DIALECTICAL BEHAVIORAL THERAPY

Dialectical Behavioral Therapy (DBT) is a comprehensive, multi-diagnostic, modularized behavioral intervention designed to treat both adults and children/adolescents with severe mental disorders and ~~out-of-control~~uncontrolled cognitive, emotional and behavior patterns, including suicidal and/or self-harming behaviors.

DBT was originally developed as a treatment for individuals with Borderline Personality Disorder (BPD). BPD is characterized by a range of self-destructive behaviors (potentially including self-injury, suicidality, substance use, as well as problems in interpersonal relationships) which may be best understood as the consequences of the inability to effectively regulate emotions. These deficits are often the result of biological emotional sensitivity paired with an environment that was not responsive during childhood. Over the years, DBT has demonstrated effectiveness for a wide range of disorders, most of which are associated with difficulties in regulating emotions and associated cognitive and behavioral patterns.

DBT is a research-based, empirically validated treatment delivered via four modalities – individual therapy, group skills training, telephone coaching and participation by DBT-trained providers in weekly 'Consultation Team' meetings.

DBT is a model used within the service set for outpatient therapy by licensed practitioners. See Section 2.3 -Outpatient Therapy by Licensed Practitioners of this manual chapter.

Evaluation of the Evidence Base for the DBT~~EBP~~ Model

Evaluation of the evidence base for the DBT model has been conducted by national registries.

DBT is listed as an evidence-based practice by the following national registries:

1. National Registry of Evidence-based Programs and Practices (NREPP);
2. California Evidence-Based Clearinghouse for Child Welfare; and
3. Suicide Prevention Resource Center.

National Registry of Evidence-based Programs and Practices (NREPP)

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) scored DBT in 2006 as a "highest rated" practice, with a rating of 3.7 out of 4 in terms of the quality of evidence showing DBT's effectiveness in reducing suicide attempts. This review gave strong ratings to DBT in terms of the quality of evidence for DBT's effectiveness treating nonsuicidal self-injury, psychosocial adjustment, treatment retention, drug use, and symptoms of eating disorders. SAMHSA is no longer updating NREPP program descriptions; however, the archived NREPP program description can be found here: https://sprc.org/wp-content/uploads/2023/01/Dialectical-Behavior-Therapy-NREPP-Legacy-Listing.pdf.

DBT has been implemented and evaluated in therapeutic settings in numerous countries. Service settings include inpatient, outpatient, and other community settings and across different genders, races/ethnicities, and age groups. Adaptations of DBT have been developed for numerous populations and presenting problems.

California Evidence-Based Clearinghouse for Child Welfare

https://www.cebc4cw.org/program/dialectical-behavior-therapy-dbt/
DBT is listed on the CEBC, and is rated as "Promising Research Evidence."

Suicide Prevention Resource Center (SPRC)

https://www.sprc.org/resources-programs/dialectical-behavior-therapy
SPRC designated this intervention as a "program with evidence of effectiveness" based on its inclusion in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

Target Population Characteristics

DBT was created for use with children, adolescents, and adults as a treatment for people with multiple, severe problems across multiple domains of functioning, which may include, but are not limited, to the following:

1. Borderline Personality Disorder;
2. Suicide and parasuicide;
3. Drug dependence;
4. Major drug dependence;

5. Opiate use;

6. Eating disorders;

7. Emotional dysregulation;

8. Impulsiveness;

9. Anger;

10. Interpersonal aggression; and

11. Trauma.

DBT may require adaptation for use with individuals with a psychotic disorder; these individuals will need additional support, or have their psychotic disorder symptoms well-managed concurrent with DBT.

There is a sizable and growing body of literature demonstrating the effectiveness of DBT in persons with mild or moderate intellectual disabilities and in persons with Autism Spectrum Disorders (ASDs). With adaptations, DBT should be considered as a legitimate therapy option for persons with intellectual disabilities.

Philosophy and Treatment Approach

DBT is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus, blended with acceptance-based strategies, and an emphasis on dialectical processes. A "dialectical approach" is taken to treat patients with multiple disorders and to encourage flexibility in thought processes and behavioral styles used in the treatment strategies.

Comprehensive DBT addresses five components, or functions, of treatment:

1. Capability enhancement (skills training);

2. Motivational enhancement (individual behavioral treatment plans);

3. Generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment);

4. Structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and

5. Capability and motivational enhancement of therapists (therapist team consultation group).

DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of clients.

Goals

Behaviors targeted in individual therapy sessions are as follows:

1. Eliminate life-threatening behavior;

2. Reduce therapy-interfering behavior;

3. Reduce quality of life-interfering behavior; and

4. Increase behavioral skills.

DBT targets these behaviors in the service of achieving DBT's main goal, which is defined as the individual in treatment creating "a life worth living."

Specific Design of the Service

The DBT program ensures there is a designated DBT primary therapist (usually the client's individual therapist) for each beneficiary. The DBT Team follows the Linehan model in the provision of DBT services which consists of:

1. Individual therapy with a DBT-trained therapist

An individual therapy session, typically provided for one hour per week, would include the clinician and client. Portions of a session may include important members who support the client (caregivers, other providers), as needed. These sessions focus on engagement, motivation, assessment, and tailoring of cognitive-behavioral strategies to each client. Clients are taught how to identify and measure progress toward goals, assess problems, and solve problems within

sessions. The individual therapist is available to clients outside of session times, to motivate and coach clients, avoid higher levels of care, and achieve generalization of skills into everyday life.

2. DBT skills training group

A DBT skills training group is a 120-150-minute session held weekly in a group format, with all clients participating in comprehensive DBT. Group time is divided in half, with an hour to review homework from the past week, and an hour to teach new skills and assign homework for the next week. There is often a short break between the hours, if they are taught consecutively. Group is led by a leader and co-leader, who each have separate roles to perform. Groups are limited in size to enable the group to function well and to allow each client to share about their homework every week. DBT experts suggest that DBT skills-training groups are most effective with at least two participants; there is no strict maximum number of clients in a DBT skills training group, but keeping the group to 12 or fewer participants is good practice. The focus of group is to teach new skills to address potential client deficits in the areas of mindfulness, relationships, emotion regulation, and crisis management. Handouts are provided to clients, and these plus the lecture points to be covered are found in manuals published by Linehan for adults and Rathus and Miller and Linehan for adolescents.

For the treatment of adolescents, it is highly recommended that the skills training group be a multifamily skills training group, to include as active participants both the adolescent and their caregiver(s). In the multifamily group format, caregivers learn and practice skills alongside their adolescent, helping caregivers to be better able to support the youth as they apply DBT strategies to their daily lives, and also allows caregivers to learn skills for their own use managing difficult emotions in interactions with their adolescent. The caregiver participating with their adolescent in the multifamily group, should be the same caregiver to participate throughout the duration of the group. In the case of a multifamily group with both adolescent and caregiver participation, a recommended best practice is to keep the group to seven (7) or fewer adolescent participants, each with one caregiver participating as well.

3. Telephonic, therapeutic coaching (24-hour availability)

A DBT program professional, usually the client's individual therapist, is available by telephone to each client to extend problem-solving and coach the use of skills

in real-world situations. DBT coaching is not therapy, but instead is brief, targeted, and specific support, aimed to help the DBT client generalize skillful behavior in all relevant contexts. Coaching may be conducted via text message. The amount and type of coaching may be tailored to meet individual client needs, and may include planned, proactive check-ins, and/or being available to the client in the midst of a crisis. If the coaching is provided by a professional who is not the client's primary therapist (for instance, if coaching is provided by agency staff who rotate in availability for after-hours coverage), then the coaching response should follow guidance from a detailed, client-specific DBT crisis plan completed by the client's individual therapist.

Recommended Intensity

1. Individual sessions are recommended for one hour per week; and

2. Group therapy sessions are 120 to 150 minute weekly sessions in a group format.

Recommended Duration

A course of DBT treatment is typically completed in 6-12 months but may be extended for additional 6-month time periods; the duration of treatment will vary based on the extent and complexity of need.

If MCO policy requires prior authorization for outpatient therapy by licensed providers, including treatment episodes of DBT:

1. The provider requesting prior authorization should note that the evidence-based model DBT is being used. An initial authorization to cover a 6-month episode of treatment is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the individual. A typical 6-month episode of treatment may include:

   a. Individual therapy sessions: 4 pre-treatment sessions, 24-25 treatment sessions, 3-4 termination sessions; and

   b. DBT skills training group (group therapy): 24-25 sessions.

2. If additional sessions beyond the initial authorization are needed to complete a treatment episode of DBT, the re-authorization request should indicate that the

specialty model DBT is being utilized, and should note the reason for a need for additional sessions to complete the treatment episode of evidence-based care.

Delivery Setting

As an outpatient therapy service delivered by licensed practitioners, allowed modes of delivery include individual, family, group, on-site, off-site, and tele-video. Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements.

A comprehensive DBT program is typically provided in an outpatient setting. Telehealth is an allowed modality, and use of telehealth for DBT skills training groups in particular may support continued and consistent client engagement, especially when travel or transportation is a barrier to client engagement.

Components of DBT may be delivered, with some adaptation, in a residential or inpatient setting; however, this would not be billed as a separate service, instead would be part of the active treatment plan reimbursed as part of the comprehensive inpatient or psychiatric residential treatment facility (PRTF) rate.

Cultural Considerations

DBT has been demonstrated to work across numerous populations and is amenable to cultural adaptations. DBT has been evaluated and found to be effective with individuals from diverse backgrounds in regard to age, gender, sexual orientation, and ethnicity, including children (seven to twelve year olds) and adolescents (twelve to eighteen year olds). DBT was originally developed in the United States but has since been researched and evaluated around the world, including randomized control trials in Australia, Europe, South America, and Asia. Research trials have shown that DBT can be implemented effectively across cultures.

Provider Qualifications and Responsibilities

EBP Model Requirements

To be considered a comprehensive DBT program with fidelity to the evidence-based model, DBT must be delivered by a team of clinicians, and must include the following four (4) core components:

1. **Individual therapy with a DBT-trained therapist**: Typically provided for one hour per week, face-to-face (including telehealth) with an LMHP clinician and client;

2. **Telephonic, therapeutic consultation/support/coaching (24-hour availability)**: A DBT program professional, usually the individual therapist, is available by telephone to each client at all times during the week, to extend problem-solving and coach skills to be used in real-world situations;

3. **DBT skills training group:** Typically 120-150-minute session held weekly in a group format, with all clients participating. Group is led by a leader and co-leader. For the treatment of adolescents, it is highly recommended that the skills training group be a multifamily skills training group, to include as active participants both the adolescent and a caregiver; and

4. **Peer consultation team meetings**: Each DBT team member (individual therapist, skills group leader and co-leader) participates in a weekly, one-hour consultation team meeting with other DBT practitioners in the same program. Teams are small enough that each provider can provide an agenda item most weeks. The hour-long meeting is used for peer consultation, following DBT model guidelines. The team may meet for a second hour, to be used to provide training to providers, where necessary. This format can be run consecutively or as two separate meetings in a week.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in Section 2.3 -Outpatient Therapy by Licensed Practitioners of this manual chapter and requires training in the treatment model as minimum requirements. A graduate degree in a mental health field is required.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:

   a. 6A Psychologist – Clinical;

   b. 6B Psychologist – Counseling;

c. 6C Psychologist – School;

d. 6D Psychologist – Developmental;

e. 6E Psychologist - Non-declared;

f. 6F Psychologist – Other; and

g. 6G Psychologist – Medical.

2. PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker;

3. PT AK Licensed Professional Counselor (LPC) PS 8E LPC;

4. PT AH Licensed Marriage & Family Therapists (LMFT) PS 8E;

5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;

6. PT 19 Doctor of Osteopathic Medicine PS:

a. 26 Psychiatry;

b. 27 Psychiatry; Neurology; and

c. 2W Addiction Specialist.

7. PT 20 Psychiatrist PS:

a. 26 Psychiatry; and

b. 2W Addiction Specialist.

8. PT 78 Registered Nurse (APRN) PS 26; and

9. PT 93 Clinical Nurse Specialist (APRN) PS 26.

Training

Training and resulting qualification to provide the DBT service under Louisiana Medicaid can be achieved in several ways.

DBT-Linehan Board of Certification

DBT-Linehan Board of Certification (DBT-LBC) is a nationally-recognized source of qualification to provide DBT therapy certification. Training requirements for DBT-Linehan Board certification are a minimum of 40 DBT-specific didactic hours,12 months of DBT team experience, clinical experience in DBT, skills training through homework assignments during training, a written exam, videos demonstrating DBT (submitted to certification body), and formal training in mindfulness. After training, passing a written exam is required for full certification. Once the certification process has been completed by individual therapists, they are listed in a searchable database on the website at https://dbt-lbc.org/index.php?page=101144

Office of Behavioral Health (OBH) -sponsored DBT training program

Completion of an OBH-sponsored DBT training program is another method to achieve training and qualification to provide DBT therapy under Louisiana Medicaid.

Provider agency teams who apply for and enter into an OBH-sponsored DBT training program will complete a training process that will include a minimum of seven days of didactic training and 24 consultation calls, typically over a 9-12 month period. This training program will typically begin with several days of didactic training, followed as soon as possible by DBT service provision to clients with the support of weekly (which may later move to biweekly) consultation with the expert DBT trainer, followed by additional days of didactic training and continuing consultation calls.

OBH-approved DBT qualification

The provider agency team, along with the individual practitioners on that team, will be assessed by the DBT trainer throughout the consultation process. Trainer assessment of practitioner and team competence will require practitioner submission of videotaped sessions for review. The DBT trainer will review videotaped sessions and score competence on the following scales to assess both team and individual practitioner competency in the core DBT components:

1. Coaching Scale;

2. Individual Therapy Scale;

3. Skills Training Group Scale; and

4. Consultation Scale.

To achieve completion of an OBH-approved DBT training program leading to OBH-approved DBT qualification, practitioners who are members of an agency team engaged in an OBH-approved DBT training program must:

1. Complete all didactic, consultative, and videotape submission components of the OBH-approved DBT training program; and

2. Achieve passing scores on the relevant scales assessing competency.

Upon successful completion, the individual practitioner(s) on the team will receive documentation of completion of an OBH-approved DBT qualification.

An additional option for achieving qualification to provide DBT under Louisiana Medicaid, may be used by practitioner teams who have previously engaged in a non-OBH-sponsored DBT training program by their own arrangement. For practitioner teams who have already completed DBT training, the team may seek OBH-approved DBT qualification by engaging in the steps noted above for "OBH-approved DBT qualification." To achieve OBH-approved DBT qualification, practitioners who are members of the agency team must:

1. Submit documentation of didactic and consultative components of a completed DBT training program;

2. Complete videotape submission components; and

3. Achieve passing scores on the relevant scales assessing competency.

Upon successful completion, the individual practitioner(s) on the team will receive documentation of completion of an OBH-approved DBT qualification.

Quality Assurance

Outcomes

Measuring the progress and outcomes of treatment is a critical aspect of DBT and is part of the evidence-based model. DBT typically uses a set of standard tools, for both adolescent and adult clients, all of which are open source and accessible to providers at no cost. Standard tools to measure the outcomes of treatment include:

1. **Borderline Symptom List 23 (BSL 23)**: self-report measure of symptoms such as affective instability and recurrent suicidal/self-harming behavior;

2. **Difficulties in Emotion Regulation Scale (DERS)**: self-report measure of emotion regulation problems; and

3. **Ways of Coping Checklist**: self-report measure of the individual's application of therapeutic skills to cope with stressful events.

Outcomes measures must be completed by DBT program clients at minimum pre- and post-treatment, and at least at six-month intervals. If a client is receiving a twelve (12)-month episode of care, it may be beneficial to schedule outcomes measurement at four (4) month intervals to better support progress tracking and treatment adjustments over the course of the episode of care.

Client-level data on outcomes metrics will be documented in the client's health record, interim measures of progress should be documented in requests for continued service authorization, and pre/post measures included in documentation such as discharge summaries.

DBT provider teams shall aggregate client outcome data at the program level, and submit de-identified program-level aggregate outcomes data to all contracted MCOs (or their designee) semi-annually.

Model-Specific Documentation Requirements

The DBT model does not prescribe a specific format for progress notes, however, use of the DBT model in therapy can be observed in a client's record by the presence of specific references in the progress note for each session:

1. Clients complete "Diary Cards" each week to bring to their individual therapy session. Data from client-completed diary cards is documented in the progress note for each session. This data on client symptoms and behaviors is then used to set the agenda for the session;

2. Agenda for the session, including the behavioral targets for the session;

3. In most sessions, reference to a DBT-specific assessment (chains, missing links, behavioral assessment) that is used to determine interventions; and

4. Reference to the intervention (i.e. cognitive modification, skills, contingency management, exposure, problem solving) used in the session, and what the client committed to doing for homework or in the future.

Fidelity

As a team-based model, fidelity to the DBT model is best assessed at the team/program level. A DBT program may demonstrate fidelity to the DBT model through delivery of specific program components, policies, and procedures.

These include:

1. **Team**
   Delivery of the comprehensive DBT model requires a team, preferably with 4-6 clinicians trained and qualified to provide DBT individual therapy, and each qualified clinician carrying a caseload of at least 2-3 clients for DBT individual therapy. A DBT team of two DBT-trained and -qualified clinicians is the minimum to maintain qualification as a DBT program; the status of having only two qualified clinicians on a DBT team should be considered temporary while the team works to replace team members and coordinate replacement training for new team members, to build back up to a full DBT team;

2. **Training**
   All DBT team members providing DBT individual therapy must be trained and qualified to provide DBT; please see "Training" in this section for requirements:

   a. A qualified DBT team may add new team members (based on need for expansion of services, and/or need to replace practitioners due to staff

attrition) initially by allowing new DBT team members to begin co-leading skills training group prior to completing DBT didactic training, as long as:

i. The primary skills training group co-leader has completed DBT training; and

ii. The new team member completes DBT training within 6 months of starting to co-lead DBT skills training groups.

b. A qualified DBT team may add new team members providing DBT individual therapy after the new team member has completed initial DBT didactic training.

3. **Individual therapy**, delivered weekly by a DBT trained clinician;

4. **DBT skills training groups**, held weekly with two clinician co-leaders;

5. **Peer consultation group** with all team members, held weekly, facilitated by the lead clinician from the DBT team. Consultation group with team members addresses group functioning, planning, and dynamics, in the therapy group; and

6. Telephonic, therapeutic coaching with 24-hour availability to each client.

Annually following completion of DBT training and qualification, the DBT program will complete a **self-assessment of program fidelity** using an OBH-approved process adapted from the DBT-LBC Program Certification Self-Assessment. The DBT program shall use this self-assessment process to review and if needed revise policies and practices, including implementing a corrective action plan as needed for improved alignment with best practices. The self-assessment, and if applicable the corrective action plan, shall be made available at the request of OBH or LDH-contracted managed care organizations.

Following completion of DBT training and qualification, qualified DBT programs will be **externally-reviewed for DBT program fidelity** on a regular basis, using an OBH-approved process adapted from the DBT-LBC Program Certification Self-Assessment and inclusive of practitioner completion of DBT continuing education. DBT program fidelity reviews will be completed at a frequency of every 2 years following DBT program qualification. Fidelity reviews may be requested at a higher frequency if issues are identified that trigger additional review.

Limitations/Exclusions

Limitations and exclusions noted in Section 2.3 -Outpatient Therapy by Licensed Practitioners of this manual chapter apply.

Billing

A DBT practitioner may receive reimbursement for the DBT service, when delivering DBT as part of a DBT team that is:

1. Trained and qualified to deliver DBT as described in the "Training" section, demonstrated by either:
    a. Certification from the DBT-Linehan Board of Certification (DBT-LBC);
    b. OBH-approved DBT qualification; or
    c. Engaged consistently and in good standing (as documented in writing by the OBH-sponsored training organization) in an OBH-sponsored DBT training program that will lead to an OBH-approved DBT qualification, following the agency and practitioner's completion of the initial didactic training sessions, while under consultation with an OBH-approved DBT trainer.
2. Following initial qualification to deliver DBT, the team also must complete periodic fidelity reviews; please refer to the "Fidelity" section;
3. Only direct staff face-to-face time with the individual or family may be billed. DBT is a face-to-face intervention with the individual present. Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements;
4. The DBT model is delivered in three (3) modalities:
    a. Individual therapy;
    b. DBT skills training group sessions; and
    c. Therapeutic coaching (24-hour availability), not billed.

5. The group therapy session must be co-led by two (2) DBT practitioners, and must be delivered for a minimum of 90 minutes; in standard practice the DBT skills training group typically has a duration of 120-150 minutes; and

6. For DBT skills training groups which are co-led by two practitioners, one practitioner submits the group therapy claim for a client, with progress notes to be co-signed by both of the group co-leaders. All standard record-keeping requirements must be met, including recording start and end time of service. The co-leader of the DBT skills training group who does not submit the claim, may not have completed the DBT qualification, but must complete initial DBT didactic training within six (6) months of beginning to co-lead DBT skills training groups.