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Implementing Dialectical Behaviour Therapy: organizational pre-treatment

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Abstract Implementing change in organizational systems is challenging, and implementing a new psychotherapeutic approach is no different. A literature exists on issues in implementation across a wide range of domains (technological, healthcare, justice). However, little of it is utilized in endeavours to implement innovations in psychological treatments. This paper draws on the implementation literature and on the experiences of the British Isles DBT Training Team (BIDBT) in implementing Dialectical Behaviour Therapy (DBT) in mental healthcare systems in the UK over the last 13 years. This paper describes principles and strategies of 'organizational pre-treatment' as a necessary prerequisite to implementation.

Key words: Dialectical Behaviour Therapy (DBT), implementation, organizational change.

Introduction

The recently published NICE guidelines on the treatment of borderline personality disorder (BPD) recommend Dialectical Behaviour Therapy (DBT) for the treatment of women with a diagnosis of BPD in whom reduction of suicidal and self-harm behaviour is a clinical priority (NICE, 2009). Implementing a new approach to treatment is a complex process (Fixsen *et al.* 2005) that is not simply reducible to training practitioners in new therapeutic approaches. Policy documents rarely cover in any detail the additional aspects of organizational structure and function needed to address the implementation of new procedures. Similarly, treatment manuals often ignore this aspect of implementation altogether. Failure to attend to the wider organizational context of an innovation may increase the likelihood of implementation failure.

DBT is a *recursive* treatment, i.e. it encourages the use of the strategies used to treat the client to treat the therapists in the team to increase their capabilities and motivation to treat the client. Similarly, by conceptualizing the organization as the first 'client' of the DBT programme, the DBT team can employ the principles of the therapy to address the capabilities and motivation of the organization to deliver the treatment programme. Organizations, defined as 'business or administrative concerns united and constructed for a particular end'

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(Collins English Dictionary, 1986) can be analysed at the level of the individual or group, the *micro* level, or at the level of the entire organization, the *macro* level (Rollinson, 2008). At the macro level, organizations can develop goals; 'behaving' in much the same way as a colony of ants, and also comprise of multiple individuals, who can 'behave' and respond to contingencies. For example, recent government policies on financial penalties for failure to meet targets have driven changes in investment priorities and working practices in many NHS organizations.

For the past 13 years, throughout the UK and Eire, the British Isles DBT Training Team (BIDBT) has provided training to teams working in highly disparate organizational settings: in-patient and outpatient services, adult mental health and child and adolescent mental health services (CAMHS), generic services and specialist personality disorder services, the NHS and the private sector, and in settings with varying levels of security, including prisons. Of the 161 teams trained at national intensive training events, implementation success has varied considerably (B. Taylor, M. Swales & R. Hibbs, unpublished observations). This paper describes four stages of organizational pre-treatment, highlighting principles that will assist organizations and practitioners to successfully implement a DBT programme.

Organizational pre-treatment

The processes involved for an organization in deciding to implement a DBT programme resemble the pre-treatment stage of treatment for clients. In the treatment of the client, there are four pre-treatment tasks (Swales & Heard, 2008). The therapist must first establish whether DBT treatment is an appropriate treatment for the presenting problems. Next, if DBT is appropriate, the therapist assists the client to identify his/her goals for treatment and relate these directly to the focus of the treatment. Third, the therapist orients the client to the treatment, including possible difficulties and challenges. Finally, the therapist elicits commitment from the client to engage in all aspects of the treatment programme. In DBT treatment, the primary therapist is responsible for accomplishing the four pre-treatment tasks. Similarly, a DBT programme requires an identified individual, who will probably become the leader of the DBT team†, to take responsibility for: establishing the organization's goals and whether DBT is a good fit with these goals; assessing the readiness of the organization to change; orienting the organization to the requirements of the DBT programme; and eliciting commitment from the organization to these requirements. The next four sections discuss each of these steps.

Identifying organizational goals

Goal identification and clarification are vital components of pre-treatment in therapy, and similarly, an important step in implementation (Webster-Stratton & Taylor, 1988; Fixsen *et al.*

† In any implementation endeavour, a lead individual is required to take responsibility for the change process. This may be a clinician or it may be a manager. In the former case, the clinician following the organizational preparation stage often goes on to become the DBT team leader. Throughout the paper I will continue to refer to the person leading the implementation as the DBT team leader, even though there may be services where this function of structuring the environment is led by a manager outside the clinical DBT team.

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Table 1. *Organizational goals for which DBT may be a good match*

Organizational goal	Relevant policy documents/research	Organizational data
To manage/treat suicide risk in high-risk groups	DBT outcome trials (Linehan *et al.* 1991, 1999, 2002, 2006; Koons *et al.* 2001; Verheul *et al.* 2003; Clarkin *et al.* 2007).	Numbers of suicides (with and without a PD diagnosis)
		Repetition rates of DSH (with and without a PD diagnosis)
	NICE (2004)	Numbers of crisis hospital admissions following
	NICE (2009)	DSH/suicidal behaviours
Decrease length of stay or admissions to acute psychiatric care	DBT outcome trials (see above) showing reduced hospital admissions and number of in-patient days	Average length of stay for clients with a PD diagnosis
Absence of coordinated team-based care	NIMHE (2003)	PPI/user experience data
		Amount of staff time currently offered to the client group
Increased cost control/possibility of decreased costs	Brazier *et al*. (2006)	Costs per year in terms of DSH episodes, length of stay and out-of-area placements

PD, Personality disorder; DSH, deliberate self-harm; PPI, patient public involvement.

2005; Sanders & Turner, 2005). Organizations have multiple levels and hence, often multiple goals, presenting a challenge to team leaders in this task. Team leaders, as far as possible, must secure commitment and agreement to implementation at all relevant levels of the organization (Panzano & Roth, 2006).

Team leaders along with organizational representatives need to weigh the evidence for DBT, comparing it to other treatment options, and to the current organizational priorities in order to determine if DBT is a good match for the organization's goals. Table 1 summarizes four aspects of DBT that may relate to the goals of mental health services, the data available in the public domain and the information that the organization will need to collect in order to assess whether DBT is a possible candidate to address these goals. Each of these aspects of the treatment will now be considered.

First, the current policy context (DoH, 2008; NICE, 2009) increasingly emphasizes using an evidence-based approach to healthcare. Whilst a comprehensive review of the evidence base and its limitations for DBT is beyond the scope of this paper, the NICE guideline (NICE, 2009) systematically and comprehensively review the data for DBT and other treatments developed in recent years to treat borderline personality disorder. In summary, efficacy studies of DBT demonstrate reductions in suicide attempts and non-suicidal self-injurious behaviour, premature treatment termination, in-patient and A&E admissions, depression, anger and impulsiveness, and increases global and social adjustment (Lieb *et al.* 2004). Treatments with the most promise for clients with BPD tend to be highly structured, follow a coherent theoretical model, be high intensity and/or multi-modal and possess a strong emphasis on supervision of therapists or team working (NIHME, 2003; NICE, 2009). DBT possesses all of these characteristics.

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Table 2. *Functions and treatment modalities in DBT*

Function	Aim	Example modalities
Capability enhancement	Acquisition and a degree of strengthening of new skills of clients	Skills training groups
Motivational enhancement	Identification and treatment of factors that inhibit the utilization of more skilful means, such as emotions, cognitions, reinforcement contingencies	Individual DBT psychotherapy
Generalization	Further strengthening and generalisation of new skills to the non-therapy environment	Telephone consultation
Structure the environment	(1) Assist environment of the client to support and reinforce new skill use (2) Intervene in the system around the treatment programme to ensure effective delivery of the treatment	(1) DBT family therapy (2) DBT project group meetings
Enhance therapist capabilities and motivation	Acquisition of new skills and sustaining of motivation of therapists	DBT consultation team

Second, the principles of clinical governance emphasize a pro-active approach to risk management. DBT therapists precisely define clients' high-risk behaviours, most commonly suicidal behaviours. In-depth analyses of these behaviours form the core of the treatment. As the therapist and client study the antecedents and maintaining factors to the behaviours, the therapist develops comprehensive solution analyses to the problematic behaviours of the client. In specifically targeting suicidal and other high-risk behaviours as the first priority in each session, DBT not only continually monitors risk but crucially treats factors that increase risk in order to ameliorate it.

Third, Department of Health Guidance on risk management (DoH, 2007) and the National Confidential Inquiry into Suicide and Homicide (2006) emphasize the importance of coordinated, team-based, high-intensity treatment for clients at high risk of suicide. DBT provides one such a treatment approach as it is both a psychotherapy and a comprehensive, coordinated approach to the care of the client. DBT requires a team of practitioners who together deliver a five-function comprehensive treatment providing an entire service to the client group (Swales & Heard, 2008). Table 2 lists the five functions of a DBT treatment programme, with some example modalities.

The DBT team provides regular consultation to therapists providing an opportunity to identify problems in therapy and providing solutions for them. In addition, because of the multi-modal nature of the programme, clients are in contact with more than one therapist. Consequently clients receive support from other team members during a therapist's absence, e.g. holiday or sickness, and can receive coaching from another member of the team when difficulties arise in their relationship with their primary therapist

Fourth, public healthcare organizations increasingly must ensure the delivery of cost-effective services. At face value, the comprehensive team-based approach of a DBT programme increases its cost to an organization. Treatment gains in areas of healthcare that are often high cost (A&E visits, acute medical treatment resulting from suicidal behaviours, in-patient psychiatric treatment) may offset investment in the treatment programme. In services

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where clients may spend time in high-cost private or specialist NHS facilities the savings may be more substantial. Brazier *et al.* (2006) conducted a cost-effectiveness evaluation of DBT, amongst other treatments for BPD. Their study analysed four studies of DBT. In those where suicidal behaviour was a significant clinical feature of the client group the study concluded that the cost of a parasuicidal event avoided was £50 or less.

Assessing organizational suitability

Just as in therapy, prior to commencing DBT, a therapist assesses client suitability for the intervention; assessment of organizational characteristics (or of the part of the organization that will host the DBT programme) is an important first step. A number of studies suggest that larger organizations are more likely to innovate and implement new programmes of care (McCormick *et al.* 1995; Rogers, 2003; Turner & Sanders, 2005). This is one of the most robust findings in the innovation literature, although, size *per se* may not relate to innovation. Other variables associated with larger size that relate to innovation may account for the association, such as spare or 'slack' resources (Stirman *et al.* 2004; Panzano & Roth, 2006) or staff with high levels of specialism and/or expertise (Rogers, 2003). The relationship of these variables to innovation and implementation may vary depending upon the stage of implementation focused on in the study (Panzano & Roth, 2006). For example, complex organizations with highly knowledgeable and expert staff have a high rate of innovation proposals but often struggle to agree on what to implement. Organizations with high levels of bureaucracy and centralization are less likely to innovate but may have more success in ensuring long-term maintenance of implemented programmes (Rogers, 2003).

The culture and climate of an organization relate to innovation and implementation of new interventions. Organizational culture refers to the norms or rules, both explicit and tacit, within an organization about how the organization conducts its business. Climate, on the other hand, refers to the perceptions of workers about the organization and their role within it. Climate captures employees' intellectual and emotional responses to their work. These two constructs are related (Glisson & James, 2002; Scott *et al.* 2003) but refer to distinct aspects of an organization. A number of studies have begun to explore the relationships between these two constructs and aspects of implementation and outcomes within programmes of care. Constructive organizational cultures focus on the individual's capacity to develop and emphasize achievement and motivation. Such organizations are friendlier towards evidence-based practice (Aarons & Sawitzky, 2006) and staff rate them as more supportive (Glisson & Hemmelgarn, 1998; Gotham, 2004). Implementation of new practices is more difficult in organizations with 'defensive' cultures that focus on conformity and consensus (Hemmelgarn *et al.* 2006). Positive organizational climates directly affect client outcomes (Glisson & Hemmelgarn, 1998; Schoenwald *et al.* 2003) and indirectly influence outcomes through positive associations with other variables with a direct impact on outcomes, for example, therapeutic alliance (Aarons *et al.* 2003). Poor organizational climate also relates to a disparity between normal organizational performance and utilization of evidence-based practices (Aaron & Sawitzky, 2006).

Synthesizing some of these features of organizations, a number of research groups have begun to develop measures to assess organizational readiness to implement mental health interventions (Lehman *et al.* 2002; Simpson, 2002). Some programmes have their own particular scales. For example, Multi-Systemic Therapy (MST), an intervention for

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adolescents with offending behaviour as a primary problem (Henggeler *et al.* 1991), has its own site-assessment instrument to assess organizational readiness to implement.

When planning to implement DBT, reviewing the organization in terms of the factors discussed above relating to innovation may constitute a useful starting point. Formal assessment of organizational culture and climate is a possibility (Scott *et al.* 2003), but may only be worth the time investment in the case of large-scale implementations. Interviews/discussions with relevant staff are an alternative strategy. In the most common scenario, clinicians will implement DBT within their own organization and will be aware of some of the relevant aspects of culture and climate.

In pre-treatment, an important area for the therapist to examine is the client's previous experience with therapy. Similarly, team leaders may find it helpful to ascertain information about the history of implementation of new practices within their organization prior to commencing implementation of DBT. Interviewing those involved in previous implementations may prove useful in establishing the relevant organizational factors especially if there is a history of failed implementation. This analysis may reveal relevant organizational characteristics that need to be addressed prior to implementing DBT, or the decision not to implement DBT.

Orienting the system

Before gaining commitment from a client the therapist needs to orient him/her fully to the components of the treatment and what he/she will need to do to increase the likelihood of success. Similarly, in organizational pre-treatment, the team leader will need to orient the system, at each relevant organizational level, to what will be required in order to implement the treatment effectively. Comprehensive orientation comprises several components; a description of the client group for whom the treatment is designed; the evidence base for the treatment and the limitations of this evidence base; the main outcomes the programme aims to deliver; the comprehensiveness of the treatment programme; and resources required to deliver the programme. Orientation of the system is a separate task but in practice, as in therapy, the team leader in organizational pre-treatment weaves orientation together with gaining commitment, the final task of pre-treatment to which we now turn.

Gaining commitment

If the organization decides that DBT is an appropriate match for addressing some of its organizational goals, the team leader must gain commitment, or a series of commitments, from the organization to implement the treatment programme. In much the same way as in therapy, the client may express certainty that they want to change, but find it difficult to make all the necessary commitments to achieve the change, organizations are often keen to initiate organizational change but struggle in making the modifications required to deliver on their initiatives.

The implementation literature identifies this process of goal identification and commitment to the process of change as a vital component in any implementation sequence (Backer *et al*. 1998; Martin *et al.* 1998; Chorpita *et al*. 2002; Torrey *et al*. 2002; Barwick *et al.* 2005). Despite the agreement on gaining commitment to goals in the published literature, there is less discussion on the process and how to achieve this. Two aspects of this process will now be considered further.

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Resolving competing organizational goals

While an organization may desire the potential benefits offered by DBT, or indeed other treatment innovations offering similar outcomes, the organization also has a range of other goals and groups of clients whose needs must also be met. Some of these other goals may either directly or indirectly compete with the organizational goals relevant to DBT. If an organization decides to implement DBT, or any other innovation in practice, identifying and resolving these potentially competing goals increases the likelihood of successful implementation.

The implementation literature does not refer directly to the resolution of incompatible goals; however, there are parallels between clients changing the behaviours that led to a diagnosis of personality disorder and organizations changing the way in which they deliver services. Thus, in approaching the resolution of incompatible goals DBT team leaders may utilize similar strategies to those used in pre-treatment with clients. First, team leaders must identify whether implementing a DBT programme will meet the goals of the organization (see Table 1) and make these links explicit to organizational representatives. The second step is articulating clearly, which of the organizational goals are competing and working with organizational representatives on finding syntheses to these conflicts.

Active engagement in problem-solving the genuine difficulties presented by changing practice by both managers and clinicians is recommended. Most frequently, services prematurely foreclose on this debate and organizations invest in training in new approaches without any attention to the realities of implementation, in particular changes in working practices. Fixsen and colleagues (2005) name this approach the '*train and hope strategy*', i.e. you train staff and hope they will implement the new approach. Data from other treatment approaches would indicate that this is an ineffective implementation strategy (Kavanagh *et al.* 1993; Fadden, 1997; Turner, 2003; Poole & Grant, 2005; Turner & Sanders, 2006). Staff do train, which represents a cost to services, but seldom implement.

For example, rarely are additional funds and resources available for the implementation of a new treatment approach and thus the most common tension in services lies between the initiation of new programmes of care and the maintenance of current provision. Often management expects services to do both simultaneously. As DBT is an intensive treatment to deliver in terms of staff time, this tension will require active resolution before committing to implement the treatment. To facilitate finding syntheses to competing goals, the team leader endeavours to find the validity within both of the goals. Clinicians, including the team leader, can find this difficult if they have already developed a strong investment in delivering the treatment. They often fear that validating a management goal of maintaining current provision will lose them the opportunity of delivering the treatment; this fear in some cases will prove justified. However, recognizing the validity in the management perspective may lead, on occasion, to recognition by management of the value of the clinicians' perspective of offering a new treatment. From this position, it is then possible for both parties to evaluate whether there are any possibilities for service restructuring to resolve the tension, thereby enabling the service to continue to deliver current programmes of care and introduce a new treatment approach. Table 3 identifies a common pair of competing goals and shows some areas for the exploration of syntheses.

If syntheses to resolve the incompatible goals prove impossible to find, then a pros and cons analysis of implementing DBT can facilitate the organization in deciding whether to

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Table 3. *Identification and resolution of competing goals*

Goals	(1) To offer a structured intensive service to clients with a diagnosis of borderline personality disorder (BPD) (2) To maintain current waiting times for services
Potential goal conflict	To deliver goal (1) staff need allocated time from other duties leading to a decrease in available time to contribute to goal (2)
Areas in which to explore syntheses	(1) Do clients with BPD present in crisis, engage briefly and then end up being re-referred? Would a structured service impact this 'revolving door', reduce drop-out and re-referral? (2) Do clients with a BPD diagnosis present in crisis, consume a lot of resources in an unplanned way, reducing capacity to attend to the routine work of the service? Would providing more structured, intensive input smooth out the 'peaks and troughs' in demand and allow for more planned services to be offered with less disruption? (3) Do clients with BPD consume a lot of high-cost resources, e.g. out-of-area placements? Would offering a more intensive, local service release resources that could be deployed into the routine service offered? (4) Do staff experience high levels of stress and burnout from dealing with unpredictable crises and /or high-risk clients? If so, does this translate into high sickness rates or reduced effectiveness in the service? Would a more structured service with attention to staff training and support increase morale and reduce sickness, increasing availability for more routine work? (5) Do clients with a BPD diagnosis who are suicidal receive intensive monitoring and/or numerous uncoordinated interventions? Would a more targeted, active approach to risk reduction use more or less resources, or be resource neutral in terms of time, than the clients currently receive?

implement or not. The organization may decide to implement DBT and accept the adverse impact on waiting times, for example. Organizational representatives may decide that they would prefer clients to wait a little longer for an evidence-based service rather than have more rapid access to a regular service. Equally, the organization may decide not to implement DBT and to tolerate whatever the problems were that led to the consideration of DBT in the first instance. Either decision is reasonable. DBT is not the only treatment that a system needs to consider and it may not be the right moment for the organization to implement the treatment.

From the literature on implementation, a number of commentators suggest that following on from a commitment to implement, forming a steering or advisory group for the project is beneficial. This group would have representatives from key stakeholders in the organization and may include client representatives. The purpose of this group is to ensure that the implementation remains on track, to keep stakeholders informed of the project's progress, to ensure that organizational objectives are kept in mind, and to brief all parties on implementation successes and difficulties. Such a group can also help buffer the project against inevitable system and personnel changes that will occur along the way (Backer *et al.* 1986; Barwick *et al*. 2005; Stirman *et al.* 2004).

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Therapeutic stance in organizational pre-treatment

How to conduct discussions to gain commitment to implementation is not a particular focus in the broader literature. Within DBT, however, given the recursive nature of the treatment, the natural place to begin is by applying the treatment strategies to the process. In commitment discussions, the spirit in which strategies are utilized is as important, if not more so, than the particular strategy employed. Just as in therapy with a client, the team leader employs the strategies in the best interests of the organization and the clients that it serves. Persuading a system to implement DBT by employing these strategies dishonestly, for example by only paying lip-service to the organization's goals or over-selling the evidence base for DBT, does not serve the long-term interests of either the clients or the treatment and is not recommended.

To be maximally effective in commitment discussions with management and to avoid agreement to implement in the absence of sufficient organizational commitment, three strategies are especially useful. The first is remaining dialectical. Dialectical philosophy emphasizes that no one perspective holds a monopoly on the truth and thus promotes searching for validity in multiple perspectives. Maintaining a dialectical stance will enable the team leader to more effectively evaluate whether DBT will meet the organization's goals when contrasted with other options. Moreover, if DBT is selected as the intervention to implement, remaining dialectical will assist the team leader in pursuing solutions to resolve incompatible goals, reducing the likelihood of agreeing to implement without the necessary organizational commitments.

Second, team leaders will benefit from holding onto any attachment to doing the treatment lightly. Zen Buddhism is a core philosophy at the heart of DBT. One challenging principle from this tradition is 'Attachment is the root of all suffering'. Once we attach to an idea, a person, a situation, a state of mind, the possibility of losing this desired idea, person, situation, state of mind, or not achieving it, is an inherent part of the attachment. Suffering occurs when we do not accept the loss or try to prevent it. In Zen philosophy the idea is not to hold on too tightly to attachments, as this may activate strong emotions and potentially drive us down unhelpful avenues, but rather to notice attachments and be aware of the consequences of them. Therefore, in commitment discussions embracing a willingness to let go of the desire to perform the treatment may help clinicians avoid premature foreclosure in the absence of sufficient organizational commitment.

The third strategy for clinicians to embrace is a non-judgemental approach to both the organization and its representatives with whom discussions are taking place. Adopting a non-judgemental stance originates in the mindfulness component of DBT. The term 'judgement' in this case refers to value judgements ('good/bad', 'should/shouldn't', 'ought/oughtn't). Clinicians are used to the idea of being non-judgemental towards their clients (although therapists often find maintaining this stance with clients with a BPD diagnosis a challenge in the long term) and, with a bit of encouragement, towards themselves too. Developing a non-judgemental stance towards the systems in which they work and of the managers and administrators with whom they work seems significantly more difficult. Among clinicians in healthcare settings, engaging in judgemental thinking and discussion about the system is frequently reinforced, both overtly by fellow clinicians, but also covertly. Clinicians often report finding judging enjoyable and self-validating of the every-day challenges they face in their work. A judgemental stance often leads to an escalation in affect which dysregulates thinking processes and may block effective problem solving. A judgement that

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the organization 'should' just support the introduction of DBT prevents an active discussion about the very legitimate barriers to a change in practice. Therefore, in organizational pre-treatment discussions mindfulness of judgements and, if they are especially intense, cognitive restructuring of them are prerequisites. Finally, and this is rather advanced, team leaders need to develop the capacity to validate the organization's perspective!

Summary

Implementing any innovation in practice is a challenge. Prior to implementation, conceptualizing the process within an organization as a form of pre-treatment enables the identification of clearly identified stages and strategies for clinicians to follow. In summary, these are as follows:

- Identify organizational priorities in respect of the client group and for mental health services.
- Evaluate whether DBT is a genuine fit for these priorities.
- Assess the readiness of the organization to implement an innovation. On the basis of the assessment address any factors likely to interfere with implementation.
- Comprehensively orient the system to the requirements for implementation.
- Gain commitment for time to train, and necessary changes in working practices.

These stages may facilitate clinicians in the difficult task of introducing a new treatment or new service delivery mechanism to healthcare settings.

Declaration of Interest

Dr Swales is Director of BIDBT that delivers licensed training in DBT in the UK. She is married to the managing director of the company that produces BIDBT training events. She was a member of the guideline group that wrote NICE Treatment Guideline No. 78 on the Treatment and Management of Borderline Personality Disorder. She is also a member of the guideline development group for the guideline on the Longer-Term Management of Self-Harm currently in development with NICE.

Further reading

- A comprehensive review of the implementation process is provided by Fixsen *et al*. (2005).
- Swales & Heard (2008) provides a brief introduction to DBT including discussions of pre-treatment with both clients and systems (chapters 13 and 15).
- Swales (2010) discusses the tasks in selecting and training a team in DBT.

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Learning objectives

(1) Understand the four tasks in organizational pre-treatment and how they apply to implementing DBT in healthcare settings.
(2) Know the four main organizational goals for which DBT provides a potential treatment solution.
(3) Understand how DBT treatment principles and strategies can be applied to obtaining organizational commitment to implementation.

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