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National Dissemination of Cognitive Behavioral Therapy for Depression in the Department of Veterans Affairs Health Care System: Therapist and Patient-Level Outcomes

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Objective: The Department of Veterans Affairs (VA) health care system is nationally disseminating and implementing cognitive behavioral therapy for depression (CBT-D). The current article evaluates therapist and patient-level outcomes associated with national training in and implementation of CBT-D in the VA health care system. ***Method:*** Therapist competencies were assessed with the Cognitive Therapy Rating Scale (CTRS). Patient outcomes were assessed with the Beck Depression Inventory–II and the World Health Organization Quality of Life–BREF. Therapeutic alliance was assessed with the Working Alliance Inventory–Short Revised. Two-hundred twenty-one therapists have received training, and 356 veteran patients have received treatment through the VA CBT-D Training Program. ***Results:*** Of therapists who have participated in the program, 182 (82%) completed all training requirements and achieved competency, reflected by a score of 40 on the CTRS. Of 356 patients, nearly 70% completed 10 or more sessions or improved sufficiently to stop therapy before the 10th session. Mean depression scores decreased by approximately 40% from initial to later treatment phase. Effect sizes of changes ranged from $d = 0.39$ to $d = 0.74$ for quality of life and from $d = 0.47$ to $d = 0.66$ for therapeutic alliance measures. ***Conclusion:*** National training in and implementation of CBT-D within the VA health care system is associated with significant, positive therapist training outcomes, as evidenced by increases in CBT core competencies. The implementation of the protocol by newly trained CBT-D therapists is associated with significantly improved patient outcomes, as evidenced by large decreases in depression and improvements in quality of life.

Keywords: dissemination, cognitive behavioral therapy, depression, psychotherapy training, veterans

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Depression is a major public health concern. The 12-month prevalence rate of major depressive disorder in the United States is approximately 7% (Kessler et al., 2005), and rates of diagnosed depression have been reported as almost twice as high (12%) in individuals treated within the Veterans Health Administration (VHA)—the health care component of the Department of Veterans Affairs (VA; Blow & Owen, 2003). At the same time, a number of psychotherapies have been shown to be effective in reducing depression symptoms (Hollon & Ponniah, 2010), including cognitive behavioral therapy (CBT), a structured, time-limited, present-focused approach to psychotherapy that helps patients learn and apply specific strategies to modify unhelpful cognitions and behaviors that are associated with depression. CBT has been shown to be efficacious in treating mild, moderate, and severe depression symptoms (e.g., DeRubeis et al., 2005; Elkin et al., 1989; Tang, DeRubeis, Beberman, & Pham, 2005). CBT has also been shown to be as efficacious as psychotropic medications for depression with nonveteran samples in the short term (cf. DeRubeis, Gelfand, Tang, & Simons, 1999) and often more efficacious than medications in the long term (for a review, see DeRubeis, Siegle, & Hollon, 2008; Hollon, Stewart, & Strunk, 2006). Further, research has shown that CBT, in combination with psychopharmacotherapy, is typically more effective than either treatment alone (Friedman, Wright, Jarrett, & Thase, 2006; Hollon et al., 2005).

Despite the clear benefits and sustained gains associated with CBT for treating depression, this treatment, as implemented in research protocols, has not been widely adopted in clinical practice (Freiheit, Vye, Swan, & Cady, 2004; Goisman, Warshaw, & Keller, 1999; Jameson, Chambless, & Blank, 2009). Chief among the reasons for the limited availability of CBT for depression (and other mental health conditions) is limited intensive training of mental health providers and lack of organizational support (Karlin et al., 2010; Rosen et al., 2004). With respect to the former, most mental health providers have received only limited training in CBT as part of their formal professional training; in fact, research has shown that when clinicians deliver CBT or other evidence-based psychotherapies, they often do so with low fidelity (Madson & Campbell, 2006).

In an effort to bring evidence-based psychotherapies (EBPs) to veterans who can benefit from them, the VA has developed national training programs to disseminate and implement EBPs for depression, posttraumatic stress disorder, serious mental illness, insomnia, and other conditions throughout the VA health care system (Karlin et al., 2010). As part of this effort, VA has developed a national program to disseminate and implement CBT for depression (CBT-D), which includes a national, competency-based staff training program. This CBT-D Training Program represents the largest and most comprehensive CBT training program in the United States. The overall goal of this training program has been to provide competency-based training in CBT to core VHA mental health staff (e.g., psychologists, psychiatrists, clinical social workers, and advanced practice nurses with specialty training and background in mental health) who treat veteran patients for depression. The overall training model for the training program includes participation in (1) experientially based workshop training on the theory and application of CBT for the treatment of depression, followed by (2) ongoing, weekly consultation with an expert in CBT-D. The training is designed around a CBT for depression protocol and a manual that has been adapted specifically for veterans and military service members (see Wenzel, Brown, & Karlin, 2011).

Although training alone is not sufficient to promote implementation, it is a fundamental strategy for implementing and sustaining EBPs in the community (Aarons, Hurlburt, & Horwitz, 2011; Herschell, Kolko, Baumann, & Davis, 2010). Often, EBPs have been intricate, multisession treatment protocols that have been dependent upon the therapist's execution of a set of therapeutic strategies with fidelity to the specific protocol or manual (Carroll, Martino, & Rounsaville, 2010; Chorpita & Regan, 2009; Herschell et al., 2010). Adequate training can reduce variability in therapist behavior and increase the quality of service delivery (Aarons et al., 2011; Feldstein, Glasgow, & Smith, 2008; McManus, Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010; Stirman, Crits-Christoph, & DeRubeis, 2004). Most importantly, increasing the competency or skill of clinicians in the implementation of CBT has been shown to predict symptom improvement and clinical outcomes (DeRubeis et al., 1999; Hogue et al., 2008; Kingdon, Tyrer, Seivewright, Ferguson, & Murphy, 1996; Kuyken & Tsivrikos, 2009; Schoenwald, Carter, Chapman, & Sheidow, 2008; Shaw et al., 1999; Strunk, Brotman, & DeRubeis, 2010; Strunk, Brotman, DeRubeis, & Hollon, 2010).

Despite the central role of training in the implementation of EBPs, comprehensive reviews of research on training have highlighted serious gaps in knowledge regarding best training practices (Herschell et al., 2010; Rakovshik & McManus, 2010; Shafran et al., 2009). Researchers and policymakers have emphasized the need for comprehensive program evaluations in this area (McHugh & Barlow, 2010; Rakovshik & McManus, 2010). Most previous studies of training practices often have lacked external validity (e.g., have been conducted under controlled conditions with highly motivated therapists), rarely assessed fidelity objectively, had poor follow-up rates, and have demonstrated less than optimal results (Beidas & Kendall, 2010; Herschell et al., 2010; Rakovshik & McManus, 2010). Several studies published in relationship to the United Kingdom's Improving Access to Psychological Therapies (IAPT) program have been notable exceptions (Keen & Freeston, 2008; McManus et al., 2010). However, training of the length reported in these studies is not likely to be feasible for therapists already in practice in most settings in the United States. For example, McManus et al. (2010) reported the results of 278 therapists undergoing 36 days of training over three 12-week terms to earn a diploma in cognitive therapy. The amount of clinical training consisted of 200 hr, and therapists were expected to devote an additional 200 hr in preparation and reading. Keen and Freeston's (2008) course consisted of a 5-day induction and 35 days of training on a day-release basis over a 10-month period. The training consisted of 2 hr of clinical supervision (in pairs) and 3.5 hr of lectures or workshops per week.

The purpose of the present article is to present VA's national approach to training mental health clinicians in CBT-D and to report initial therapist and patient-level program evaluation findings. In this article, we describe these results for VA mental health clinicians who participated in the training program with respect to changes in their (1) CBT-D skill level assessed via training consultant ratings of taped therapy sessions using a validated assessment, (2) self-efficacy in providing CBT-D treatment, and (3) attitudes toward CBT, specifically, and toward evidence-based

therapies in general. We also report follow-up data collected approximately 6 months after training completion on the number of patients treated for depression and the proportion of those treated with CBT-D consistent with the training program. In addition, we describe clinical outcomes of veteran patients treated by therapists participating in VA CBT-D Training Program, including depression and quality of life outcomes, as well as changes in the therapeutic alliance.

Method

Program Description

CBT-D protocol description. The CBT-D protocol was adapted specifically for veterans and military service members and was designed to be administered in approximately 12 to 16 individual psychotherapy sessions. This comprehensive CBT-D protocol was designed with clear emphasis on the "therapy" in cognitive behavioral therapy, distinguishing it from purely psychoeducational or skills-based approaches to CBT. Accordingly, as further described below, the protocol places significant emphasis on (1) developing a clear CBT case conceptualization to enhance the understanding of the patient and to guide the selection and implementation of specific cognitive and behavioral strategies, (2) fostering a strong therapeutic alliance between therapist and patient, (3) structuring therapy sessions to promote close adherence to the CBT model, and (4) assisting patients in learning specific CBT skills that they can apply in their lives.

First, the CBT model described in the protocol incorporates an approximately equal weighting of theoretical elements of both Beck's cognitive model (Beck, Rush, Shaw, & Emery, 1979) and Lewinsohn's behavioral model (Lewinsohn, 1975) of depression that are applied in a tailored manner, based on the needs and the therapist's understanding of the patient. Because veterans seeking treatment for depression in VHA frequently have high levels of depression and physical limitations or other life changes or circumstances that contribute to limited activities associated with pleasure and/or mastery, the protocol typically begins with a focus on behavioral aspects to activate the patient and promote engagement in treatment prior to significant cognitive work. The strong focus of the protocol on developing an idiosyncratic, well-defined case conceptualization allows the CBT-D therapist the flexibility to select specific cognitive and behavioral strategies that target depressed patients' specific problems.

Second, the CBT-D protocol recognizes that a strong therapeutic alliance is critical for the successful implementation of the cognitive and behavioral strategies. Therapists in the training program are taught to work in a highly collaborative manner with patients to identify the specific goals for treatment, to select specific CBT strategies, and to develop homework or practice assignments that are tailored to the patients' needs and treatment goals. Furthermore, therapists are instructed to systematically monitor the therapeutic alliance using the Working Alliance Inventory–Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) and to utilize strategies to improve the alliance, when necessary, such as providing empathy and understanding.

Third, a hallmark of the CBT-D protocol includes the structuring of sessions to maximize the potential for reaching treatment goals. The session structure in the protocol includes, at the outset of the session, conducting a brief mood check including the administration of standardized assessment measures, monitoring drug and alcohol use, and assessing compliance with medication and other treatment services. Following the review of the issues discussed in the previous session, a prioritized agenda is collaboratively developed with the patient and followed during the session. The agenda items are discussed with a focus on helping the patient learn and apply specific CBT skills and is followed by developing a collaborative homework assignment. A final summary of the session is then provided and feedback on the most helpful aspects of the session is obtained.

Fourth, as previously described, the therapist and patient collaboratively decide on specific cognitive and behavioral strategies that were guided by the CBT case conceptualization of the patient's problems. Behavioral strategies include identifying pleasant events, monitoring and scheduling activities to improve mood, setting up graded task assignments, teaching problem solving skills, conducting relaxation and guided imagery exercises, and conducting behavioral experiments. Cognitive strategies include identifying stressful situations, negative mood states, negative automatic thoughts, as well as developing alternative, more adaptive responses to these negative thoughts, and developing coping cards. During the later phase of treatment, therapists typically work to identify particular core or intermediate beliefs and utilize specific strategies to modify these beliefs, such as the downward arrow technique and examining the advantages and disadvantages of holding such beliefs.

CBT-D training program overview. VA staff eligible to participate in the VA CBT-D Training Program include VA mental health staff who provide direct psychotherapy services and work in settings where depression is commonly treated. Clinicians are selected for the training program using a structured application process. To participate in the training program, clinicians agree to complete the workshop training and follow-up case consultation, as well as participate in program evaluation. Regional mental health leaders and facility local evidence-based psychotherapy coordinators help to coordinate a process of nomination of clinicians from each facility in the region that is being targeted for a particular training cohort. While clinicians may express interest in participating in the training program, it is the facility and regional mental health leadership who determine what training applications are sent forward to the training program for review and final selection. Clinicians who work at facilities with less capacity to provide CBT for depression are prioritized by the training program for selection. In addition to the training application, applicants are asked to complete and submit a training agreement that includes consent from their supervisor for their participation and the time commitments involved for completing all aspects of the training.

The training consists of two core components. The first component includes participation in a 3-day workshop that focuses on both CBT theory and core CBT-D strategies. In addition to providing a basic introduction to CBT using didactic lectures, the workshop strongly encourages participants to be interactive with workshop leaders and with each other. A significant component of the workshop involves review of video recordings of therapists working with veterans and military service members, skills practice using role plays in small groups, rating of other therapists implementing CBT-D, and small-group and large-group discussion.

The workshop emphasizes "depth over breadth" by focusing on learning and practicing selected CBT skills in a comprehensive manner. For example, workshop participants receive didactic training on the rationale and detailed instructions on using thought records. They subsequently observe several videos demonstrating this technique with an expert CBT-D therapist and veteran (actor). Next, training participants break into small groups of 2–3 participants to practice the technique using the thought record and to receive individual feedback from a training consultant. Finally, participants have the opportunity to review their experience and what they learned in the larger group and to ask specific questions.

Following the workshop, training participants engage in weekly, 90-min telephone-based consultation sessions in small groups of four consultees led by an expert CBT-D clinician who serves as a training consultant in the training program. The consultation phase lasts 6 months. The training program was developed with a strong belief that ongoing consultation and feedback is critical for the development of CBT competency and for facilitating the implementation of CBT with veterans at local VA facilities. A total of 13 different expert training consultants have provided weekly consultation for the first 7 cohorts of therapists enrolled in the training program. Therapists are instructed to identify two patients to participate in the 6-month follow-up consultation process. Potential patients include those who were seeking treatment for depression. Patients with mental disorders in addition to depression and medical comorbidities are permitted so long as there is a primary focus on decreasing the severity of the depression rather than on decreasing the severity of other conditions. Patient consent is required for participation and the use of audiotape sessions in consultation. Therapists are required to provide at least 10 full-session audio recordings to the training consultant for review, rating, and feedback during the 6-month training consultation phase. Consultants typically listen to 2–3 tapes from the initial, middle, and later phases of the CBT-D protocol, which is consistent with the process reported for other CBT training programs that have included tape review (e.g., James, Blackburn, Milne, & Reichfelt, 2001).

Training consultants are selected to participate in the training program through a structured application process that includes an interview and submission of CBT session tapes that are reviewed and rated by one or more master trainers of the training program. In addition, training participants who demonstrate outstanding CBT and interpersonal skills may be recommended by their training consultant for consideration to serve as a training consultant following their completion of the program. This process has allowed for the establishment and ongoing expansion of internal consultation capacity within VHA.

Consultation sessions typically include (a) discussion of key implementation and administrative issues and challenges at the outset of the calls, (b) provision of feedback to therapists based on the review of audiotaped sessions, (c) engaging of therapists in an open dialogue about implementing these skills, (d) practicing skills using role plays, (e) reviewing or assigning specific readings in CBT, (f) reviewing overall progress in learning CBT, and (g) obtaining frequent feedback on the helpful aspects of the call. A key function of the consultation calls is to foster a supportive learning environment for learning CBT as well as to sustain the implementation of CBT after the 6-month consultation process and formal training program has ended.

To successfully complete the training program, each training participant must meet the following requirements: (a) attend the 3-day CBT-D training workshop, (b) participate on at least 75% of the weekly CBT-D consultation calls, (c) apply CBT-D with at least 1–2 cases in consultation; (d) provide a minimum of at least 10 audio recordings of full CBT-D sessions to be rated by the training consultant, and (e) obtain a total score of 40 or higher on the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) for one full CBT-D session. Therapists who successfully complete the program are added to a VA CBT-D clinician roster, and those clinicians receive a certificate certifying successful completion of both the process and competency requirements of the training program.

CBT-D training materials. Training participants are provided with a comprehensive, stand-alone therapist manual, *Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers: Therapist Manual* (Wenzel, Brown, & Karlin, 2011), which describes in detail the theoretical and applied components of the protocol. Included throughout this manual are fictitious cases that represented composites of depressed veterans and military service members that have been derived from the authors' clinical experience. These cases were included in the manual to illustrate the application of CBT skills with patients. The manual also includes all CBT-D therapist and patient forms, worksheets, and other tools needed in implement the protocol. A companion therapist training video (U.S. Department of Veterans Affairs, 2010) has also been developed that includes therapist–patient clips, didactic instructions, and commentaries that illustrate how to deliver core components of CBT for depression in veterans and military service members. The training program is supplemented by a variety of multimodality CBT-D training materials. Two textbooks specifically written for developing CBT skills, *Cognitive Therapy: Basics and Beyond* (Beck, 1996) and *Learning Cognitive Behavioral Therapy: An Illustrated Guide* (Wright, Basco, & Thase, 2006), are provided to therapists when they enroll in the training program. Therapists also receive other materials that can be provided directly to patients such as the book, *Mind Over Mood: Change How You Feel By Changing The Way You Think* (Greenberger & Padesky, 1995).

Program Evaluation Measures

Workshop evaluation forms. A five-item workshop evaluation form was developed to measure speaker/presenter content, delivery, audiovisual (AV) aids, and overall quality. Two items were developed to assess implementation and confidence. Thirty-two additional items with a 5-point Likert-type response scale, ranging from "*Strongly Disagree*" to "*Strongly Agree*" were developed to assess specific aspects of the workshop (e.g., "I have learned new psychotherapy skills/techniques, etc."). Therapists were also asked to report what they liked most and least about the training and how it can be improved. The Workshop Evaluation Form was administered and collected immediately following the workshop training. For quality assurance, each item on the Workshop Evaluation Form was compared with the mean and range of items from previous workshops. Workshop leaders were provided feedback as to any noticeable change in ratings and were also provided comments by therapists of workshop strengths and weaknesses.

Therapist self-efficacy, attitude, and behavior intention. A 36-item form was developed to measure therapist self-efficacy, attitudes, and intentions related to CBT skills and the delivery of CBT. Each self-efficacy item has six response options ranging from 1 (*Not at all Confident*) to 6 (*Extremely Confident*). Subscales assess therapists' general psychotherapy skills self-efficacy (8 items, $\alpha = .92$) and CBT skills self-efficacy (14 items, $\alpha = .97$). A seven-item form was developed to assess therapists' attitude toward CBT (e.g., CBT is an effective treatment for patients with depression). Each item had five response options ranging from 1 (*Disagree*) to 5 (*Strongly Agree;* 7 items, $\alpha = .71$). Therapists also completed the Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004), a 15-item measure that assessed four subscales of attitudes toward adoption of evidence-based practice (appeal, requirements, openness and divergence.). The overall Cronbach's alpha reliability for the EBPAS is good (previously reported $\alpha = .77$; current data $\alpha = .83$), and subscale alphas range from .59 to .90 (Aarons, 2005). National norms are also available (Aarons et al., 2010). Therapist self-efficacy, attitude, and intention measures were administered preworkshop, postworkshop, after completion of the 6-month consultation, and 3–12 months following the completion of full training program.

CBT competency. The Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980), an 11-item measure that assesses therapist competency in CBT, was used by training consultants for assessing overall and specific CBT competencies of clinician training participants. Items are scored on a 7-point scale: 0 (*Poor*), 1 (*Barely Adequate*), 2 (*Mediocre*), 3 (*Satisfactory*), 4 (*Good*), 5 (*Very Good*), and 6 (*Excellent*). The 11 items are summed to indicate a CTRS total score, ranging from 0 to 66. Items are also summed for two subscales that cover (1) general therapy skills (feedback, understanding, interpersonal effectiveness, and collaboration) and specific CBT skills (guided discovery, focus on key cognitions and behavior, strategy for change, application of CBT techniques) and (2) session structure (agenda, pacing and efficient use of time, and homework assignments; Vallis, Shaw, & Dobson, 1986). The CTRS has been shown to have adequate internal and interrater reliability (Vallis et al., 1986), with strong interrater agreement for general competence, but only moderate agreement for specific items of the scale (Williams, Moorey, & Cobb, 1991). Traditionally, a CTRS total score of 40 or higher has been used as the predetermined standard for competency. A CTRS total score of 39 or lower is one standard deviation below the mean score of a group of certified cognitive therapists as rated on the CTRS (Shaw, 1984; Shaw et al., 1999). Following initial training on the CTRS, the VA CBT-D training consultants met for a 1-day meeting to blindly rate tapes and discuss and calibrate ratings as a group. Raters shared their item-by-item ratings to determine a consensus rating for each item. Training consultants recorded the CTRS total score for each tape that was reviewed during the initial phase of treatment (Sessions 2–4), the middle phase of treatment (Sessions 5–8), and the later phase of treatment (Sessions 9 or later). During the 6-month consultation period, the highest CTRS scores from the first phase (Sessions 1–3 of the first patient) and later phase (Session ≥ 9) were selected for evaluating the competency of each therapist.

Demographics. At the first session, patients completed a demographic form that included their age, gender, highest level of education, and ethnicity.

Depression. The Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996; Beck, Steer, & Garbin, 1988) was used to measure the severity of depression symptoms. The 21 items are scored on a 0–3 scale to reflect the absence or severity symptoms. The range of possible scores is 0–63, with higher scores indicating greater severity of depression. Score ranges indicating minimal, mild, moderate, and severe symptoms of depression are respectively: 0–13, 14–19, 20–28, and 29–63 (Beck et al., 1996). Psychometric properties of the BDI-II have been well documented (Beck et al., 1988). The BDI-II was administered by therapists before or at the outset of every therapy session. Both the mixed effects regression model estimation and the last BDI-II score carried forward were used for intent-to-treat (ITT) analyses.

Quality of life. Quality of life was assessed using the World Health Organization Quality of Life–BREF (WHOQOL-BREF), an abbreviated 26-item version of the WHOQOL-100. Four major quality of life domains include physical, psychological, social relationships, and environment. The WHOQOL- BREF has been shown to have good discriminate validity, content validity, and test–retest reliability (Skevington, Sartorius, & Amir, 2004; World Health Organization, 1993). The WHOQOL was administered at Session 1, Session 7 (approximately the midpoint of treatment) and the final session (at or following the 10th session).

Therapeutic alliance. The Working Alliance Inventory–Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) was used to assess therapeutic alliance. The WAI-SR is a 12-item scale that measures three aspects of therapeutic alliance: goals (agreement on the goals of therapy), tasks (agreement on the tasks of therapy), and bond (the development of a relational bond between client and therapist). The WAI-SR has demonstrated good psychometric properties in a variety of settings (Munder, Wilmers, Leonhart, Linster, & Barth, 2010; Perdrix, Roten, Kolly, & Rossier, 2010). The WAI-SR was administered after Sessions 1, 3, 7, and 11.

Follow-up adoption. Approximately 6 months after completion of the training program, therapists were asked to complete a posttraining survey that assessed the degree to which they continue to deliver CBT. Additional questions assessed their confidence in applying CBT, their attitudes about CBT, and the barriers to ongoing implementation, if any, they have encountered.

Program Evaluation Procedures

Information obtained from patients by the therapists in training, including the demographic form, the release of information and consent to audiotape forms, data from the program evaluation measures, and data on the total number of completed therapy sessions for each patient, as well as the reasons, if any, for failure to complete the full CBT protocol (e.g., 10 or more sessions), were sent to the CBT-D Training Program evaluation team, whose main function is to monitor quality of the training through formative and summative program evaluation. Each therapist participating in the training program was assigned a unique code number by program staff, and each patient was assigned a code number by the therapist. Information that linked the identity of specific patients with the information that was collected for program administration purposes was not provided to the Program Evaluation Team. The Institutional Review Board (IRB) at Stanford University determined that this program did not qualify as human research and was exempt from further IRB review.

Results

Therapists

There were 221 VA mental health therapists that participated in the CBT-D training workshops and consultation across the initial seven training cohorts. Of these, 152 (69%) were female. In terms of professional discipline, 112 (51%) were social workers, 91 (41%) were psychologists, 12 (5%) had nursing degrees, and six (3%) were psychiatrists. Of the initial 221 therapists enrolled, 182 therapists (82%) successfully completed all process and performance-based components of the training, 27 (12%) dropped out, 10 (5%) did not meet minimum competency criteria, and two (1%) were lost to follow-up. Dropouts were related to change in position/job ($n = 6$), facility/time issues ($n = 5$), trouble recruiting and/or keeping patients ($n = 5$), disagreement with treatment method ($n = 2$), inability to commit to the program ($n = 2$), health issues ($n = 1$), maternity leave ($n = 1$), and unknown reasons ($n = 5$).

Patients

There were 356 patients who received CBT from therapists who participated in the CBT-D Training Program. Of the 356 patients, 260 (73%) were men, 91 (23%) were women, and 15 (4%) did not indicate their gender. In response to a question on race/ethnicity, 266 (75%) identified themselves as Caucasian/White, 42 (12%) identified themselves as African American/Black, 38 (11%) identified themselves as Asian Indian, Asian, American Indian, Alaskan Native, Pacific Islander, or other race/ethnicity, and 20 (6%) did not indicate race/ethnicity. In response to the question, "Do you consider yourself to be Hispanic/Latino?" 316 (89%) answered "no," 18 (5%) answered "yes," and 22 (6%) did not answer. The mean patient age was approximately 52 years ($SD = 13.1$) and ranged from 24 to 90 years. Of the 356 patients, 227 (64%) completed 10 or more CBT sessions, 14 (4%) finished early due to symptom relief, 70 (20%) dropped out of therapy prior to completion, 12 (3%) were lost to follow-up because their therapist dropped out of training, 15 (4%) were unable to attend regularly, 15 (4%) were lost to follow-up for unknown reasons, and three (1%) were not lost to follow-up but did not provide BDI-II scores during the later phase of treatment. All patient data were included in ITT analysis of reduction in severity of symptoms of depression.

Workshop Ratings

Overall, therapists' ratings of the workshop were very high for the seven workshop trainings as displayed in Table 1. Almost all therapists felt the workshop training met the stated objectives, met their own educational expectations, and was relevant to their practice, and they indicated an intent to use CBT skills that they learned during the workshop to treat patients.

Therapist Outcomes

CTRS scores from the initial and later phases of treatment were available from 167 (76%) of the originally 221 enrolled therapists. Of the 54 with missing CTRS ratings, 26 were therapists who dropped from the training, six were unsuccessful in completing the training and did not have a later phase rating from their training consultant, six were provided an extension and did not have a later phase rating, and 16 reached competency but did not provide either the initial phase or the later phase session tape. Mean CTRS total scores for the 167 therapists with initial and later CTRS ratings increased significantly from an average of 38.2 ($SD = 8.6$) during the initial phase of treatment (obtained during the first third of the training consultation period) to 45.0 ($SD = 6.9$) during the later phase of treatment tapes, $t(166) = 10.4$, $p < .001$, $ES = 0.79$. The percentages of therapists who scored ≥40 on the CTRS during the initial and later phase of training were 41% and 87% respectively.

As indicated in Table 2, mean scores for the individual CTRS items increased from the initial phase to the later phase of treatment. Therapists significantly improved the CBT skills for all CTRS items. For the CTRS structure subscale (agenda setting, pacing, and homework; $\alpha = .71$), mean scores increased from 3.4 ($SD = 0.9$) to 4.0 ($SD = 0.8$), $t(166) = 7.0$, $p < .001$, $ES = 0.62$. For the skills subscale (understanding, feedback, interpersonal effectiveness, collaboration, guided discovery, focus on key cognitions or behaviors, strategy for change, and application of techniques; $\alpha = .89$), mean scores increased significantly from 3.5 ($SD = 0.8$) to 4.1 ($SD = 0.6$), $t(166) = 10.5$, $p < .001$, $ES = 0.79$.

Of the 221 therapists who enrolled in training, 210 (95%) completed the preworkshop and postworkshop survey assessing therapists' self-efficacy, attitude, and behavior intention; only 113 (51%) completed this survey at both postworkshop and posttraining consultation time points. Training participants' self-assessment of general psychotherapy skills did not change appreciably from preworkshop to postworkshop evaluations. Self-efficacy specific to delivering CBT improved from an average item score of 3.7 ($SD = 0.9$) to 4.0 ($SD = 0.7$) on a 6-point scale from 0 (*Not at all Confident*) to 5 (*Extremely Confident*), $t(209) = 4.2$, $p < .001$; ES = 0.27. There was a significant change in training participants' perceived self-efficacy with respect to general psychotherapy skills following the training consultation phase; these self-ratings

Table 1
Means (and Standard Deviations) for Postworkshop Ratings

Question	*M* (*SD*)	Range
The program met stated objectives.	4.6 (.64)	1–5
The program met my educational expectations.	4.5 (.75)	1–5
The program was relevant to my practice population at VA.	4.6 (.63)	2–5
The distributed written materials (e.g., manuals, books) were helpful.	4.7 (.57)	2–5
The videos were useful learning aids.	4.6 (.62)	1–5
As a result of participating in this workshop, I plan to use skills/techniques learned in this workshop in my work.	4.7 (.46)	3–5
As a result of participating in this workshop, I feel confident in being able to begin to apply CBT.	4.2 (.75)	1–5

Note. $n = 217$. VA = Department of Veterans Affairs; CBT = cognitive behavioral therapy.

Table 2
Mean Item Scores on the Cognitive Therapy Rating Scale (CTRS) During Initial and Later Phases of Treatment

CTRS item	Initial phase *M* (*SD*)	Later phase *M* (*SD*)	Change [95% CI]	Cohen's *d*
Agenda	3.46 (1.2)	4.11 (1.1)	0.65 [0.43–0.87]	0.55
Feedback	3.16 (1.2)	3.84 (1.1)	0.68 [0.48–0.88]	0.57
Understanding	3.95 (0.9)	4.42 (0.7)	0.47 [0.35–0.59]	0.55
Interpersonal effectiveness	4.24 (0.8)	4.58 (0.7)	0.34 [0.21–0.46]	0.41
Collaboration	3.80 (1.0)	4.41 (0.7)	0.61 [0.45–0.77]	0.61
Pacing and efficient use of time	3.51 (1.1)	4.20 (0.9)	0.69 [0.50–0.88]	0.63
Guided discovery	2.86 (1.3)	3.71 (1.0)	0.85 [0.64–1.07]	0.67
Focus on key cognitions/behaviors	3.32 (1.1)	4.10 (0.9)	0.77 [0.57–0.97]	0.68
Strategy for change	3.33 (1.1)	4.03 (0.9)	0.71 [0.52–0.90]	0.63
Application of CBT techniques	3.16 (1.2)	3.76 (1.0)	0.60 [0.42–0.79]	0.64
Homework	3.37 (1.2)	3.76 (1.1)	0.39 [0.17–0.61]	0.33
Total score	38.2 (8.6)	45.0 (6.9)	6.78 [5.49–8.06]	0.79

Note. $n = 167$. CI = confidence interval; CBT = cognitive behavioral therapy.

increased from 4.5 ($SD = 0.6$) postworkshop to 5.1 ($SD = 0.6$) posttraining consultation, $t(111) = 10.4$, $p < .001$, $ES = 0.92$. There was a similar and significant increase with respect to CBT-specific self-efficacy, which increased from 4.0 ($SD = 0.7$) to 4.8 ($SD = 0.7$), $t(111) = 11.4$, $p < .001$, $ES = 1.14$.

Therapists' attitudes toward CBT were assessed with a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Mean ratings of therapists' attitudes toward CBT were more positive following the workshop ($M = 4.1$, $SD = 0.5$) compared to preworkshop ratings ($M = 3.9$, $SD = 0.5$), $t(203) = 6.2$, $p < .001$, $ES = 0.43$. Mean attitude scores—among those who competed the posttraining consultation survey—were also significantly higher at posttraining assessment ($M = 4.2$, $SD = 0.5$) compared to mean attitude scores at preworkshop assessment ($M = 3.9$, $SD = 0.5$), $t(107) = 5.8$, $p < .001$, $ES = 0.67$. Scores on the EBPAS, which assesses more general attitudes toward evidence-based practice, were not different from baseline ($n = 207$, $M = 3.1$, $SD = 0.44$) at either postworkshop ($n = 208$, $M = 3.1$, $SD = 0.45$) or postconsultation assessment ($n = 113$, $M = 3.1$, $SD = 0.45$).

Three to 12 month postconsultation follow-up program evaluation data were collected from the first 6 cohorts. Of 146 therapists, 116 (79%) completed and returned the surveys. Therapists reported treating an average of 19 ($SD = 22.3$, range = 0–140) patients with depression since completing the training program. These therapists reported that they provided CBT consistent with the training program protocol for an average of 47% of these patients. During the posttraining assessment, therapists were asked to respond to the question, "How likely are you to recommend CBT to Veterans with depression?" using a 5-point scale ranging from 1 (*Not at all likely*) to 5 (*Very likely*). Therapists' average response to this question was 4.5 ($SD = 0.9$).

Patient Outcomes

ITT analysis was conducted using mixed effects regression model estimation (Raudenbush & Bryk, 2002), which resulted in a decrease in the BDI-II score from 28.1 during the initial phase to 16.9 ($SE = 6.2$) during the later phase of treatment, $t(355) = -15.6$, $p < .001$. This represents a 40% average decline in mean BDI-II scores from the initial to later phase (session 10 or greater) of treatment. ITT analysis was also conducted using the last observation carried forward (LOCF) for all 356 patients treated during the consultation phase. The ITT analysis using the LOCF method resulted in a decrease in overall mean BDI-II total score from 28.2 ($SD = 10.7$) during the initial phase of treatment to 19.6 ($SD = 13.4$) during the later phase of treatment, $t(355) = -15.1$, $p < .001$, $ES = 0.80$. The more conservative LOCF estimate represents a 30% average decline in mean BDI-II score from initial to later phase (session 10 or greater) of treatment.

For those patients who completed 10 or more sessions ($n = 227$) or who finished early due to symptom relief ($n = 14$), there was a reduction in mean BDI-II scores from 27.8 ($SD = 10.7$) during the initial phase to 17.0 ($SD = 13.1$) during the later phase, $t(240) = -14.6$, $p < .001$, $ES = 1.01$, a 39% average decline in mean BDI-II scores from initial to later phase of treatment. The proportion with a decrease in BDI-II scores of at least 50%, at least 40%, and at least 30% were 45% ($n = 108$), 54% ($n = 130$), and 64% ($n = 154$) of these patients, respectively. The number of patients who had moderate to severe symptoms of depression decreased from 193 (79%) at baseline to 85 (35%) at a later phase of treatment.

Of the 227 patients who completed 10 or more CBT sessions, 181 (80%) also completed the WHOQOL-BREF. As displayed in Figure 1, mean scores for all WHOQOL domains increased significantly ($p < .001$), from the initial phase to the later phase of treatment: Psychological domain: $t(180) = 10.1$, $ES = 0.74$; Physical domain: $t(180) = 8.3$, $ES = 0.48$; Social domain: $t(180) = 5.9$, $ES = 0.44$; Environmental domain: $t(180) = 6.6$, $ES = 0.39$.

The mean therapeutic alliance (WAI-SR) scores increased significantly from the first therapy session to the later phase of therapy (session 10 or later) on all three subscales, among the 162 patients who completed this measure at both of these two time points. Mean "Goal" alliance scores increased, on a Likert scale from 1 to 5, from 4.1 ($SD = 0.7$) to 4.5 ($SD = 0.6$), $t(160) = 6.7$ $p < .001$, $ES = 0.51$. Mean "Task" alliance scores increased from 3.5 ($SD = 0.8$) to 4.0 ($SD = 0.7$), $t(161) =$

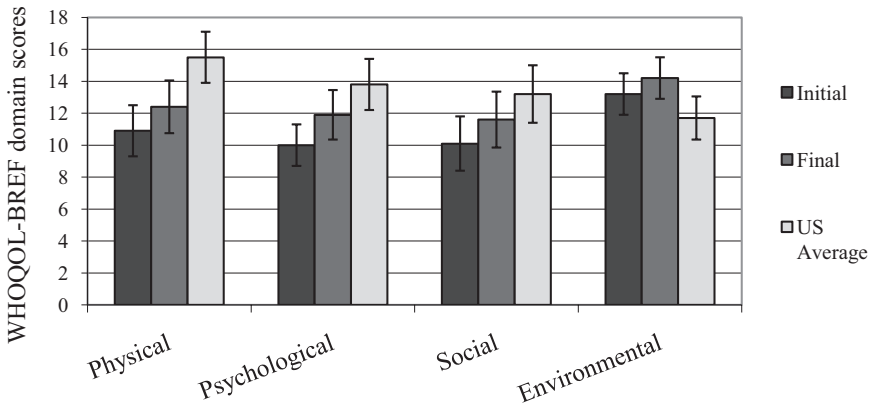

Figure 1. World Health Organization Quality of Life–BREF (WHOQOL-BREF) scores at the initial phase and the later phase of treatment ($n = 181$). For comparison, United States averages are also displayed (Skevington, Lofty, & O'Connell, 2004). Error bars represent standard deviations.

8.2$p < .001$, $ES = 0.66$. Mean "Bond" alliance scores increased from 4.1 ($SD = 0.8$) to 4.5 ($SD = 0.6$), $t(161) = 6.6$, $p < .001$, $ES = 0.47$.

Discussion

The aim of this article was to describe and examine the effectiveness of a national training program designed to provide competency-based training in CBT for depression to a large number of VA mental health professionals, as part of a major initiative to fully bring EBPs from research settings to clinical practice within the nation's largest integrated health care system. The VA CBT-D Training Program is unique in providing training to a wide-range of mental health practitioners who serve a large number of highly depressed veterans in a wide variety of settings and geographic areas. Results indicate that therapists who participated in the CBT-D training significantly increased their overall and specific CBT skills as measured by the CTRS, the standard clinical assessment for assessing level of competency in CBT. More than 80% of therapists successfully completed the process and performance-based requirements by the end of workshop training and consultation phases. Moreover, the current training led to significantly increased therapist confidence to provide CBT for depression and to more positive attitudes toward CBT, in general. These findings are at least equivalent to the results of other CBT training programs reported in the literature, which have typically included fewer therapists and have had more limited evaluation and/or follow-up (Rakovshik & McManus, 2010). We identified only two studies that have reported on training programs that have provided training in CBT to large samples of diverse therapists practicing in multiple settings (Keen & Freeston, 2008; McManus et al., 2010). Compared to the current program, those programs required significantly greater time investment of training participants and typically required clinicians to suspend or take leave from their employment. The data reported here demonstrate that a shorter training is feasible to implement in a variety of mental health treatment settings and achieves at least comparable results to these longer programs.

Perhaps even more significant, the implementation of CBT-D by the therapists in training was found to result in very significant reductions in depression symptoms and improved quality of life of veteran patients. The observed reductions in BDI-II scores compare favorably to the results of randomized controlled trials (RCTs) of CBT for nonveteran samples with depression (DeRubeis et al., 1999; Dimidjian et al., 2006; Hollon et al., 1992; Hollon & Ponniah, 2010; Jarrett et al., 1999; Murphy, Carney, Knesevich, Wetzel, & Whitworth, 1995; Rush, Beck, Kovacs, & Hollon, 1977). Overall, veterans presenting for treatment for depression and beginning a course of CBT typically had clinically significant levels of depression at or near the severe range on the BDI-II that by the later phase of treatment was in the mild or mild-to-moderate range of depression on the BDI-II. Unlike RCTs, these results reflect real-world settings with greater external validity and limited exclusionary criteria. The reductions in depression are also significant when considering that veteran patients are often characterized by chronic depression and other medical and psychiatric comorbidities (e.g., Forman-Hoffman et al., 2005). The clinical outcomes reported in this article are based on CBT-D implemented by non-CBT expert therapists still undergoing training in CBT-D.

It is also noteworthy that there was a low attrition rate of patients treated with CBT. The finding that nearly 70% of patients completed 10 or more sessions or finished early due to symptom relief is at least as good as or better than attrition rates reported in the literature. For example, a meta-analysis of 125 studies on psychotherapy reported a mean dropout rate of 47% (Wierzbicki & Pekarik, 1993). Similarly, Bados, Balaguer, and Saldana (2007) reported a dropout rate of 44% for a group of 203 patients receiving CBT. The current finding is an important addition to the literature, as there are very limited data reported on dropout rates among veterans receiving CBT or other evidence-based psychotherapy. Further, this finding is especially significant given that CBT is a new treatment approach for many VHA users who may have been more accustomed to psychopharmacotherapy and case management services prior to VA's national EBP dissemination initiatives. Moreover, the finding that therapists reported using CBT for depression with, on average, a full half of the patients they saw with depression 6 months after the completion of training is markedly higher than the rates of EBP delivery reported in the literature by therapists not formally trained in CBT or other EBPs,

including within VHA prior to VA's EBP dissemination initiatives, as well as outside of VHA (e.g., Goisman et al., 1999; Rosen et al., 2004).

High WAI-SR scores, with increases reported on all WAI-SR subdomains by the end of the CBT-D protocol, indicate that therapists paid close attention to the therapeutic relationship, which may have contributed to the low attrition rate. Moreover, the WAI-SR findings reaffirm that CBT can enhance and need not be antithetical to relationship factors, as some have believed and mischaracterized CBT. The focus on attention to and assessment of the therapeutic relationship in the VA CBT-D Training Program and therapy protocol and the emphasis on careful case conceptualization and understanding of the patient likely contributed to these positive relationship findings.

The more than two-fold increase (from 41% to 87%) in the number of therapists that met the criterion score of 40 for competency on the CTRS from postworkshop training to the later stage of consultation strongly supports the importance of consultation in evidence-based psychotherapy training. This finding is consistent with a growing body of research that has demonstrated superior learning and competency outcomes associated with consultation, supervision, or coaching relative to other learning formats that do not include active feedback (e.g., Beidas & Kendall, 2010; Sholomskas et al., 2005). The current findings provide further evidence to support Beidas and Kendall's (2010) observation that "Reading a manual and attending a workshop may start the transfer of knowledge (i.e., dissemination), but ongoing supervision may be needed for actual therapist behavior change and skillful implementation" (p. 3). Moreover, as others have articulated, reviewing and rating session tapes provides an invaluable feedback loop for improving psychotherapy skills, promoting implementation, changing or adding to traditional habits, and developing core CBT competencies (Schmidt & Taylor, 2002).

It is significant to note that the CBT competency on which clinicians, overall, received the lowest CTRS rating at baseline was guided discovery (2.86 out of 6). This was unsurprising, as clinicians, particularly those without formal training in CBT or similar evidence-based psychotherapies and more accustomed to teaching approaches than self-discovery processes, often find this to be a particularly challenging CBT skill. However, guided discovery is also the domain on which training participants exhibited among greatest improvement relative to other CBT domains.

While this article has a number of important strengths (e.g., large number of therapists from a variety of backgrounds, a large number of highly depressed patients treated in a real-world context, multilevel assessment, multiple sites), there are limitations that warrant consideration in the interpretation of the results. First, many of the therapists who participated in the training program had interest in CBT, which could yield greater training success. That said, while interest in participating in the training program among applicants was preferred, some therapists participated in the training because they were asked or encouraged by their facility's mental health leadership to do so, as noted above. Second, the definition of competency, which included a rating of 40 or higher on the CTRS for only one session, does not necessarily reflect competency that generalizes across all sessions and patients. That said, the focus of the training, like most training, is on the highest level of competency that a clinician is *capable of*, not on how well therapy is delivered in all instances. Moreover, the CBT-D sessions have a standard structure, so a strong demonstration of skills (using a well-established CTRS cut score) during one session may serve as a reasonably generalizable indicator. Third, while the training consultants did attend the workshop training and underwent training and calibration on the CTRS, the program did not have independent evaluations of the tapes. Training consultants could have rated therapists in their consultation groups differently than they would have rated therapists unknown to them. However, the CTRS manual and training on tape rating provided to the training consultants were behaviorally based, making this less likely to be a significant issue. Fourth, we do not have data on the patients' comorbid medical and psychiatric conditions, concomitant treatment, or disability status, all of which can affect outcomes. Fifth, it is difficult to fully interpret the finding that trained therapists used CBT-D with approximately 50% of their cases when surveyed 6-months following the CBT-D training, given that data were not collected related to reasons for therapists not using CBT. Additional research is needed on rates of and barriers and facilitators to *ongoing* adoption and sustainability of CBT. Nevertheless, as indicated above, the rate of CBT delivery reported at 6-month follow-up is significantly higher than rates of CBT delivery reported prior to VA's CBT dissemination initiative. Sixth, the lack of a control group limits precise conclusions regarding the effectiveness of the specific treatment.

It is worth noting that in addition to the development of the competency-based staff training program in CBT-D (and several other EBP training programs), VA has implemented several additional mechanisms designed to facilitate the implementation and sustainability of CBT in VHA. This includes developing and implementing national policy requiring that all veterans with depression and other mental health and behavioral health disorders have full access to CBT and other specific evidence-based psychotherapies (U.S. Department of Veterans Affairs, 2008). In addition, VA has placed a local evidence-based psychotherapy coordinator at each VA medical center. The local EBP coordinator serves as a champion for EBPs at the local level by helping to develop local clinical infrastructures to enable the delivery of intensive, time-limited psychotherapy; providing information and education on EBPs to leadership and other staff; providing for ongoing clinical consultation to therapists to promote local implementation, fidelity, and sustainability; and tracking the delivery of EBPs. Furthermore, session-by-session CBT-D documentation templates have been developed for VA's national computerized health record system that will allow for the tracking of the delivery of CBT-D and of specific patient and session characteristics—both locally and systemwide.

In summary, the findings reported herein indicate that large numbers of therapists practicing in a variety of urban and rural settings in a large national health care system can be trained in CBT to competency and in a manner that promotes sustained delivery of the therapy well after the completion of training. The results further indicate that CBT is associated with significant engagement and reductions in symptoms of depression, as well as improved quality of life, for veterans, many of whom have limited, if any, experience with evidence-based psychotherapy and contend with multiple medical and mental health comorbidities. These findings, yielded far outside of the laboratory environment, suggest that CBT may indeed be transportable to and flourish in complex, real-world settings. It is hoped that these findings will

help to inform and be generalizable to the design and implementation of similar CBT training programs and dissemination initiatives intended for providers in other community and private health care settings in this country and abroad.

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