULTS

#### History of DBT Training Among VHA Clinical Providers

Each site was asked to identify from a list which training activities any DBT provider in their setting had received. Fifty-seven sites completed these questions. Training activities were grouped as high (e.g., intensive training), medium (e.g., 1 to 2-day workshop), and low intensity (e.g., reading DBT books). The average number of high-intensity training activities ranged from 0 to 5 (mean [M] = 1.68, SD = 1.34). The average number of medium-intensity training activities ranged from 0 to 5 (M = 1.89, SD = 1.26). The average number of low-intensity training activities ranged from 0 to 3 (M = 2.60, SD = 0.73). Most sites reported engaging in low-intensity training activities. See Table I for a list of all training activities.

#### Training Needs and Desired Resources

For the needs assessment, the survey assessed use of online or technology-related DBT resources and resources desired. Of the 54 sites responding, the majority indicated use of the VHA DBT resource Web site (n = 35; 65%). Other technology used included online DBT training (n = 14, 26%), DBT mobile phone app (n = 9, 17%), and “other” (n = 8, 15%). Other responses included DBT videos (n = 2, 4%), the international DBT listserv (n = 3, 5%), creating a mindfulness DVD (n = 1, 2%), and a Web site (dbtselfhelp.org; n = 1, 2%).

To identify desired resources, sites ranked ordered a list of 10 possible resources. The top-rated resource was formal DBT training, followed by funds for training (see Table II). Responses entered for other resources (n = 17) were categorized; themes included (a) materials/supplies/tools (n = 6), (b) staffing/funding (n = 4), (c) education/training (n = 3),

### Data Analysis

Data were analyzed using SPSS 21.0 for Windows (Armonk, New York). Analysis included frequencies and descriptives on the needs assessment data related to history of training and training needs. Measures of central tendencies were calculated to obtain rankings of resources. There were a total of 67 survey responses. As data were collected about implementation of DBT in each site, when there were multiple respondents, data were combined, so each site had only one entry. The 67 responses included eight sites with more than one respondent. The research team identified each survey by site based on facility information provided by respondents.

Weekly meetings to review survey information guided team decision making on the combination of data. When there were discrepancies between respondents at a site, a team of two raters determined the most appropriate answer based on a number of rules. Rules included averaging data when appropriate; defaulting to a “yes” answer for yes/no items; and, when only one respondent completed an item, using that respondent’s data. After the data were cleaned and combined so that each site had one entry, there were a total of 59 sites. Missing data exist for some variables and were noted accordingly.

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The aims of this article were to identify the history of training and training needs for sites implementing DBT in VHA. While DBT intensive training is considered the gold standard of training, only one-third of sites reported having any staff with a history of this high-intensity training. In terms of workshop attendance, the most frequently endorsed workshop training was 1- or 2-day workshops, with about three-fourths of sites reported having any staff attend this medium-intensity training. The most frequently endorsed type of low-intensity training was reading of DBT books.

While empirical DBT training literature suggests that reading manuals and attending brief workshops may not be sufficient for changing provider behavior, results from this study may indicate otherwise. In this study, low-intensity training of self-study with DBT books may be at an acceptable level of learning for clinicians "initiating" DBT in VHA settings. Nonetheless, results of the training needs assessment reveal that sites would like additional DBT training, specifically training at higher intensity levels (e.g., intensive training) offered within VHA or in the community. This finding is consistent with a previous national survey of clinicians in VHA, which indicated a desire for training in DBT, among other therapies. Given what is known about training in EBPs in general, additional training such as intensive training and consultation is likely needed for clinicians to become adherent to DBT (as opposed to initiating a DBT program).

With regard to resources, the most frequently endorsed technology resource was VHA’s internal DBT resource Web site developed to create a virtual community of practice. This Web site brings together clinicians and sites engaged in DBT.
and serves as a central repository for DBT information and resources. Sites likely use this site for a number of reasons, including that it is freely available, links them to other VHA providers, allows for interaction and sharing of DBT information, and has tangible DBT resources that can be used with little training (e.g., client worksheets).

IMPLICATIONS
Given the low number of sites endorsing high- or medium-intensity DBT training and results of the training needs assessment, there is a clear indication that sites want more formal training in DBT within the VA health care system. This education request may be influenced by the relatively recent investment into the national EBP program disseminated VHA wide. These specific treatments have workshop training, practice cases, and consultation. Many also have implementation and training resources such as videos for therapists to aid in learning, videos and materials for clients, and monthly consultation calls. Some of the EBPs include cognitive processing therapy, motivational interviewing, social skills training, and cognitive behavioral therapy for depression.18

Examining this list, the VHA has invested in treatments for mental health problems such as depression and post-traumatic stress disorder, commonly regarded as high clinical need areas. Suicide prevention is also a high clinical need area and an issue that cuts across populations, settings, and clinics. To our knowledge, there has not been an EBP specifically targeted to address suicide prevention that has garnered national dissemination, despite VA/DoD CPG recommending outpatient treatments such as cognitive therapy for suicide prevention,19 problem-solving therapy,20 and DBT. However, one EBP, cognitive behavioral therapy for depression,21 does include information about how to address suicidality in terms of assessment and crisis management.

The importance of suicide prevention and the data presented here highlight the need for increased attention to the intensity of training, desired resources, and consideration of existing dissemination models for supporting the VHA-wide implementation of EBPs for suicide prevention, such as DBT. In addition to being effective for treating suicidal behavior, DBT has been shown to be effective for female veterans with BPD and helpful in reducing the treatment utilization and cost of services for veterans (male and female) with BPD features in VA health care settings.

LIMITATIONS
The results of this study are limited by the small sample size, post-only design, and the selection bias of sites that participated. Although sites represent all potential sites from VHA facilities across the country, the design and sample only included sites that had implemented DBT and may not generalize to other sites in VHA. In addition, the study relies on self-report data from one respondent per site. Additional information may have been obtained from different respondents in the same site and/or by using an observer-rated instrument. Nevertheless, as a national program evaluation, this study specifically outlines the training history and resource preferences that are useful to inform national policy makers and VHA clinical managers on preferred training factors that may affect the design and development of a national DBT implementation plan.

CONCLUSIONS
This study offered feedback from sites on the training needs and desire for training resources to be considered when planning for the future. Results indicate that less-intensive training models can aid staff in initiating implementation of DBT in real world health care settings. While more training is requested, a number of VHA facilities have successfully implemented DBT into the continuum of care for veterans at risk for suicide.

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REFERENCES