WDBTA
World Dialectical Behavior Therapy Association

RECOMMENDED GUIDANCE ON IMPLEMENTING DBT WITHIN CLINICAL SYSTEMS

WDBTA Training and Implementation Expert Committee

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Introduction

Purpose of the Document

As the international organization for DBT, the WDBTA aims to support and guide those implementing, or preparing to implement, DBT programs. This document draws on the expertise of individuals with extensive experience establishing DBT in large-scale systems, sometimes across wide geographic regions. It also incorporates findings from the science of dissemination and implementation (D&I Science), including research on DBT-specific implementation efforts.

Our goal is to provide practical guidance to support high-fidelity implementation of DBT, grounded in established models with demonstrated effectiveness. Ultimately, we aim to ensure that people receiving DBT have access to high-quality treatment. To that end, the Training and Implementation Expert Committee of the WDBTA has developed this document to encourage those involved in DBT implementation to consider and aspire to the principles outlined here.

How the Document Was Developed

The committee sought to identify approaches to DBT implementation that effectively and efficiently support the development of adherent DBT programs that fulfil the five functions of comprehensive treatment programs (Chapman & Dixon-Gordon, 2020; Davison, 2019).

To do this, we reviewed recent literature on implementation and integrated these findings with the committee's extensive practical experience. As with our recommendations on training models, the diversity of settings in which DBT is implemented—along with wide variation in economic, cultural, linguistic, and national contexts—led us to adopt a suggestive framework rather than prescriptive policies. A selection of references are provided that may provide useful background on implementation science (Curran, 2020; Bauer & Kirchner, 2020; Leeman et al, 2017; Nilsen et al, 2019).

The committee reached consensus that the principles outlined below represent the fundamental steps and core elements of DBT implementation.

Definitions

While the terms dissemination and implementation are sometimes used interchangeably, it is important to distinguish between these two terms as well as diffusion.

- Dissemination is the active, targeted, and planned distribution of information and intervention materials to a specific audience. Given this definition, the tasks of dissemination fall under the auspices of the International Dissemination Committee of the WDBTA and will not be considered further here.
- Implementation refers to the process of integrating and using evidence-based practices within specific settings to improve outcomes. Broadly speaking, implementing DBT requires two things: 1) Establishing and maintaining the program elements of DBT, and 2) the application of specific strategies, procedures, and protocols by treatment providers in their work with those receiving the treatment.
- Diffusion is the passive, untargeted, and unplanned spread of new practices or innovations. In many ways the global spread of DBT has occurred through processes of diffusion.

Within the literature the term fidelity is used most often to refer to how close a DBT programme is in terms of its structure of functions and modes to those described in published descriptions of the treatment and tested in randomised controlled trials. For example, a DBT programme that provides weekly skills classes, delivering one of the evidence-based curricula, weekly individual therapy sessions, out-of-hours contact between clients and individual therapists, and a weekly consultation team would be delivering comprehensive DBT to high fidelity. Adherence refers to how close to the manual the delivery of the treatment is in any specific individual therapy or skills group session. Whilst adherence is a property of a dyadic or group-based interaction in each session, therapists who consistently deliver adherent therapy can be considered 'adherent' therapists. The goal of implementation is to ensure high fidelity DBT programmes which constitute a consultation team of therapists delivering adherent therapy. Without the context of a high-fidelity DBT programme therapists may experience difficulties in delivering adherent therapy.

DBT programmes rarely develop in isolation. Most commonly they are situated in larger healthcare organisations which themselves host multiple programmes. Implementation of DBT within such organisations typically happens in one of two ways: bottom-up or top-down. Bottom-up implementation starts out from one or many small components and builds up to a comprehensive program, emphasizing grass roots involvement. For example, a team may seek funding commence meeting as a consultation team and deliver a skills class with the aim of shaping up to a more comprehensive programme without any significant involvement from their wider organisation. In contrast, a top-down implementation approach is designed and driven by senior leadership with the aim of delivering comprehensive DBT from the start. Even with the backing of senior leadership, however, a shaping approach to implementation is often what occurs in practice with teams starting with fewer modalities of the treatment to begin.

Whether the implementation involves one DBT program or an entire system or network of programs, there are certain steps that facilitate movement toward fidelity. This guidance reviews each of these steps in turn providing recommendations and the typical outcomes of each step.

Early stage of implementation: Preparation

The consensus among most implementation theorists and scientists is that implementation begins with the process of determining whether to move forward with the adoption of an intervention or treatment. The variables of consideration at this stage have been defined as acceptability of the intervention, the decision to adopt, appropriate fit of the intervention, and feasibility (Peters et, 2013).

The primary task here is structuring the environment so that – if DBT is a good fit – implementation can proceed. The primary mechanisms for this task are orientation and commitment of both staff who are intended to deliver the intervention and the wider organisational context.

Recommendations

- Determine whether DBT is acceptable to both providers and those who will receive the treatment. Important considerations here are the cultural relevance and appropriateness of DBT
- Be clear about how the treatment fits in the healthcare delivery context e.g., staffing resource for skills training classes (two facilitators) and time of consultation team meetings
- Assess the organization's readiness through multiple methods e.g., surveys to determine staff's interest, conversations with key stakeholders to gauge levels of support. Consider here other competing demands or interventions that the organisation is delivering or considering implementing. How will DBT fit or not fit with the organisation's other models and ethos?
- Identify the key stakeholders in the community who will impact the implementation
- Secure funding for training; ensure that the training provided will meet minimum requirements towards certification as defined by national and international independent organisations with responsibility for standards of certification and is in line with WDBTA guidance on both content and the expertise of those delivering the training.
- Consider the resources necessary to implement and maintain the treatment program e.g., ensure sufficient funding for sustainability in the long-term, protected time for staff doing DBT
- Communicate to decision-makers, funders a concise summary of available evidence for implementing the treatment with the target client population and in the location it is going to be used
- Identify what are the important outcomes both for the implementation itself, for example, number and size of programme (s), the resources required and for the client group to be treated. Identify appropriate outcome measures that match both the outcomes of the implementation and the clinical outcomes expected from the DBT programmes themselves.
- Identify appropriate leadership for the implementation. Implementation leaders need knowledge of DBT and knowledge of their organisation. Implementation leaders will take responsibility for liaising with key stakeholders and those delivering training to maximise the chances of successful implementation.

Outcomes for this stage

- Clarity that DBT is the appropriate intervention to implement
- Commitment of the organisation to provide resources (staff and other) for continued implementation. Commitment will need to be evidenced at multiple layers of the organisation. High level sign-off is vital and without sign-up from 'middle' managers' who are often responsible for managing staff resource and waiting lists the implementation will fail.
- A strategy for how to proceed with the implementation. For single teams in an organisation deciding to introduce DBT this may simply involve informed management agreement to proceed. For more large-scale implementations involving multiple teams an 'implementation team' who will design and launch the program and attend to sustainability will be required. All disciplines, including management, should be represented on the implementation team and work to build as-strong-as-possible commitment to the implementation of the program.

Commencing implementation

Once the organization has decided that DBT is the intervention that they wish to implement and they have decided on an appropriate approach, implementation can begin. This stage of implementation primarily involves staff identification, including the appointment of DBT Team Leaders, training of staff and the setting up of DBT programmes. More intensive training models with implementation support are linked to improved knowledge acquisition, motivation, DBT use, and, in some cases, client outcomes (Harris, Lamers & Swales, 2026). In what

follows for smaller scale bottom-up implementations, the 'implementation team' maybe synonymous with the identified team of clinicians who intend to deliver the treatment.

Recommendations

- The implementation team engage in activities that assist them to obtain needed information to make informed decisions and guide the implementation process. These activities may involve reading the literature, attending training events and consultation with experts.
- With the help of expert consultation, the implementation team designs the programme or programmes to be implemented.
- The implementation team recruits clinicians, designates / recruits team leader (s) and forms a consultation team (or several consultation teams in a system implementation). Generally, DBT teams benefit from a diversity of professional backgrounds and skills as this can support a dialectical response to clinical challenges and there may be fixed rules in some jurisdictions about which disciplines can deliver psychological therapies. In such contexts, DBT teams may have a narrower number of disciplines participating.
- Clinicians identified or selected as DBT Team leads require passion and dedication to learning DBT, skills in motivating others to do likewise, influence in the wider system to secure resources for the developing DBT team (s), and organisational skills to ensure that the developing team commences delivering a programme.
- The DBT Consultation Team(s) that will attend training engage in preparatory activities to gain a rudimentary knowledge of the treatment (history of treatment development, nature of patient populations, nature of treatment targets, bio-social theory, DBT assumptions, core strategy groups (problem-solving, validation, dialectical strategies), and especially Functions and Modes of treatment). Examples of these activities are reading the key texts and engaging in learning communities.
- The consultation team(s) attend a DBT training that comprehensively addresses all of the training domains outlined in the WDBTA guidance document on Suggested Domains for Comprehensive DBT Training https://wdbta.org/training/ over an extended period of time that adequately allows for acquisition of all relevant knowledge and competencies. Part of the training must include the team presenting their beginning implementation and program design for consultation as well as samples of their clinical work for expert feedback. Desired program outcomes are identified along with methods for acquiring and measuring them.
- The training should be delivered by those who meet the competencies for trainers as outlined by the WDBTA https://wdbta.org/training/
- Teams benefit from becoming engaged in the delivery of the treatment, often commencing with DBT Consultation Teams and skills classes as soon as possible after, if not before, training has commenced.
- Expert consultation occurs periodically prior, during and following the training.

Outcomes from this stage

- A team or set of teams delivering comprehensive DBT
- Each team will consist of sufficient members with sufficient time allocation to be able to deliver a comprehensive programme to the number of clients in system requiring the treatment (typically teams will have a minimum of 5 members with a minimum of 2 days a week each for the programme).
- Each team will have a designated team leader who will coordinate the training of the team, liaise with the wider system to ensure appropriate resourcing of the team and develop their own skill in DBT.

Sustainability

Programme Sustainability

This phase of implementation requires the successful changing of existing mental health systems to incorporate discreet DBT teams. **A designated DBT team leader is essential for effective sustainability**. The DBT Team Lead will ensure that the DBT team has sufficient resources to deliver a programme with fidelity negotiating with organisational structures outside of the programme for these resources. In this role the DBT Team Lead also takes responsibility for addressing any behaviours from the organisation that threaten the delivery of DBT with fidelity such as unplanned removal of resource. This 'outward-facing' role is complimented by their 'inward-facing role' within the team where they take responsibility for ensuring that team members make the necessary commitments to the team and the model; support and enable progress towards increasing adherence to the model; proactively address behaviours on the team that threaten the delivery of adherent DBT.

Recommendations

- DBT Team Leads align the requirements of a DBT programme and the needs of its clients with organizational priorities
- Effective implementation requires significant job planning for DBT team members. This may require significant negotiation with the wider organization by DBT Team leaders. Ideally, DBT therapists will have their weekly DBT time protected from encroachment of other organisational demands. DBT therapist capacity may be determined through DBT job planning and case load capacity calculators.
- Given that in most mental health systems there is significant staff turn-over, and DBT teams are no exception, organisations will require a plan for sustainability. This will require funds to train new staff members and to ensure ongoing professional development for existing team members.
- Clinical outcomes need to be monitored from referral, pre-treatment, throughout treatment and discharge. Monitoring ranges from collecting data on the diary card to more formal measures. Teams will require processes to ensure that outcomes are regularly reviewed and impact practice both at the individual client level and at the programme level
- DBT Teams will benefit from knowing the types of outcomes stakeholders value. A system for identifying and monitoring resource use to achieve the valued outcomes is also useful.

Consultation / supervision

Successful implementation and sustainment of DBT involves significant shaping of therapist behaviour. RCTs often involve extensive monitoring of therapists' performance and this is less typical in routine implementation in mental health services. Within a DBT context two different terms are used to describe the process whereby a more experienced therapist reviews and comments on therapy sessions or case conceptualisations. In some jurisdictions this process is referred to as supervision and in others it is referred to as consultation, which may be the favoured term to avoid any clinical governance confusion about who is responsible for the clinical work. In DBT responsibility for treatment always remains with the individual therapist and the DBT Team.

Consultations to teams and individual therapists are likely most effective when they follow the therapy itself and focus on skilling teams and individual therapists to recognise adherent and non-adherent treatment. Ideally supervision / consultation emphasises "showing" therapy provided and development of skills through the sharing of recorded clinical material, use of modelling / demonstration of the treatment followed by behavioural rehearsal, imaginal rehearsal, and incorporation of analysis of client related outcome data into consultation processes. DBT sessions to clients without behavioural rehearsal are not likely meet adherence standards and relatedly consultation / supervision without practice generally leads to slow behavioural change on the part of therapists and teams.

Adherence to the model, is an attribute that can be ascribed to a session, between a particular dyad, in a moment in time and is therefore not an attribute anchored in a therapist. Once a therapist has produced sessions that are adherent to the model across several sessions and dyads, it can be understood that they have the capacity to produce behaviour that is adherent to the DBT model. Consultation/supervision, in addition to usual continuing professional development, throughout one's career is recommended as the complex nature of DBT leads to frequent drift from adherence.

Recommendations

- Following training in DBT, therapists and teams are advised to seek consultation / supervision from a person with greater expertise in the treatment.
- The consultation / supervision should involve direct observation of the therapist / teams' performance either in vivo (for teams) or via recordings of sessions (individual and group skills sessions).
- Consultants / supervisors (who should be recognised as being capable of delivering adherent therapy themselves) should utilise similar processes to therapy to shape behaviour of therapists with a strong emphasis on behavioural rehearsal.
- Consultants / supervisors should receive training in the process of assessing for adherence / fidelity so that they can provide behaviourally specific feedback to individuals and teams about when their performance deviates from what is recognised as DBT.
- Teams will require ongoing access to CPD to remain up to date with their skills and new developments in the treatment.

Outcomes

- Teams that provide all the functions of comprehensive treatment.
- DBT teams that produce transparent inclusion and exclusion criteria
- Teams have a clearly identified leader
- Treatment programmes that are based on the needs of the population
- Teams that have a strategy for sustainability
- Teams that have mechanisms in place to enable their members to deliver adherent DBT
- DBT Teams have systems in place to collect clinical outcomes of clients in their programme and to reflect on those outcomes to improve practice.

Summary

The process of implementing DBT can broadly be divided into three stages: preparation, commencement and sustainability. Each stage has unique challenges which the recommendations provided intend to assist practitioners to overcome.

Appendix 1: Implementation Science Definitions

Curran (2020)

In this paper Curran describes describes key aspects of implementation science in everyday language. His descriptions applied to DBT are as follows:

- Effectiveness Research looks at whether DBT works in practice
- Implementation Research looks at how best to help people / places to do DBT
- Implementation strategies are the things that experts do to try and help people and places do DBT
- Implementation outcomes are how much and how well people and places do DBT

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