



Evaluation of an implementation initiative for embedding Dialectical Behavior Therapy in community settings



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ABSTRACT

We examined the effectiveness of Dialectical Behavior Therapy (DBT) training in community-based agencies. Data were gathered at four time points over a 2-year period from front-line mental health therapists ($N = 64$) from 10 community-based agencies that participated in a DBT implementation initiative. We examined change on therapist attitudes toward consumers with Borderline Personality Disorder (BPD), confidence in the effectiveness of DBT, and use of DBT model components. All measures were self-report. Participating in DBT training was associated with positive changes over time, including improved therapist attitudes toward consumers with BPD, improved confidence in the effectiveness of DBT, and increased use of DBT components. Therapists who had the lowest baseline scores on the study outcomes had the greatest self-reported positive change in outcomes over time. Moreover, there were notable positive correlations in therapist characteristics; therapists who had the lowest baseline attitudes toward individuals with BPD, confidence in the effectiveness of DBT, or who were least likely to use DBT modes and components were the therapists who had the greatest reported increase over time in each respective area. DBT training with ongoing support resulted in changes not commonly observed in standard training approaches typically used in community settings. It is encouraging to observe positive outcomes in therapist self-reported skill, perceived self-efficacy and DBT component use, all of which are important to evidence-based treatment (EBT) implementation. Our results underscore the importance to recognize and target therapist diversity of learning levels, experience, and expertise in EBT implementation.

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Expert panels have recommended incorporating evidence-based treatments (EBTs) into standard clinical practice, calling it a priority for improving the quality of mental health services (President's New Freedom Commission on Mental Health, 2003). These efforts are particularly important for the public mental health sector (Adelmann, 2003; Mental Health: A Report of the Surgeon General, 1999), which serves individuals with severe and chronic mental health disorders (Adelmann, 2003), yet only 10% of public health systems deliver EBTs (Rones & Hoagwood, 2000). A number of factors have been identified that contribute to the success or failure of implementation efforts (Beidas & Kendall,

2010; Herschell, Kolko, Baumann, & Davis, 2010) including positive stakeholder attitudes toward EBTs, therapist professional background (degree type), organizational culture and climate, agency resources (financial, including post-training funding, leadership), and training strategies.

The field has highlighted the need for effective training strategies, but there is a lack of both comprehensive guidelines to support the transfer of EBTs to community therapists (McHugh & Barlow, 2010) and empirical information regarding effective knowledge and skill transfer (Fixsen, Naom, Blase, Friedman, & Wallace, 2005; Gotham, 2004). There is a particular paucity of data about how to most effectively train those who provide care in community settings (Herschell et al., 2010). To date, the most common way to train community therapists in EBTs has been to ask them to read written materials (e.g., treatment manuals) or attend workshops, but there is little to no evidence that this 'train and hope' approach (Henggeler, Schoenwald, Liao, Letourneau, &

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Edwards, 2002), similar to continuing education formats, will result in positive, sustained increases in skill and competence (Beidas & Kendall, 2010; Herschell et al., 2010). More extensive training models that include multiple training days with time in between for therapists to practice skills with consumers and receive feedback from experts through coaching or consultation seem to be necessary (Beidas & Kendall, 2010; Herschell et al., 2010; Sholomskas et al., 2005). There also is often a need for considering the organizational context (e.g., culture, climate, resources, leadership engagement) in which the intervention will be implemented (Damschroder et al., 2009).

One example of a therapy for which a comprehensive training approach has been developed is Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b). DBT is a Cognitive Behavioral Therapy that has been identified as an EBT for individuals diagnosed with Borderline Personality Disorder (BPD; Kliem, Kröger, & Kosfelder, 2010; Lynch, Trost, Salsman, & Linehan, 2007). DBT has been shown to improve outcomes for individuals with emotion regulation difficulties in adolescence through adulthood (e.g., Groves, Backer, van Der Bosch, & Miller, 2011) across disorders (e.g., Bipolar Disorder; Eating Disorders; Bankoff, Karpel, Forbes, & Pantalone, 2002) and settings (e.g., Dimeff & Koerner, 2007; Ritschel, Cheavens, & Nelson, 2012). Effectiveness trials (e.g., Pasioczny & Connor, 2011) and multiple efficacy trials support the effectiveness of DBT in diverse settings.

DBT is principle-based and includes specific modes and components (Linehan, 1993a). Specific DBT treatment modes include individual outpatient psychotherapy, group-based skills training (e.g., mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness), telephone consultation, and case consultation meetings for therapists. Specific treatment components include core strategies (validation, problem solving, behavior therapy, dialectics), consumer-oriented therapy agreements (e.g., attendance, suicidal behavior, therapy-interfering behavior, skills training), therapist-oriented agreements (e.g., “every reasonable effort,” ethics, personal contact, respect-for-consumer), treatment targets (e.g., decreasing life-threatening behavior such as suicide behavior and self-harm behavior; decreasing therapy-interfering behavior such as non-attendance; decreasing behaviors that interfere with quality of life such as heavy alcohol use; and increasing skills), and monitoring of treatment targets (daily diary card). The DBT protocol also acknowledges the occasional need for ancillary treatment (e.g., medication management, vocational rehabilitation). While some studies have found benefits for using selected modes (individual only rather than combined individual and group; Andion et al., 2012; group only rather than group in addition to other modes; Blackford & Love, 2011) or components of DBT (e.g., Salamin, Guenot, Bénon, Walthier, & Surchat, 2011), the largest empirical base and assumed optimal outcomes are found for DBT when it is implemented in its entirety (rather than only implementing selected modes or components).

The primary population for whom DBT was developed and has accumulated an evidence base (consumers with BPD) is one that has been described as difficult to treat and has experienced antagonistic judgments from professionals (e.g., Bodner, Cohen-Fridel, & Iancu, 2011; Bourke & Grenyer, 2010). Surveys have demonstrated professionals' negative feelings toward (Westwood & Baker, 2010) and reluctance to treat consumers with BPD (e.g., Jobst, Horz, Birkhofer, Martius, & Rentrop, 2010). In fact, targeted trainings have been developed to improve professionals' attitudes toward and confidence in treating consumers with BPD (e.g., Krawitz, 2004; Shanks, Pfohl, Blum, & Black, 2001). There often is a need to change therapists' attitudes about consumers with BPD before an EBT for consumers with BPD can be implemented.

While attitudes toward and confidence in treating consumers with BPD cannot predict professionals' behavior, positive attitudes

have been described as fundamental to high quality treatment of consumers with BPD (e.g., Ma, Shih, Hsiao, Shih, & Hayter, 2009; Woollaston & Hixenbaugh, 2008). The DBT model recognizes the importance of this through highlighting the need for a strong therapeutic relationship between the therapist and consumer; the impact of the therapist on the consumer (e.g., therapist-interfering behavior) and the necessity of support for therapists working with consumers with BPD (Linehan, 1993b). DBT also recognizes that a therapist cannot have a negative opinion of a consumer and be helpful (i.e., genuine, validating) at the same time.

DBT has been widely disseminated, with qualitative (e.g., Herschell, Kogan, Celedonia, Gavin, & Stein, 2009) and quantitative studies (e.g., Dimeff et al., 2009; Dimeff, Woodcock, Harned, & Beadnell, 2011) examining issues related to implementation (Ben-Porath, Peterson, & Smees, 2004; Dimeff et al., 2009, 2011; Frederick & Comtois, 2006; Hawkins & Sinha, 1998; Herschell et al., 2009). Topics have included training methods for mental health professionals before (Frederick & Comtois, 2006) or after (Dimeff et al., 2011; Hawkins & Sinha, 1998) completion of their terminal degree as well as factors that facilitate or impede implementation (Herschell et al., 2009; Van den Bosch, Verheul, Schippers, & van den Brink, 2002). Specific DBT training methods that have been studied include: self-study (Dimeff et al., 2011), 2-day workshops (Dimeff et al., 2009), electronic-learning (Dimeff et al., 2009, 2011), a residency program (Frederick & Comtois, 2006), and multi-component implementation processes (Hawkins & Sinha, 1998).

The training approach recommended for DBT is the DBT Intensive Training Model (ITM; Landes & Linehan, 2012), developed iteratively from 1991 (the publication of the first Randomized Controlled Trial demonstrating DBT's efficacy) until now. This extensively used model includes two 5-day trainings separated by a 6 month self-study and trial implementation, team building, contingency management procedures, and targeted coaching on specific strategies to reduce barriers to full DBT implementation.

Since 1993, ITM has been used to train 600 teams in 19 countries (Landes & Linehan, 2012). Annually, 5–8 ITM courses are offered in the United States and 9–10 are conducted internationally. The model has been included in efficacy and effectiveness trials to train study therapists (Koons et al., 2001; Trupin, Stewart, Beach, & Boesky, 2002; Verheul et al., 2003) where positive client outcomes have been obtained.

However, there has been only one empirical examination of the ITM itself. This study, similar to the current study, examined implementation of the full DBT model with community-based mental health professionals participating in a state initiative. Hawkins and Sinha (1998) evaluated the conceptual mastery of the therapists trained using the recommended multi-component training protocol (ITM; Landes & Linehan, 2012) within a State Department of Mental Health Initiative. Using a knowledge questionnaire administered to participants at varying points within the training, results indicated that (1) therapists with diverse training backgrounds and disciplines were able to acquire a sophisticated understanding of DBT; (2) the sophistication of knowledge acquired correlated strongly with the amount of training received; (3) reading, peer support, consultation, study group attendance, and time spent applying treatment were all important components of training; and (4) learners benefited most from expert consultation after acquiring a substantial DBT knowledge base.

The present study is an empirical examination of a real-world DBT implementation initiative launched by a partnership among a large managed-care behavioral health organization, four Eastern Pennsylvania counties, and 10 community mental health centers. This study is only the second of its kind for DBT. It adds to and extends the growing field of research on factors influencing EBT implementation in real-world settings. More specifically, this study offers several unique contributions and improvements. First, the

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