REGION V SYSTEMS

Promoting Comprehensive Partnerships in Behavioral Health

Evidence Based Practice (EBP)

Fidelity Monitoring and Evaluation Plan

Dialectical Behavior Therapy (DBT)

FY 22-23

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WHAT IS DIALECTICAL BEHAVIOR THERAPY? – SECTION I

Dialectical Behavior Therapy (DBT) is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice. Widespread adoption of effective practice interventions is at the center of SAMHSA's mission to improve service and is a major part of achieving its strategic goals of improving accountability, capacity, and effectiveness.

DBT was developed by Marsha Linehan, PhD in 1961, as a standard cognitive behavioral treatment for chronically suicidal adults and validated with women who met criteria for borderline personality disorder (BPD). It is known as a "third wave treatment" where it balances change strategies found in traditional behavior therapy approaches with acceptance-based and mindfulness strategies. The goal is to "build a life worth living."

DBT is a comprehensive treatment for severe and complex clients and persons with self-injurious behaviors. It is evidence based to treat:

- Borderline Personality Disorder (or someone who meets all five areas of dysregulation)
- Substance Use Disorders co-occurring with BPD
- Bulimia or Binge Eating Disorder
- Suicidal and or Non-Suicidal Self-Injurious Behavior
- Treatment Resistant Depression in the Elderly

Modes and intended objectives of DBT treatment:

- individual therapy (enhance motivation)
- skills training (increases skill acquisition/capabilities to change)
- inter-session coaching (increase skill generalization)
- consultation team (increase skill and motivation of the therapist, decreases drift)

Expected outcomes of adherence to DBT:

- decreased suicide attempts (Harned et al., 2022)
- decreased treatment dropout (Harned et al., 2022)
- improvement in non-suicidal self-injury (NSSI), specifically with DBT interventions that feature skills training (Linehan et al., 2015)
- cost savings when comparing the year prior to DBT with the first year of DBT. Utilization of crisis or emergency services, in particular, dramatically decreases (American Psychiatric Association, 1998).

REGION V SYSTEMS IMPLEMENTATION OF DBT – SECTION II

The Nebraska Division of Behavioral Health (DBH) and Region V Systems are committed to the high-quality implementation of Dialectical Behavior Therapy as an evidence-based practice. Region V Systems, along with industry expert Josh Smith of the *DBT Institute of Michigan*, will assist agencies with the implementation of evidence-based DBT and a 5-year implementation plan has been developed.

A 1-day administrative training occurred in the Fall of 2021, open to key stakeholders (Regional Behavioral Health Administrators and other crucial employees) and Region V Systems Network provider administrators. Agencies submitted applications to participate in DBT trainings, selecting their intent to implement either an evidence-based or informed practice. Included in the application was a self-assessment for agency staff to complete on their program, consultation team, treatment, client outcomes, documentation, training and sustainability, and administration support. Applications were reviewed by RVS and Josh to evaluate the readiness of the organization and its staff to implement a DBT practice and determine the feasibility of implementation in the intended setting.

RVS will coordinate the following trainings/activities:

- Administrative Training, 1-day
- Introduction to DBT, 2-day
- DBT Skills Training, 3-day
- DBT Training for Clinicians - Part 1, 5-day
- DBT Front Line Staff Training, 2-day
- On Site Reviews, 1 day per agency per quarter
- DBT Training for Clinicians - Part 2, 5-day

Fidelity to the DBT model, program standards and practices will be monitored to prevent drift. Doing so will be crucial to ensuring the desired and evidence-based outcomes occur. In pursuing performance-based contracting, specific deliverables, performance objectives, and outcomes will be outlined. Region V Systems will establish measures and data reporting schedules.

QUALIFIED CRITERIA FOR DBT TEAM MEMBERS – SECTION III

Listed below are the standards each team member must meet to be considered for Region V's approval for model fidelity/integrity and value-based outcome reimbursements.

Team Leader

- 60 hours of DBT Training (must submit copies of all proof of attendance certificates)
    - Introduction to DBT, 2-day
    - DBT Skills Training, 3-day
    - DBT Training for Clinicians - Part 1, 5-day
    - DBT Training for Clinicians - Part 2, 5-day
- Read
    - "Cognitive Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan, PhD
    - "DBT Skills Training Manual, 2nd ed." by Marsha Linehan, PhD
    - "Dialectical Behavior Therapy in Clinical Practice: Applications across Disorders and Settings, 2nd ed." by Linda Dimeff, PhD and Kelly Koerner, PhD
    - "DBT Teams: Development and Practice" by Jennifer Sayrs
- Participate in 80% of Monthly Coaching Calls
- Knowledge in Mindfulness practice (please submit written overview of how you learned and currently practice mindfulness)
- Pass DBT Practice Knowledge Exam (Clinician/Team Lead version) with a 90%
- Letter of recommendation from at least two team members

Clinician

- 60 hours of DBT Training (must submit copies of all proof of attendance certificates)
    - Introduction to DBT, 2-day
    - DBT Skills Training, 3-day
    - DBT Training for Clinicians - Part 1, 5-day
    - DBT Training for Clinicians - Part 2, 5-day
- Read
    - "Cognitive Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan, PhD
    - "DBT Skills Training Manual, 2nd ed." by Marsha Linehan, PhD
- Participate in 80% of Monthly Coaching Calls
- Knowledge in Mindfulness practice (please submit overview of how you learned and currently practice mindfulness)
- Pass DBT Practice Knowledge Exam (Clinician/Team Lead version) with an 80%
- Letter of recommendation from team leader

Skills Coach

- 20 hours of DBT Training (must submit copies of all proof of attendance certificates)
    - Introduction to DBT, 2-day
    - DBT Skills Training, 3-day
    - DBT Front Line Staff Training, 2-day
- Participate in 80% of Monthly Coaching Calls.

If there are Skills Coaches on the team who are Line Staff/Techs, they will not be expected to meet 80% attendance. Instead, the team should designate a Skills Coach who can attend at least 80% of the monthly calls/site reviews and who will act as liaison between all Skills Coaches and the team.

- Read
  - "DBT Skills Training Manual, 2nd ed." by Marsha Linehan, PhD
- Pass DBT Practice Knowledge Exam (Skills Coach version) with a 70%
- Letter of recommendation from team leader

MODEL FIDELITY/INTEGRITY – SECTION IV

On-Site Program Description Manual

To become an approved DBT program, the Provider must:

Present a manual that will show that the DBT program adheres to the fidelity of DBT, and that the Provider is consistent with meeting the standards of a fully implemented DBT program. This manual will be kept on-site and will contain information related to the DBT program's policies and procedures which guide how DBT is delivered and how fidelity is maintained regardless of staff turnover.

The manual will consist of the following information (in this order):

I. Name of team leader and team members along with DBT start date
II. Credentials and training description of each team member
III. Description of the Provider and the clientele it serves
IV. Reason(s) for DBT and Mission Statement of the DBT Program
V. Criteria used to determine inclusion vs. exclusion into the DBT Program
VI. Protocol for treating and moving clients through Stages of Treatment
VII. Referral process and how clients are assigned clinicians
VIII. Detailed description of roles of contracted/employed clinicians, front line staff, case managers and peer support specialists and services they provide that are related to the delivery of DBT
IX. How each mode is structured and delivered to serve its function (if modes have been adapted from the evidenced-based model of DBT, please explain in detail why the adaptation(s) was made and how you are monitoring whether or not the adapted mode is serving the function)
X. Orientation and commitment procedures for new staff to join DBT team, staff training procedures, procedures for supervision (will be trained on tools to provide team members supervision and feedback)
XI. Vacation, termination, and transfer protocol
XII. Program evaluation procedures
XIII. Suicide and risk assessment protocol
XIV. DBT requires that skills coaching be provided by a trained DBT staff member and is available 24 hours a day, 7 days a week, 365 days a year. Describe how the team provides twenty-four/seven-365 skills coaching. What is the process for a DBT client to access contact with someone from the DBT team or someone who has training in DBT skills coaching and crisis/suicide management after normal business hours?

XV. Attachments:
   a. Individual therapy progress note
   b. Diary Card
   c. Skills training progress notes
   d. Any adapted skills training handouts
   e. DBT contract
   f. Emergency contact form
   g. Consultation agenda/template used to structure meetings

Site Review and On-Site Technical Assistance

During the first year of implementation, agencies will participate in quarterly site reviews. The site reviews will function to help agencies and trainer assess to what degree that agency is set up to support evidenced-based practices such as DBT. Specific activities will include

- Interviews of persons served, administrators, DBT team members
- Observation of various DBT components (e.g., skills group)
- Completion of the General Organizational Index (GOI)
  The GOI assesses the degree to which an organization has the capacity to implement and sustain an evidence-based practice.

Following the site review, on-site Technical Assistance will be designed to provide specific training to each team based on the results of their site review. An exit interview will occur, and a summary report will be completed.

Monthly Coaching Calls

In the first year of training, DBT teams will have monthly coaching calls with the industry expert. The purpose of these calls is to prevent treatment "drift" and to provide effective dissemination of DBT within their specific agency and with their specific clientele. DBT teams will set the agenda ahead of time and document the calls. Common discussion points include clarifying laws of DBT and case/client consultations).

DBT Champions (under development; estimated release January 2023)

To help maintain DBT within the Region V Network, staff at participating agencies will be recruited to be DBT Champions. Champions will facilitate trainings and assist with 3-year reviews of other agencies. Technical assistance for DBT champions with industry expert, pending funding availability.

Ongoing Program Maintenance Approval

Agency Attestation

Team Lead will annually attest to the ongoing application of DBT within the agency/program and complete an agency self-assessment utilizing identified checklist (e.g., staff continuing to participate in ongoing DBT-related trainings/CEUs, all DBT modes still occurring) and DBT Program Fidelity Checklist (DBT PFC).

Site Visits

The model fidelity/integrity assessment team (to include DBT champions and RVS staff) will complete agency site visits every 3 years after the agency is approved for fidelity payments. Included:

- Interviews of persons served, administrators, DBT team members
- Observation of various DBT components (e.g., skills group)
- Completion of the General Organizational Index (GOI)

An exit interview will occur, and a summary report will be completed. Potential outcomes are a 3-year award, 1 year award, or no award. For any areas not in conformance, the agency will complete a Quality Improvement Action Plan on how they will get into conformance. The QIAP is approved by RVS.

OUTCOMES MEASUREMENT – SECTION V

Providers will submit outcome measure data to Region V Systems on a quarterly basis.

Client Outcomes

- Reduced treatment dropout
- Reduced hospitalizations and emergency room visits
- Reduced suicide attempts
- Reduced self-harm (NSIB) behaviors
- Reduced quality of life interfering behaviors
- Reduced Borderline Symptom severity, as measured by Borderline Symptom List (BSL-23)
- Increased DBT skills use and reduced dysfunctional coping, as measured by the DBT-Ways of Coping Checklist (DBT-WCCL)
- Increased report of reasons for living, as measured by the Reasons for Living Scale (Short Form)

Data Fields	**Timeframe**
Client Identifier = LLLLYYYYMMDDSSSS (First 4 letters of last name, Date of birth, last 4 digits of SSN)	All
Referral Source	Intake
Demographic data (DOB, gender, ethnicity, race, zip code)	Intake
Service	Intake, every 3 months, and discharge from DBT
Therapist	Intake, every 3 months, and discharge from DBT
Concurrent service utilization/list of services (e.g., community support, day rehabilitation) *N/A for Residential/Inpatient Services	Intake, every 3 months, and discharge from DBT
Residential/Living Arrangement status (use CDS values) *N/A for Residential/Inpatient Services	Intake, every 3 months, and discharge from DBT
Employment status (use CDS values) *N/A for Residential/Inpatient Services	Intake, every 3 months, and discharge from DBT

Quality of Life Interfering Behaviors (yes/no for each behavior/domain) • Substance use • High-risk or unprotected sexual behavior • Extreme financial difficulties • Criminal behaviors that if not changed may lead to jail • Serious dysfunctional interpersonal behaviors • Employment or school-related dysfunctional behaviors • Housing-related dysfunctional behaviors • Illness-related dysfunctional behaviors • Mental health-related dysfunctional behaviors • Mental illness-related dysfunctional patterns	3 months prior to DBT, every 3 months, and discharge from DBT
Suicide attempts (#)	1 year prior to DBT, every 3 months, and at discharge from DBT
Self-Harm (NSIB) behaviors (#)	1 year prior to DBT, every 3 months, and at discharge from DBT
Emergency Room visits (# of visits) • for suicide attempt • for NSIB • for suicidal ideation	1 year prior to DBT, every 3 months, and at discharge from DBT
Psychiatric hospitalizations (# of visits, # of days) • for suicide attempt • for NSIB • for suicidal ideation	1 year prior to DBT, every 3 months, and at discharge from DBT
Medical hospitalizations (# of visits, # of days)	1 year prior to DBT, every 3 months, and at discharge from DBT
Borderline Symptom List – 23 (BSL – 23), only first page	Intake, every 3 months, and discharge from DBT
DBT-Ways of Coping Check List (DBT-WCCL)	Intake, every 3 months, and discharge from DBT
Reasons for Living Scale (Short Form)	Intake, every 3 months, and discharge from DBT
DBT Discharge Summary, to include: ☐ Length of time client received DBT ☐ Target behaviors treated during treatment ☐ Treatment complete (successful completion of Stage 1: No life-threatening behaviors; No severe quality of life interfering behaviors in last 3 months; 2 cycles of the DBT skills curriculum that is unique to the level of care the person received treatment in) ☐ If not Stage 1 was not successfully completed, list reason.	Discharge from DBT

Intake is at the time of the initial assessment, prior the start of pretreatment.

Satisfaction Surveys

Agency staff will collect satisfaction surveys from:

Persons Served

- Satisfaction Surveys (quarterly/every 3 months) - submit to RVS aggregate data every 6 months.
- Skills Group Questionnaire (end of every module) - these will be reviewed at 3-year site visits (aggregate report or original surveys are acceptable)
  If questions need to be read to, or interpreted for, persons served, it should be by a staff member other than skills trainer.

Family Members (twice a year/every 6 months) - submit to RVS aggregate data every 6 months.

Staff (twice a year/every 6 months) -completed by all DBT members; submit to RVS aggregate data every 6 months.

Stakeholders (once a year) - submit to RVS aggregate data once a year.

Staff Retention

Agency will report the number of DBT team members/staff leaving each quarter and for what reasons (assessed in exit interviews).

Cost Analysis

Utilizing agency reported data on hospitalization and emergency room visits (1 year before DBT and first year of DBT), cost analyses will be conducted. *Patrick reaching out to hospitals (and/or Hospital Association)*

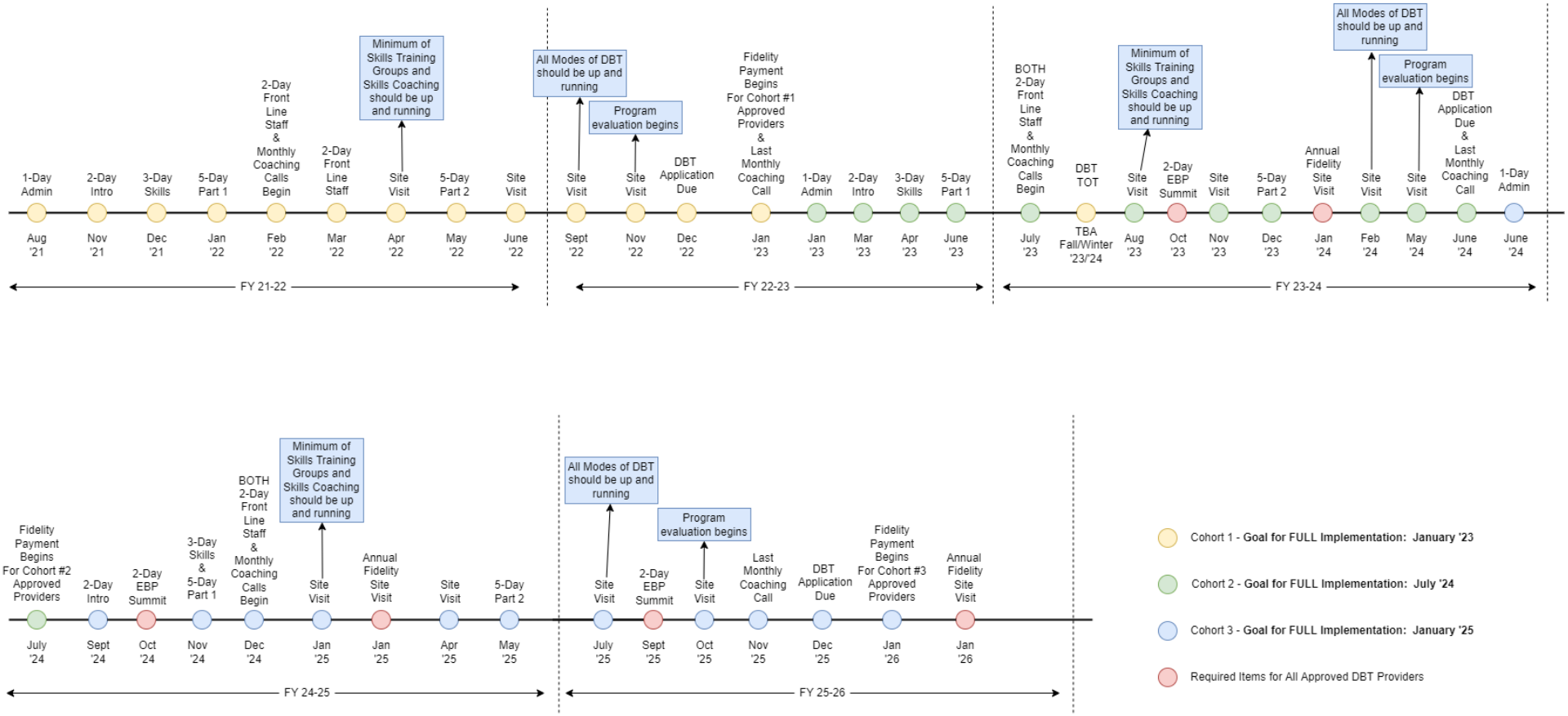
Region V Systems will engage with the UNL Public Policy Center to complete evaluation of impact (Year 2 or 3).

PARTICIPANTS – SECTION VI

	Agency	**Level of Care Applied for**	**Levels of Care Approved**
Cohort 1 (Evaluated for approval in December 2022). First opportunity to receive reimbursement January 2023.	CenterPointe	Residential (Dual Disorder Residential)	
	Integrated Behavioral Health Services	Outpatient, Residential (Secure Residential – MH, Psychiatric Residential Rehabilitation – MH), Day Psychiatric	
	Lincoln Regional Center	Inpatient	
	Lutheran Family Services	Outpatient	
	St. Monica's	Residential (Short Term Residential – SUD, Therapeutic Community – SUD)	
	Telecare	Residential (Secure Residential – MH)	
Cohort 2	TBD (could be "replacement staff" for above agencies)		

TIMELINE – SECTION VII

Contingent upon available funding



NOTE: Train-the-Trainer (TOT) under development

CITATIONS – SECTION VIII

American Psychiatric Association (1998). Gold Award: Integrating dialectical behavior therapy into a community mental health program. Psychiatric Services, 49(10). 1338-1340.

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Linehan MM, Korslund KE, Harned MS, et al. Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: a randomized clinical trial and component analysis. *JAMA Psychiatry*. 2015; 72:475-482.