National VA Mental Health Wellness & Recovery Webinar Series: Dialectical Behavior Therapy Implementation and Initial Outcomes at the Baltimore and DC VA Medical Centers

Drs. Lea Didion, Jessica Grossmann, and Peter Phalen

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Dr. Samantha Hack: Welcome everyone, this is the Mental Health Recovery and Wellness Webinar Series. This series is made possible by the VA Office of Mental Health Suicide Prevention, Psychosocial Rehabilitation and Recovery Section, and the VISN 5 Mental Illness Research, Education and Clinical Center or MIRECC, in partnership with the Employee Education System. The planning committee members for this webinar series include: Daniel Bradford, Amy Foster, Valerie Fox, Richard Goldberg, Catherine Lewis, Marty Oexner, Kathryn Peacock-Dutt, Donna Russo, Tim Smith, my co-host Ralph Schneider, and myself, Samantha Hack. Today's Webinar is entitled Dialectical Behavior Therapy Implementation and Initial Outcome at the Baltimore and DC VA Medical Centers. Our presenters for today's webinar are Drs. Leah Didion, Jessica Grossmann, and Peter Phalen. Dr. Didion is a Clinical Psychologist and the DBT Clinical Services Coordinator at the Washington DC VA Medical Center. She has been practicing DBT since 2009. In 2018, Dr. Didion introduced DBT services at the Washington DC VA, and in 2019 she created the Comprehensive DBT Clinical Service. Dr. Grossmann is a Clinical Psychologist at the Baltimore VA Medical Center Trauma Recovery Program and is a member of the DBT Clinical Service. Dr. Grossmann has been practicing DBT since 2013, and has participated on three VA DBT teams. Dr. Phalen is the Post-Doctoral Fellow at the Baltimore VA Medical Center, where he is a member of the DBT Clinical Service. He has been practicing DBT since 2012 and spent two years as a research assistant in Marsha Linehan's Clinical Laboratory at the

University of Washington. He has a particular interest in applying DBT for people struggling with severe mental health conditions, such as schizophrenia. At this time I'm happy to turn the webinar over to our presenters.

Dr. Jessica Grossmann: Hi everyone. Thank you Sam. Thank you all for attending. Dr. Didion, Phalen, and I are excited to speak to you all today to share our experiences within the DC and Baltimore programs. We will start with just an overview of the 'What is DBT' as a treatment modality and then we will discuss more specifics to our unique program development process, our program evaluation data and then offer some lessons learned to hopefully facilitate some discussion in the Q&A section at the end. As required, we have no disclosures to make, but obviously the material presented today is the result of work supported with the resources from the local VAs in DC and Baltimore.

Okay, so what is DBT? DBT was developed by Marsha Linehan originally for women with Borderline Personality Disorder, but then quickly expanded to include other populations such as men, adolescents, and other community facilities or centers, including the VA. DBT is an intensive treatment and incorporates many different components, which makes it intensive. Specifically, it includes individual therapy and group skills training each week, and then there's an option for clients to utilize something called phone skills coaching. This is when a client can call any member of the DBT team to ask for support in the moment of an emotional crisis to utilize the skills that they have learned in the skills group in their real life. Within the VA this is typically done within staff members tours of duty and then the Veterans Crisis Line is utilized on the off hours. However, in the community many DBT team members carry pagers or cellphones and are available 24/7. Therapists on DBT teams are also required to attend weekly consultation and groups, and this ensures individual providers adherence to DBT, the model

and philosophy and the behavioral treatment principals, but also it serves as an avenue for therapists to receive support from one another given the challenging nature of this work. DBT lies on the foundation of biosocial theory and the transactional model and uses a more behavioral lens to describe how certain behaviors develop and then continue over the course of a lifespan. These theories suggest that as individuals express their emotions and needs, as these needs are invalidated or neglected or ignored, behaviors will continue until a desired response is achieved. These theories describe how this behavior can present among individuals with Borderline Personality Disorder and the behaviors we focus on typically in DBT are things like self-harm, and suicidality which evolve over time as these needs are or are not met. However, just of note, DBT has since been applied to other behaviors, which we will talk about as the presentation continues. DBT also includes components of CBT, it is under that larger umbrella. The skills in DBT are taught, are more behavioral, so emphasizing the big B of CBT and the goal is to allow for more wise-minded thinking. This is the goal to reduce emotional crises, distress and overwhelm using specific behavioral interventions, which will then explore and allow for more space for different types of thinking, cognitive flexibility, etc. Validation is a really important skill of intervention that therapists will provide in their individual sessions, as well as the group skills training. It is utilized frequently, and the goal is to find the kernel of truth in the experience of the emotional crisis to then help individuals experiencing the crisis move towards change. So, DBT incorporates dialectics, which, in a nutshell, is the recognition that truth is found in two opposites. So, in DBT, the big dialect that is emphasized is the idea of acceptance and change. They may present as opposites, but they're both possible. In this concept, this dialectic of acceptance and change really formulates this idea of a life worth living, which is, overall, why clients

participate in DBT. Despite any sort of unwanted emotional experience, a history of trauma, adversity, difficulties, etc., clients are taught that really the goal is to be present in the moment, but also look ahead and improve their lives, setting meaningful goals for themselves, and this obviously varies from person to person and is part of what makes DBT really unique. We address specific behavioral target behaviors in individual sessions using specific skills learned in the skills group, which I'll talk about in a moment, and these targets are meant to, um, work on the things that are getting in the way of a life worth living. So we address life interfering behaviors, which may include suicide attempts, preparatory behaviors or non-suicidal self-injury. Therapy interfering behaviors, which could look like nonattendance to sessions or refusal to practice skills learned in group for home practice, or quality of life interfering behaviors, which could be risky driving, substance use – anything that's really getting in the way of the life worth living goals, but aren't necessarily placing someone at risk to die. So the DBT skills group is an influential piece of the treatment. Without this you do not have a full model DBT program. The group skills practice is taught similar to the class. The group structure includes mindfulness practice at the start of each group, review of home practice, introduction of new skills, and then a discussion of new skills and the practice and application of those new skills. Learning each skill once takes approximately six months, so this is typically considered the minimum commitment, or requirement, for participation in a DBT program. Within the VA, I've heard that DBT programs could be a minimum of six months with the option to renew indefinitely until those treatment targets were met. Some programs have a six-month minimum and maximum, and others are about one year. So, it really varies, but six months is across the board the minimum that somebody can participate in DBT. So, in brief, each of the modules within DBT have a different goal. So, the

Mindfulness Module teaches individuals the ways to be aware of their thoughts, emotions, physiological reactions, which are the building blocks for all of the other DBT skills. This module also teaches that idea of wise-mind, which you may have heard me mention just a moment ago, and this is the synthesis of both emotional mind or reasonable mind, so, emotional overwhelm versus logic, and this is, again, another dialectic focused on in the treatment. The Stress Tolerance Module focuses on teaching skills to reduce the intensity of emotions during crises as they are occurring, so these are more fast acting in the moment skills that we want people to have in their back pocket for when they need it in their daily lives. Emotion Regulation skills focus on education about the experiences of emotion, how to label and identify emotion, ways to reduce emotional vulnerabilities, so things that are contributing to feeling emotions more sensitively or more intensely, and the hope is that the emotional crisis will occur less frequently. So, overall, how to maintain and reduce negative emotional experiences. And then the final module, Interpersonal Effectiveness, focuses on teaching a structure for communication. You may have heard of the deer man skill. Um, so, exactly what to say, specifically when making requests or asserting themselves, and also when saying no, while also balancing individuals' personal needs to achieve an objective, improve or end relationships, and then also maintain or improve self-respect.

Dr. Lea Didion: So as Dr. Grossmann just outlined, the components of the comprehensive DBT, and one of the questions that we have sometimes have gotten is, what is the difference between comprehensive DBT and DBT informed treatment? So, um, as Dr. Grossmann had mentioned, comprehensive DBT has many elements and components, and conceptualizes, as a patient, moving through different stages of treatment, where Stage 1 is addressing those life-threatening behaviors, things like

suicide behavior, self-harm, homicide behavior, things that get in the way of the life worth living goals, and then moving all the way to the stage of a life of completeness and connection. DBT informed therapy might have elements of comprehensive DBT, so for instance, many VAs or many different places may have a DBT skills only group, or an individual therapist may use a diary card to identify target behaviors that need changing. DBT informed treatment might be a holding space for people who are preparing to go into a comprehensive DBT program or even as a phase-based approach to treating other conditions. We, for the rest of this presentation, are really going to be focusing on the implementation and creation of comprehensive DBT, particularly within the VA system and what our experiences have been. I like this graphic though that shows the different stages of treatment. All the way from Stage 1, which is typically where comprehensive DBT starts. We will sometimes describe this as this is where life feels as though it's on fire, and we have to put out the fire before we can move on to any other stage of treatment. And so this is where comprehensive DBT starts. I think it's important to note that DBT informed therapy could really be done at any stage. You could use it for Stage I, but you can certainly use it for Stages 2, 3 or 4 to help increase coping skills or just to, again, for identify certain targets that need to be addressed. So, as Dr. Grossmann described, a comprehensive DBT program is time intensive, and one of the reasons, that, anecdotally it hasn't been as widely implemented in the VA system, is because of its time intensiveness, um, and sometimes the costs that can be associated with it. However, I think there's some really compelling reasons to offer DBT in the VA. So, first of all, DBT is an evidenced based treatment for reducing suicide attempts and self-harm behaviors and, as we all know, Veterans are at an increased risk of suicide. And also, if you look at our population with high rates of things like PTSD, other disorders of

emotion dysregulation, things like depression, substance use, ADHD, other mood disorders, presenting issues like anger and hostility, impulsivity, I think it does make sense to apply DBT to our population. And interestingly, um, one concern about implementing DBT at a comprehensive programmatic level, is that it could decrease resources, but actually several studies have shown that over time DBT can actually reduce facility costs and mental health utilization, especially when you consider that the patients who benefit from DBT are often those who are utilizing services at a high rate, or utilizing high cost resources, such as inpatient hospitalization. Oh, I'm sorry, I think we just moved to a poll. Okay, so I'm going to just quickly [inaudible] on DBT in the VA and hopefully that will come up soon. Um, so where is DBT in the VA currently? Oh shoot, I did it again. Um, DBT is not yet rolled as an EBP in the VA. Um, as of right now, there are at least 143 skills groups, DBT skill groups that are offered in the VAs across the country, and there is a sharepoint that generates discussion and disseminates resources about DBT in the VA. We will actually link to that later on our resources slides. In terms of comprehensive DBT programs, there are currently 38 comprehensive DBT programs across VAs in the country, and this is up from 13 comprehensive programs back in 2013, and I want to give a major shout out here to Dr. Laura Meyers from the Orlando VA, who has really created a wider dissemination and training initiative to bring comprehensive DBT to VAs in the country and both, um, the Baltimore VA and the DC VA utilize this highly in order to create our program.

Dr. Grossmann: Yes, highly utilize that service, which we will be talking about at the end when we get to lessons learned in a little bit. But, at the Baltimore VA, our service was initially just an idea, um, formed by informal feedback from providers and different stakeholders, which included clinicians, leadership members, suicide prevention teams and Veterans themselves. This

information collected informally, so I don't have that specific qualitative data to present to you today, but I wanted to give you a sense of what the steps were to get the program started. So a small grant application was submitted, following again, approximately six years of seed within our facility, and this seed grant was received and funded by the VISN 5 MIRECC. In December of 2018, two trainers from other VAMC DBT programs came to Baltimore to provide a three-day training. And that's what the seed grant really paid for. Two days of this training were offered to any clinician just interested in learning the foundational skills of DBT, and the third day was reserved for clinicians forming the DBT team. The DBT clinical service was then founded in December 2018 by a team of five psychologists and one post-doctoral fellow, and today our team has seven psychologists, including [inaudible] dedicated administrative time, one psychology post-doc and one psychology intern. In February of 2019, so just a couple of months after that initial training, our consult opened within CPRS so we could receive referrals from providers within our catchment area. Within a month we had enough consults, had completed enough screenings, and initiated treatment with Veterans to fill a full skills group, which then began in March of 2019, so it was a pretty quick turnaround, really demonstrating the need that our VAMHCS had. The process of DBT engagement is provided in a slide at the very end of this slide show, so if you download it, you will be able to have access to that just as a resource. It describes really the course of from receipt of the consult to completing the DBT program, what the steps are for Veterans who are participating. And then Lea will talk a bit about DC.

Dr. Didion: So our steps after the DC VA steps after we applied for our MIRECC grant, are almost exactly the same as Baltimore's. So, I wanted to actually go back in time to talk about what we did, even before that. So, unofficially, back in about March of

2018, there were enough providers at the DC VA who were interested in DBT and saw the need from our Veterans that we decided to create DBT skills only groups. So, doing that DBT informed treatment, and these were clinic specific. There was one in our Trauma Services Program, there was another in the Mental Health Clinic, there was one in our PRRC and we just began this and there were, again, enough of us that we unofficially started to meet as a DBT consultation team. And while we were running these groups we started to see more and more need, so I set up seven different consultations with people at VAs across the country, um, everywhere from Puget Sound to Salt Lake City to Salem, Virginia, and talked with different DBT program leads at those VAs to find out how they went about creating their program. So I asked them things like, how were their programs structured, how did they get funding, how did they get leadership buy in and allocation of resources and from there, that's actually one of the ways that we learned about Laura Meyers and her initiative and the MIRECC grant. So before even doing that, um, we had established our DBT skills group. I conducted an informal needs assessment with thirteen different staff members at the DC VA to find out from their perspective how widely DBT was needed in our hospital, and got really good feedback there that I presented to leadership, so they said things like "We 100% need DBT", um, "I have at least five patients a week who would benefit from DBT", or "You know there are X number of patients in the past six months that I would refer to DBT if that were a treatment option." So while presenting the data from providers, we were simultaneously gathering survey data for quality improvement purposes to prove that the DBT skills groups were effective. And I will present on that in just a minute. Another thing that we did very thoughtfully, was we began to offer DBT as, uh, a rotation for our psychology intern. Often times in the VA, because there is such a strong, wonderful emphasis on training, this was a way to

not only establish ourselves as a program, a growing program, but also to highlight that we would be able to offer needed training on an ongoing basis. And so after these steps were taken, I presented to our leadership, both the feedback from providers, the survey results from Veterans, outlined the different steps that we had taken, and then got approval to apply for the MIRECC grant, I do want to mention, um, I am not a grant writer, and when I first heard that there was a grant option available I felt rather intimidated, but really want to stress that this was not a time consuming or intensive process, um, largely because the folks at the MIRECC, and I'm gonna give a shout out to Dr. Lucksted who was is on this call right now, they're so incredibly supportive and so focused on having you succeed, that there was just so much support offered every step of the way that it felt, um, it felt like a very seamless process for most of the time. Getting funding and those kinds of things is always more difficult, but, but the actual process was really fantastic. So, then after we had the MIRECC grant approved, we created, formed a consultation team and interestingly, because we had providers from different clinics, we were able to create a consultation team that required no extra resource allocation from the VA, and at no cost to the VA because it was MIRECC-funded for the training. So, I think these are also really important selling points if you are considering building a DBT comprehensive program.

Dr. Grossmann: And one consideration as you're building your programs, is to consider who you want to provide the services for. So obviously DBT itself has been used to great a myriad of difficulties, but within the VA setting, especially each respective VA, you may have specific, um, specific populations that you want to increase access to care for, or provide more intensive services for. So that was one thing we, in Baltimore, spent a lot of time discussing, on that third day of the training with our

consultant, who stayed with us to kind of problem solve within this development process. We settled on the following eligibility criteria, as well as exclusionary criteria; however, I will say that our team really looks at each referral in a lot of detail and does a lot of chart reviews to make sure that we are considering all of the facets of that person's needs to make sure we are providing care as needed to whatever population they're representing. So, in a nut shell, we wanted to ensure we were accepting Veterans who would most benefit from the service, specifically Veterans who were at the highest risk, so presenting with more current or more recent suicidality, suicide attempts, self-harm behaviors, or impulsivity. And we did this for a couple of reasons. The first was we needed to preserve our own resources; we were a new team, we're rather small, and we wanted to make sure that we were providing care to the Veterans who needed it most. We also, however, wanted to be able to provide some flexibility for access to care broadly. Um, so, the eligibility criteria includes, again, Veterans who present with recent self-harm or suicidality, but also those who may just be demonstrating a pattern of emotion dysregulation or impulsivity. To narrow in on that recency of self-harm behavior, we, in the first bullet-point you will Veterans with multiple psychiatric hospitalizations in the past five years, with at least one in the past year. So we really emphasize that one hospitalization within the past year, or a history of suicide attempts with, or self-harm behaviors within the past five years, in addition to that emotion dysreg or impulsivity. So we're really allowing referring providers to consult with us about that eligibility criteria. If somebody is on the border they may not fit specifically within those times frames, but they are likely somebody that would still really benefit from DBT, we will accept those referrals and our team will continue to do some of the screening or intake process to make sure a DBT would meet their needs, whatever those treatment goals might be. Our

exclusion criteria was also discussed during that third day of the training with our consultant which, again, being extremely helpful being able to learn from somebody who had a program that was up and running that they were leading and to get their input, um, was great. We didn't have to reinvent the wheel. So Veterans who were unwilling to commit to the full six-month cycle, were just not admitted. We would not continue with a screen with them. We would often call Veterans to schedule that and just remind them that it does require a six-month commitment. A lot of Veterans don't necessarily know that DBT is as intensive as it is, and so we wanted to make sure that they knew what they were signing up for. Veterans who presented with significant cognitive impairment or were in need of medical detox, or are generally referred to other services within our VA , prior to consideration of a program, just so that we can make sure that those needs are being met before they engaged in a six-month program. Antisocial Personality Disorder is generally, um, excluded from our program, just because the program does rely so heavily on the group to each those skills and, as you all likely know, there is some research that suggests that individuals with antisocial PD are not necessarily great for a group milieu, so um, in that sense we will, do again, through chart reviews, consult with referring providers, and if we have difficulty identifying where the assessment is located, or if it's unclear when or how the assessment was done to establish that diagnosis, we will again do the screening so that we can have more assessment be done within our team. We also require all Veterans have a home base, so to speak, so that if they discontinue DBT they have some mental health provider that is able to follow-up with them, and this might look like a psychiatrist or a case manager or an individual therapist, and this helps us maintain the contingencies and limits set within the

DBT program, and also ensures that our highest risk Veterans have some sort of care and follow-up available should DBT not be the best fit.

Dr. Didion: So at the DC VA, our eligibility and exclusionary criteria are similar to Baltimore. So I'm going to highlight some areas where they are a little different and, and I purposely want to talk about this because if anybody in the audience is considering building a DBT comprehensive program I think it can be really helpful to just know that there are different models out there and different ways to structure things, and that each of those ways can lead to a very thriving program, and so um, just depending on the needs of your Veterans and the needs in your hospital, I think you can set things up to look very differently. So, our, in our eligibility criteria, where we differ a bit from Baltimore, is we require that in the past year an individual, um, has at least two incidents of either suicide behaviors, non-suicidal self-injury, or psychiatric hospitalization. So our criteria there is a bit narrower. Um, and we did that, or, I purposely chose to have very narrow criteria because at the time I wasn't sure exactly what the need from Veterans would be. Um, I didn't know what our census would be and what our capacity would be like, given that we were a new and emerging program, with a fairly small team. And what I have learned over time is that you can always loosen your eligibility criteria, it is very difficult to become more stringent down the line. The only other difference really from the Baltimore program is in our exclusionary criteria we specifically state that if a Veteran is ready for another evidence based treatment, um, say PTSD treatment or treatment for social anxiety or OCD, so if they are ready, if they are able to tolerate the distress of those treatments without engaging in a life-threatening behavior, that they should be referred to

that treatment. Really we are um, trying to get people attached to and connected to the most efficacious treatment for them and their presenting needs.

Dr. Peter Phalen: This is Peter, just had to unmute myself. So um, we've been picking pretty comprehensive program evaluation data, um, at the Baltimore VA and the DC VA. So I wanted to report on some of that and what that seems to show. Um first of all, some information just on the consults, where those have come from and kind of where they have ended up. So this is somewhat dry, so I guess I'm gonna focus on the part that illustrates some learning experiences for us. So first of all, we received 63 consults, 20 of those attended screenings and among those, 24 engaged we got an additional six screenings that were scheduled at the time of writing this presentation. Twenty-nine of those consults we decided to not screen. Eight of those declined to be screened, which I think illustrates that what Jessie, had heard, Dr. Grossmann, described earlier, that, you know, not, this program isn't necessarily right for everyone, it's also just very intensive, not everyone wants a program that is that intensive, and some people just can't. So, for example, at the Baltimore VA we've only got one group, one phase, and if you're working eight hours a day on Wednesdays, then you're not gonna be able to make the group, so there's some sort of basic practical considerations that might cause someone to decline to join our program, irrespective of whether the treatment would be right for them. And, of course, there are reasons people might decline because they just don't think that that's a good fit. Um, another eight of these screens were deemed ineligible, which illustrates a pattern that I think was especially acute at the beginning of our program, where we had some difficulty communicating to prescribers and just people in the VA system about who was a good fit for our program and who might be a bad fit. Part of that is because, I mean as you see

even between the DC VA and the Baltimore VA, we've decided on different eligibility criteria, you know, I mean, there's some discretion there and providers might have their own opinions of what DBT is good for, and those opinions might be valid, but also may just not match up with what our actual criteria are, so. Part of our struggle at the beginning was just communicating what our criteria were to providers. We ended up kind of taking steps to that effect. For example, sending out kind of emails to providers reminding them of our program, that it exists, and that we want referrals and then just putting the criteria at the base of the email. And, of course, when providers reach out and refer someone we can always use that as an opportunity to provide feedback and say that this person doesn't meet criteria for this reason, so there was also that kind of room for corrective feedback. Um, six people engaged in other programs and then seven people were lost to follow-up meaning, for example, that we tried to schedule with them, they stopped at the consult and we were unable to reach them or whatnot. We also had 24 people who fully enrolled in the program. Among those we've had nine graduates so far. We have seven people who form this, which is the DBT specific term for a drop out. In DBT you're only dropped out if you miss four consecutive sessions in a row, so I you don't do that you're in, but if you do that you're sort of automatically out. So seven people did drop out. Um, this wasn't always like some kind of, you know, sign that treatment wasn't working, this is a long program, right, like six months and then you allow people to re-up for another six months. So, for some people it's a year. So some people, you know will drop out because they just, they got a job or something that they want to commit to, or they wanted to go to a different program, but other people did, you know, have trouble making it though the entire six months and ended up leaving. And then we have eight currently active patients. We keep track of hospitalization suicide attempts, and also actually self-

harm among people that are currently involved in the program. We've had, fortunately, zero hospitalizations among people actively enrolled in DBT, and zero suicide attempts among people actively enrolled, which I think is a really encouraging sign, especially given that, as you've seen, we are actively selecting for people who are at high risk for suicide and have engaged in very recent suicidal behavior. We don't keep track of these variables after people leave the program. We do know off hand that we've had at least one hospitalization after the program, and we did have one completed suicide, unfortunately, which was sobering and, I think, which illustrates, once again, just how high risk these patients are and, you know, just because you complete DBT doesn't mean that you're sort of out of the woods necessarily. So, um, those are kind of the basics of where people have come from and where they've ended up. We've also kept pretty strong outcome data for people as they've walked through the program. So, especially pre-COVID, we were keeping pretty detailed outcome evaluations. So we would, we had a small repeated measures battery that we would deliver at screen to decide whether people were a good fit. For example, were there, was their emotion dysregulations really high, that sort of thing, and to provide that as a baseline. But then we also repeated these measures at the end of every module. So, DBT is divided into four modules, I guess rotating groups of three with mindfulness separating them, and that means every six to eight weeks we have an opportunity to re-administer this repeated measures packet and kind of get a picture for whether people are improving on average. It also allows us to kind of notice when people are kind of getting worse, and checking in on that as well. These graphs show the data, with fitted regression lines, so these are just straight lines through the data showing how people have been doing. So we've seen, you know, strong decreases on the C-SSRS, which is a measure of suicidal behavior, decreases in emotion

regulation on the DERS decreases in depression on the PHQ9. These are all statistically significant decreases, but they're also clinically significant. So, for example, if you know the PHQ9 you can see just on the Y axis, that these anchors, um, suggest that people are starting having fairly severe depression and during, and ending, with on average, you know, moderate or even mild depression. We also had significant decreases on the BSL. This is a measure of sort of dysregulated behaviors that are often associated with emotion dysregulation in BPD, for example, you know, reckless driving, reckless sex, drug use, that sort of thing, and we see significant decreases on that as well. Skills use has also improved, so, um, adaptive skills use has gone up, general dysfunctional coping has gone down, and blaming others has gone down. One thing I wanted to kind of point out that's a little bit difficult to see on these graphs, well, you can't see it, they're just straight lines fitted through the data, right, so, these are summary statistics, but in fact the raw data suggests that actually the gains are happening um, in sort of a curve, so we see the biggest gains at the beginning of treatment. With gains continuing as people progress, but kind of um, leveling out. So, some of the biggest gains are happening definitely in the first couple of months of treatment, which I think is encouraging and also helpful for a long treatment like this, where there is a high drop out rate. We get people dropping out at five and a half months, you know. And I think for people, I mean for myself, I'll just speak of myself, as soon as I get some anxiety it's like, oh they didn't complete treatment are they gonna be okay? And um, we do find that the data suggests that people are making huge gains, especially at the beginning. So just because you drop out at three months doesn't mean that you didn't, maybe didn't experience really no great improvement.

Dr. Didion: Okay, and I'm gonna jump in with some of our initial quality improvement data from the DC VA. So this is actually going back to when we had just the DBT skills only groups, when we were trying to establish our program. So I had mentioned earlier that we were collecting some survey data from those individuals who had completed the DBT skills only groups, and this was some of the data that I used to present to leadership in order to get buy in. I'm a big fan of implement what it is that you're looking for, prove that it works and then ask for more. So this was proving that it worked, sliding into asking for more. So these were Veterans who completed skills only groups. Not all of them had diagnoses of Borderline Personality Disorder, not all of them required a comprehensive program, so keep that in mind, but the feedback that we got from Veterans was just overwhelmingly positive. Everything from, I'd say, that "This program saved my life", to being able to apply the skills to enhance relationships with family members, manage anxiety more effectively, manage anger more effectively, um, people getting their needs met, decreasing their alcohol use behaviors, it just seemed as though um, the services were helpful in such a wide array of areas and, and with different needs. So, we also looked at chart review data. So again, these were Veterans who had completed DBT skills only group. This data was looked at up until about June of 2019, which is when we switched over to the comprehensive program. And, in the chart, for folks that had completed the DBT skills, we looked at the time before, about a year prior to entering DBT, and then during the time that people were actively in the DBT skills group and then compared that to data six months post completion of DBT skills group if that data was available. And what we found was that before or during DBT, about half of them had a category I flag in their chart, and none had a flag after completing DBT. Um, almost half had a referral to the suicide prevention program – again, none had a referral to suicide prevention post-DBT.

One person was hospitalized and had a suicide behavior report listed in their chart, and none since completion. So, while this data was overwhelmingly positive, we also knew that it was unlikely to be this robust once we moved into the comprehensive program. But again, this was the data that I used to show and prove to leadership that these services are effective and then asked for more, asked for the creation of a comprehensive DBT program, specifically targeting Veterans who were at the highest level of risk for suicide and self-injury. And this is our data on the comprehensive program thus far. So since about June of 2019, we have received 51 referrals about, and I apologize, this might have been an earlier slide, so we have 16 people who were enrolled and then six who are pending enrollment. So all together, just under half of the referrals have either been enrolled or will be enrolled soon. Um, about 20% who were non-responders were declined DBT for many of the same reasons as the Baltimore program. And then, about 35% who were ineligible. What we did find, is our consult came later. Our consult came in February of this year, and once we implemented the consult in CPRS our referrals became much better and much closer to the Veterans that we were looking for. So that has dramatically improved things. Of the 16 Veterans who were enrolled, five of them dropped out, and this varied. About three out of the five dropped out before, one person dropped out at session one of group, the others didn't, just completed one module, or not even one module, um, and then a few people did drop out later. Again, like at the Baltimore VA, some of these were planned dropouts. One person was moving, another person, um, finished all but the last four sessions and I think that was partly due to termination issues. Um, we have had four people complete the comprehensive program, and then, actually five people complete, because one person had opted to do a second round, and we have six people that are currently enrolled. And, again, some people that are

waiting, pending enrollment. So, of those 16 Veterans who were enrolled, and/or completed DBT, we did have two hospitalizations and two suicide behaviors. But of the people who have completed, we have had no subsequent hospitalizations or suicide behaviors from people who have completed DBT. And, unfortunately, I don't have the qualitative data on these folks because I have been tele-working since March with the outbreak of COVID and so much of that data is in a locked filing cabinet in my office right now.

Dr. Grossmann: And speaking of working from home, and COVID, we wanted to go into a discussion of some of the lessons learned, um, and future directions for our programs. Most notably, the transition to Tele-Health that both of our programs have made. Um, I'll speak to that in a little bit. But, overall, one of the biggest lessons that each program learned is that it can be extremely helpful to have some sort of point person within the program, as a representative of DBT to referring providers, to leadership, just in that administrative role. One of the benefits of that is that administrative time is extremely important in program development. It allows you to collect qualitative data and present it in a way that helps receive buy ins, so that you can increase the number of resources that you have, and it helps recruit new team members. So it's just um, incredibly helpful, and so having DBT on the ORG chart with some sort of administrative leader can be extremely beneficial to the program overall. As we've touched on already, there are a lot of different training opportunities to learn the skills of DBT, foundationally, but then also in order to develop a broader program, a more comprehensive program. And, again, we would highly recommend, um, seeking out consultation from a DBT team within the VA that already exists, just so that you are not reinventing the wheel, and if you have the time, and you're able to put together that seed grant, which again is not incredibly

time intensive, but just requires a bit of time and focus. If you have that availability then that can be incredibly helpful to have that training, and then the consultation for the year after. Continuing to consult with referring providers that can be, obviously, very helpful in helping to receive referrals so that your program can grow, but also to help hone in and make sure that the referral that the program is receiving are appropriate, and that you will be able to springboard from that to help the program to expand to different clinics that are offering new groups etc. Lea already mentioned this, but the concept of Implement, Improve, Ask is extremely important, just so that you can make sure that you are doing things that work. So, being able to demonstrate that what you're doing works, helps you get, um, more resources as you're asking for them. So, implement, try it out, prove it with your data and then ask for things, and magic happens. Um, we've already touched on this as well, but thinking about your eligibility criteria, there are pros and cons to broadening the eligibility and receiving an influx of referrals, and then also there are pros of having a more narrow focus, maybe receiving fewer referrals, but then also being able to target the treatment specifically for that population. So within a facility by facility I think that's a different decision and conversation to have with leadership and different stakeholders to see what would be most beneficial. Having a strong team is probably my favorite part of being on the DBT team at the VA Maryland. I want to shout out my team. They're a wonderful and amazing resource, highly skilled clinicians and also incredibly supportive when dealing with challenging cases. And I think that being able to receive consistent training can help with that so that you can feel like, hey, the other team members within the service have my back, I know that they can give me good advice, and help make sure that I'm adhering to this treatment, and so being able to have some sort of team [inaudible] refresher recruiting from across sites can be important just

for your reach as well. Um, Dr. Didion mentioned this earlier as well, but inviting trainees to the team can really validate the program, that you're able to be up and running, you're providing decent services, and you're able to train interns, externs, post docs, whatever means that your program has really shows that, hey, you're on the map and you're able to help spread this training to other clinicians that will be able to carry it forward. Data collection is also extremely important. Again, getting back to that idea of the Implement, Improve, Ask. And, also, a reason why it can be helpful to have a point person, somebody that can help manage the data as it's coming in, and kind of um, modify the program evaluation process as needed as the program grows.

Dr. Didion: I'm gonna wrap up just with some future directions. Um, as we were creating this presentation, actually interesting, the presentation was originally scheduled to take place in I think April, and then, you know, something minor happened to our world around that time, and it got pushed back. So, we have all had to make major adaptations to COVID-19. Um, when I spoke with Sarah Landes, who runs the DBT sharepoint, she told me that all of the DBT programs have been able to move to Tele-Health, including the Baltimore and the DC VA, and that is hasn't interfered with the delivery of DBT. Now that's not to say that some Veterans haven't expressed some concern or some dissatisfaction with Tele-Health services, there certainly have been some Veterans that have said that they don't feel like group is as cohesive or as effective or that they are able to be as engaged over Tele-Health, but at least at our two VAs we've had a number of Veterans who have said specifically that they are engaging in DBT now because it is virtual, because it reduces barriers to care with things like having to take time off work or drive to the hospital or the anxiety that comes up from doing sessions in person. So, at the DC VA we have actually

considered that even once we return to in person sessions, that we may have one DBT group offered as Tele-Health for the foreseeable future because it has really reduced some barriers to care for the Veterans at the DC VA. There are a couple of adaptations also that we've made. Things like, traditionally, if we were in person we would discourage a Veteran from being cross enrolled in DBT and another intensive program, say PRRC, but we have been much more flexible with that than moving to Tele-Health, just as we know some people do need some extra support since they're not getting their sessions in person now. I think a large issue with Tele-Health that we have run into that Dr. Grossmann and Dr. Phalen [inaudible] is in data collection, which is unfortunate. Before COVID I had spearheaded an effort to standardize the measures that are given to DBT participants. So there are several VAs across the county where we are now giving the same baseline, mid-point, and completion measures to our Veterans, and this has just been much more difficult to obtain. Um, some recommendations for things that could be helpful with that is maybe having fillable forms, fillable measures, um, some other things that we have found is mailing diary cards and group materials to Veterans has definitely helped. People do seem to be more engaged when they have the hard copy information in front of them. And finally, these are our contact information, I also included Dr. Tiffany Bruder. She's the DBT Services Coordinator of the Baltimore VA, and, oh, the DBT sharepoint site that we've talked about as well, which is accessible for any VA provider. All of us would be more than happy to talk about what our process was like in creating our DBT program. Um, I, myself, Dr. Didion, I'm more than happy to act as an informal consultant if anyone does want to talk more in depth about how, how to create the program, how to implement, etc. And I'm just gonna say, finally, we do have our engagement process. It is the same at the Baltimore and DC VAs, and we just wanted to include

this as a reference point. So I think we can turn it over, I realize we only have about five minutes, but I think we can turn it over to questions now.

Ralf Schneider: Sure, we have several questions in the chat box, the first is, “Can you discuss how you monitored adherence to DBT principals” and related “how were the providers trained?”

Dr. Didion: Sure, this is Lea. I can say, um, so our providers were trained, as Dr. Grossmann mentioned, with that MIRECC small grant, the MIRECC grant paid for two trained providers, Dr. Meghna Patel and Dr. Elizabeth Chapman, who is on this call right now, um, and they traveled out to our respective VAs and did a three-day workshop. The first two days were um, geared more generally to any provider who was interested in learning more about DBT skills and DBT philosophy, and the third day was specifically for members of the DBT consultation team and given guidance on how to create a team, implement, etc. Um, after that, after that training some of us have opted to get additional training, um, but otherwise um, the way that we have kept each other adherent is really with the use of the DBT consultation team, um, and embodying the spirit of DBT. I also, at the DC VA got permission to have an annual DBT team refresher day, so once a year we take, we’ve been able to block our grids for the entire day and kind of have broader discussions about our DBT program, about DBT principals, um, methods or interventions that we are unclear about and practicing those with each other, so that’s just another way that we’ve maintained adherence and, you know, rigor to the model.

Ralf Schneider: Thank you. And we have several questions about other training possibilities within DBT. So, for instance, “would training through an online provider like the PESI training for DBT suffice to get started, um, as a DBT VA consultant?”

Dr. Grossmann: Well, there's no one size fits all in terms of DBT training needed to begin a VA DBT program. There is no roll out initiative, for example, for DBT. The training we've been referencing was funded by the VISN 5 MIRECC and so we had the consultants come to us, but our consultants had previous training, like they didn't get that same training from a different VA provider. The, you know, the best DBT training is one that is offered by Marsha Linehan in her lab. Many individuals aren't able to access that training for a variety of reasons, though if you're able to access a different training, I see in the chat box, PESI offers one, that might be enough to give you some of the foundational awareness of DBT to then start a similar program within the VA. I've worked on a couple of other VA DBT programs, and those providers didn't necessarily have the same sort of training initiative as we did in Baltimore or DC. So if you have providers within your facility that have experience in DBT, have some sort of training, whether it's from graduate school or community practice or some sort of other CE presentation, like what PESI might have offered, um, those might be enough to help you start thinking about ways to implement a DBT program within your facility.

Ralf Schneider: Great.

Dr. Didion: Sorry. I just want to also mention that um, because there is a question in the chat about the consultants and yes, what Dr. Grossmann and I are talking about consulting that was provided to us for a year after Laura Meyers' dissemination project. However, there are other organizations out there. TIC is one of them, Behavioral Tech is another, and for a large fee, you can also hire a consultant – but just throwing that out there as another option.

Ralf Schneider: Right. And I see Peter in our chat box provided a resource responding to Shane O'Connor who asked for, "Where would it be good to find a description of the full model DBT and pros and cons of moving forward to implement one or the other, which I think you guys…

Dr. Phalen: Yeah, a description of… I'm sorry Ralf…

Ralf Schneider: Go for it Peter.

Dr. Phalen: The description of full model DBT can obviously be found in the manual. I think that's probably the best place for it, but I terms of pros and cons, the link is to a component analysis of DBT skills group alone versus DBT skills group plus individual versus DBT individual and finding that the DBT skills group is probably the most important part in terms of outcomes. But in terms of the full model and what that adds over and above a skills group, the biggest gain seems to be in adherence and dropout rates. So, dropout rates are much lower in full model DBT programs than in skills group only programs. I think, in my own experience, it is consistent in full model programs, you know, often people stick with the skills group because they like their individual provider or vice versa, whereas in a skills group it's harder to kind of get that kind of, you know, emotional engagement going sometimes. Another thing is on homework access, with the individual therapist it can be, it can increase I think performance of homework because the individual therapist is there to kind of maintain accountability and help people understand the homework worksheets and that sort of thing.

Ralf Schneider: I realize that we're just about out of time. So, um, if we can, we will answer the rest of your questions in a chat box. Um, and we thank our presenters and, um, again, if you're interested in a set of the scribe, they're available for download. If

you look at the bottom window of your screen you can pick those up and certainly you can ask further questions of the presenters and we'll get them those requests. And I think folks might be putting in their link. Thank you everyone.

Dr. Phalen: Thank you for having us.