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# DIALECTICAL BEHAVIOUR THERAPY

## AN OUTLINE FOR THE FUTURE DIRECTION AND DEVELOPMENT OF NEW ZEALAND

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## ACKNOWLEDGEMENTS

Te Pou would like to acknowledge and thank John Gawith, Clinical Director, Te Whare Mahana\* and Mike Batcheler, Clinical Psychologist for leading this report.

This report was commissioned by Te Pou to review the use of dialectical behavioural therapy (DBT) in New Zealand in 2009, and to identify future DBT training and development needs.

A statement relating to potential conflicts of interest is contained within.

*\* Te Whare Mahana is a non-government organisation provider of residential intensive therapeutic services, community outreach and employment services for the mental health sector, based in Golden Bay.*

## EXECUTIVE SUMMARY

This report was written at the request of Te Pou to assess the current status of dialectical behaviour therapy (DBT) in New Zealand, to review the therapy's recent history and to offer suggestions for future training and service development in New Zealand.

DBT is the treatment with the strongest evidence base for assisting people with complex multi-diagnostic and high-risk problems, such as borderline personality disorder. New Zealand has a small pool of expert DBT trainers, called DBTNZ, who have benefited markedly from a relationship with the world-leading Seattle-based Behavioral Tech (an organisation mandated by the treatment developer to train people in DBT). This relationship commenced through the Mental Health Workforce Development Programmes (now known as Te Pou) in 2005.

We researched the views of district health board general managers and clinical leaders, along with a sample of consumer advisors, DBT leaders and clinicians. Fourteen district health boards reported using some aspects of DBT, with eight having specialist DBT services. Generally there is strong support for DBT and a wish to improve and extend DBT provision. There are a number of barriers to improvement, including cost, access to training and expert knowledge.

The various options for training and non-training based service development have been considered. The latter include assisting services to (1) build their DBT capability, (2) structure their DBT programme effectively within current services and (3) provide clinical and leadership support. DBTNZ is the most developed local training resource but remains under-used and needs an organisational capability to increase its performance. Behavioral Tech remains a lead provider of training materials and expertise internationally. Based on the feedback from district health board respondents and consumers, it is recommended that DBTNZ is assisted to develop its organisational capability so it can become an international affiliate of Behavioral Tech and provide more cost-effective training in New Zealand.

National DBT coordination and administration will assist in training provision (with DBTNZ) and non-training-based service development. A number of options outlined will assist in assisting small, remote and non-government organisation services to access DBT training and to provide further intensive training designed to build the next cohort of services aiming to improve services available to service users.

# CONTENTS

Executive Summary .....	3
Background .....	6
An Overview of the Development of DBT in New Zealand .....	6
DBT Training in New Zealand .....	6
Strengths and Sector Relevance of DBT .....	7
The Role and Function of DBTNZ.....	7
DBTNZ History .....	7
Overall Goals of the Project .....	8
Key Relationships .....	8
Who are DBTNZ? .....	8
DBTNZ Capability .....	9
Training.....	9
Organisational .....	9
Strengths and Sector Relevance of DBTNZ .....	9
DBTNZ's Challenges and Barriers .....	9
The Role of Behavioral Tech .....	9
Behavioral Tech Training.....	10
Two-Day Formats .....	10
DBT Intensive Training .....	11
Cost-Benefit Analysis of Intensive Training.....	11
Benefits to Clients of Implementing a Formal DBT Programme.....	12
Benefits to Services of Implementing a Formal DBT Programme .....	12
A Survey of Key Issues and Ongoing Development Needs of Services and Clinicians .....	13
The Number of Clinicians Trained in DBT in New Zealand .....	13
Determining the Current Status of DBT in New Zealand .....	13
Analysis of Survey Responses .....	14
Do Organisations Provide Specialist Services for Borderline Personality Disorder? ...	14
What Level of DBT Implementation do Organisations Provide? .....	14
Use and Perceived Effectiveness of DBT .....	15
Future Training Needs .....	16
Funding Issues.....	17
How to Structure, Support and Provide a DBT Service within New Zealand Agencies	18
Barriers to Providing DBT .....	18
Consumer Feedback .....	19
Summary of Development and Status of DBT in New Zealand .....	21
Future Development.....	22
The Goals.....	22
Options for the Future Direction and Development of DBT in New Zealand.....	22
What are the Future Options for Training?.....	22
Local Training with No International Links .....	23
Training Directly from Behavioral Tech using DBTNZ trainers. ....	24
Training by DBTNZ as an International Affiliate of Behavioral Tech .....	25
What Kind of Training Should be Offered in the Future? .....	26

What are the Future Options for Other Forms of Support and Coordination of Networks to Encourage and Promote DBT? .....	27
Advice and Direction on How to Develop the Elements of Effective DBT Treatment ....	27
Advice and Direction on How to Structure and Provide a DBT Service within New Zealand.....	27
Clinician-Level Support.....	28
How to Provide Support and Coordination .....	28
Recommendations for Future Direction and Coordination .....	28
Recommendation One: National DBT Coordination.....	28
Recommendation Two: Help DBTNZ Work.....	29
Recommendation Three: Assist Small, Rural and Non-Government Organisation Services .....	29
Recommendation Four: Kick-Start Some More Services .....	30
Options and Costs .....	30
Option A: National DBT Coordination .....	30
Option B: Coordination and Development of DBTNZ .....	30
Option C: Assist Small, Rural and Non-Government Organisation Services.....	30
Option D: Kick-Start Some More Services.....	30
References .....	33
Appendix A.....	35
Statement of Potential Conflicts of Interest .....	35
Appendix B .....	36
Borderline Personality Disorder and DBT.....	36
About Borderline Personality Disorder.....	36
What is DBT?.....	36
Appendix C.....	38
Profiles of DBTNZ Trainers.....	38
Appendix D.....	41
Structured Interview Questions.....	41
Appendix E.....	42
How to Tell if a DBT Programme is Likely to be Effective .....	42
Appendix F.....	43
A Consumer Advisor’s Perspective on the Impact of DBT in One New Zealand District Health Board.....	43

# BACKGROUND

## AN OVERVIEW OF THE DEVELOPMENT OF DBT IN NEW ZEALAND

Dialectical behaviour therapy (DBT) is a well-established evidence-based treatment for people with complex multi-diagnostic problems, such as borderline personality disorder. DBT was designed to treat individuals who present with frequent suicide attempts, repeated self-harm, impulsivity, aggressive behaviour, high emotional intensity and co-morbid mental health diagnoses. Morbidity and mortality figures for borderline personality disorder are at least equivalent to those of other major mental health problems, such as schizophrenia and bipolar disorder (Paris, 2002). DBT has been a mechanism to increase the knowledge and skills of front-line mental health staff. For a more comprehensive description of borderline personality disorder and DBT see Appendix B.

## DBT TRAINING IN NEW ZEALAND

DBT treatment manuals were first published in 1993 (Linehan, 1993). The first attempts to provide DBT in New Zealand occurred in 1998, within Auckland District Health Board. Prior to 2000 most DBT training in New Zealand was self-taught, with clinical learning coming from the DBT manual, small group learning about DBT and some clinicians attending short DBT-related training courses overseas.

In 2000, Auckland District Health Board sponsored the first New Zealand intensive DBT training, supplied by Seattle-based Behavioral Tech. Three Behavioral Tech trainers from the USA (Cindy Sanderson, Amy Wagner and Kelly Koerner) provided the intensive training to approximately 70 clinicians, mainly from the Auckland and Waikato areas. The intensive format at that time was five days of training, six months of programme implementation and homework, followed by a further five days of training and programme consultation (henceforth referred to as 10-day intensive training).

During 2003–2004, Counties Manukau District Health Board hosted a 10-day intensive training with a two-day follow-up. Again approximately 70 clinicians were trained in DBT, mainly from the greater Auckland, Northland and Waikato areas. The US-based trainers were Dr Elizabeth Simpson and Dr Shireen Rizvi.

During 2005–2007 a national DBT intensive training took place in Wellington as part of the DBTNZ project, sponsored by Mental Health Workforce Development Programmes. Seventy clinicians from Wellington, Palmerston North, Northland, Waikato, Taranaki, Rotorua, and Nelson/Marlborough District Health Boards, and Te Whare Mahana (a Golden Bay-based non-government organisation service provider), took part in the 14-day course. The US-based lead trainer was Dr Elizabeth Simpson. This was the first training to include a DBTNZ trainer, Mike Batcheler.

During 2007–2008 Counties Manukau District Health Board hosted a fourth DBT intensive training in New Zealand with those trained again coming largely from the Auckland and Waikato areas. The US-based trainers were Dr Shari Manning (Behavioral Tech president) and Dr Tony Du Bose. Some sections of the training were presented by a variety of DBTNZ trainers.

Other DBT training has included a foundational training in Wellington in 2008. This was attended by approximately 60 clinicians and provided by Dr Robin McCann and Dr Emily Cooney and was designed to support already established DBT teams. The training consisted of a five-day session of didactic teaching combined with learning on the job in the context of a fully functioning programme.

In addition, there have been about six two-day introductory DBT trainings, as well as several DBT trainings carried out in the child and adolescent mental health sector in New Zealand.

From June to October 2008, Dr Robin McCann was based at Te Whare Mahana in Golden Bay for a six month residence. Te Whare Mahana developed a programme that included working with established DBT teams and offer advanced DBT training. This was a major development opportunity for New Zealand's DBT teams and the venture was extremely well received.

### STRENGTHS AND SECTOR RELEVANCE OF DBT

- DBT has a growing evidence base for complex presentations within addiction, adolescent and family services and corrections. DBT has a significantly stronger evidence base than other treatment including cognitive behavioural therapy, cognitive skills or motivational interviewing when working with people with complex, difficult to treat multi-diagnostic conditions (see Appendix B).
- DBT is a recovery-oriented collaborative treatment that is consistent with the principles outlined in *Let's get real* (Ministry of Health, 2008), *We Need to Talk* (Te Pou O Te Whakaaro Nui, 2007) and *Te Kokiri* (Ministry of Health, 2006). DBT is person-centred and fosters an enabling service culture. It is implicitly a contextually aware approach that values and validates cultural, family and personal values.
- There is evidence that DBT can be effectively taught to the regular mental health and addiction workforce and implemented in New Zealand.

## THE ROLE AND FUNCTION OF DBTNZ

### DBTNZ HISTORY

DBTNZ began in 2005 as a Mental Health Workforce Development Project following discussions with John Gawith (Te Whare Mahana), Robyn Shearer (Mental Health Workforce Development, Ministry of Health), Dr Elizabeth Simpson (Behavioral Tech trainer) and Mike Batcheler (Auckland District Health Board). The initial goals of the project were (1) to establish a high-quality New Zealand based DBT training capability with direct links to world-leader Behavioral Tech (see p. 9) and (2) to use the venture to offer subsidised DBT intensive training to help implement DBT programmes in regional services.

After broadly canvassing national DBT providers, the trainers now involved in DBTNZ (see below) were selected following assessment of their DBT involvement, DBT-related enthusiasm, training competence and regional distribution. Additionally, Emily Cooney joined DBTNZ when she arrived

back in New Zealand after working and training with Dr Linehan (Emily is the first New Zealander to be a Behavioral Tech trainer).

There were two initial phases to the project. Firstly to provide a national DBT intensive training for 70 clinicians from district health boards, mainly in the central North Island but also in parts of the South Island. The second phase involved assisting DBT trainers from New Zealand to develop further skills in training. This has been achieved through enabling the six DBTNZ trainers to observe and, when appropriate, work alongside skilled Behavioral Tech trainers at events in New Zealand, Australia, and the USA. Finance for this enhanced training was provided by Mental Health Workforce Development Programmes and later by Te Pou. Dr Robin McCann also provided valuable teaching opportunities during her stay in the country from June to December 2008.

### **OVERALL GOALS OF THE PROJECT**

To enable the effective provision of DBT services within New Zealand through:

- developing an excellent New Zealand-based training team in order to reduce access barriers to training and consultation
- building a community of adherent and effective practice to enable consumer recovery.

### **KEY RELATIONSHIPS**

An important factor in the growth of DBTNZ has been the collaborative relationship developed with Behavioral Tech. Behavioral Tech is the training company established by Dr Marsha Linehan to provide quality training and consultation in DBT. Dr Linehan is herself the original treatment developer of DBT. Through this relationship, the DBTNZ team's clinical and training skills have grown immensely.

### **WHO ARE DBTNZ?**

- Mike Batcheler, clinical psychologist, Auckland District Health Board.
- John Gawith, clinical psychologist and clinical director, Te Whare Mahana.
- Dr David Semp, clinical psychologist, Auckland District Health Board.
- Dr Roy Krawitz, psychiatrist, Waikato District Health Board and honorary clinical senior lecturer, the University of Auckland.
- Pip Bradley, nurse, Capital and Coast District Health Board.
- Dr Kirsten Davis, clinical psychologist, CAMHS, Auckland District Health Board.
- Dr Emily Cooney, clinical psychologist CAMHS, Auckland District Health Board, and trainer, Behavioral Tech.

There are currently six DBT trainers in New Zealand, see Appendix C for their profiles.

# DBTNZ CAPABILITY

## TRAINING

DBTNZ trainers have been accredited by Behavioral Tech to provide a range of two-day training courses, such as general introductory, skills training and individual DBT courses.

DBTNZ has been working towards having the capability to run DBT intensive trainings (see page 11 for a description). One DBTNZ trainer (Emily Cooney) is a Behavioral Tech trainer, while another (Mike Batcheler) has co-presented an intensive training. In addition, the entire training team is making steady progress towards achieving Behavioral Tech's accreditation standards.

## ORGANISATIONAL

As part of its agreement with Behavioral Tech, DBTNZ is required to generate an organisation capable of forming contracts, developing business and providing training. To date this has not advanced further than some initial discussion and scoping with a potential partner organisation. Behavioural Tech has recently advised DBTNZ of the need to develop locally-based infrastructure and administrative capacity in order to provide Behavioral Tech-endorsed trainings by New Zealanders for New Zealanders. The current options for achieving this are discussed in the ‘

What are the Future Options for Training?’ section on page 22.

## STRENGTHS AND SECTOR RELEVANCE OF DBTNZ

- DBTNZ has an established relationship with Seattle-based Behavioral Tech, which in turn is growing links with David Barlow's centre of excellence at Boston University for the implementation of evidence-based practice. DBTNZ also has established relationships with Te Pou and is included within its recent publications.
- DBTNZ is enabling evidence-based effective care for service users with complex, challenging and suicidal behaviours. These complex presentations are increasingly encountered by non-government organisation and district health board services and are associated with staff burnout, organisational stress and, at times, negative client outcomes (Linehan, 1993).

## DBTNZ'S CHALLENGES AND BARRIERS

- DBTNZ needs to generate an organisation capable of forming contracts, developing business and providing training.
- DBTNZ trainers all have permanent employment, which are predominantly linked to DBT. DBTNZ activities for most of them however, fall outside of their regular employment. To sustain high-quality certified DBT training that's provided locally there is a need to for DBTNZ to develop infrastructure and organisational capability.

## THE ROLE OF BEHAVIORAL TECH

Seattle-based Behavioral Tech is an organisation owned by a limited liability not-for-profit company. Behavioral Tech was founded by Dr Linehan, the originator of DBT, to provide high-quality DBT training to individuals and services.

Behavioral Tech has been seminal in DBTNZ's foundation and development. The partnership formed between Behavioral Tech and Mental Health Workforce Development Programmes in 2005 enabled DBTNZ to be founded. Mental Health Workforce Development Programmes, and more lately Te Pou, have supported the travel and associated costs for DBTNZ trainers to attend Behavioral Tech training and development events. To complement this, DBTNZ members have committed considerable amounts of time and energy to raising their practice and training standards and continuing to support the DBT treatment community.

Under the leadership of Dr Linehan, Behavioral Tech has developed materials, relationships, training systems and infrastructure that provide the gold standard in DBT training, consultation and development. DBTNZ is privileged to have developed its relationship with Behavioral Tech and all of the DBTNZ trainers have stated that their knowledge and skills in providing DBT training and treatment have been greatly enhanced through the association.

It should be noted that DBT materials are in the public domain and Behavioral Tech is not the only source of DBT training in the world. It is likely that there is as much DBT training provided worldwide by trainers who are not associated with Behavioral Tech as there is training that is endorsed by the organisation. However, such alternative trainings are not endorsed by the treatment developer (Dr Linehan) and the competence of the trainers, the fidelity of the content and the quality of the training system is unknown.

Since 2005, Helen Best, vice president of Behavioral Tech, has worked on behalf of the company to support DBTNZ's growth and development. In 2008 Dr Robin McCann was supported by Behavioral Tech to visit New Zealand for a six-month locum. Behavioral Tech has enabled DBTNZ trainers to freely attend Behavioral Tech training in the USA, Australia and New Zealand and enjoy free participation in online learning courses.

### BEHAVIORAL TECH TRAINING

Behavioral Tech provides a range of training formats and consultation services for DBT and some related treatments. The two approaches that have featured most in New Zealand DBT training to date are the two-day and intensive training formats.

#### TWO-DAY TRAINING FORMATS

These are open training days trainings that are open for anyone to register to attend. The two-day formats include a comprehensive introduction to DBT, introduction to skills training, introduction to

individual DBT and DBT for substance use disorders. Functions of the two-day trainings are to provide; a solid overview, some take-home tools, and information to help participants decide if they want to learn more.

### **DBT INTENSIVE TRAINING**

Intensive training is about implementing a programme of DBT and getting the skills to provide the treatment. It addresses the way that organisations run to enable effective client care. As DBT is a team-based treatment, the intensive training requires a team of participants (typically eight). Individuals cannot enrol. The training has many components:

- pre-training pre-requisite reading and team formation
- a solid week of DBT theory
- a six month period of homework and building a DBT programme whilst receiving monthly consultation phone calls with one of the trainers
- a solid week of case and programme review and development
- a further six months of programme building, again with monthly consultation phone calls
- a final two-day follow-up.

### **COST-BENEFIT ANALYSIS OF INTENSIVE TRAINING**

To date the daily per-head cost of DBT intensive training is not high (<NZ\$300) and includes the costs of monthly telephone consultations. However, the intensive programme is typically 12 training days and requires a team of eight staff. Costs from recent intensive programmes have been approximately NZ\$3000–\$3500 per person (approximately \$35,000 per team). This includes all the costs of having international trainers (travel, accommodation, and fees in US\$), and the significant costs of hosting such an event. Participants often also have to travel and stay in other cities and invest considerable time between the intensive weeks. Not surprisingly, many providers, especially non-government organisations and smaller organisations, find this too costly.

Costs must be weighed against benefits. DBT intensive training can provide real and sustained service change at the grassroots level of clinical practice. Clinicians across the workforce as a result develop confidence, the ability to be proactive, with improved assessment and relationship skills. Practice becomes less reactive and less reliant on utilising outside resources (e.g. emergency services).

This development impacts on the whole service. Teams of clinicians develop advanced therapeutic skills rather than individuals. Individualised training results in clinicians working in an individualised way with a small number of clients, leaving other parts of the workforce potentially undeveloped.

The intensive training monitors and supports development over the year-long period. This ensures that the learning is being put into practice and results in programme and clinician development.

## **BENEFITS TO CLIENTS OF IMPLEMENTING A FORMAL DBT PROGRAMME**

- Improved access to effective treatment.
- Focus of treatment shifting from reactivity to proactively working towards goals.
- Clear indicators of progress in reducing targeted behaviours and increasing positive experiences.
- Effective risk management approaches.
- Clear relationships with treatment providers.
- Greater sense of autonomy and control in their treatment.
- Receiving a treatment that has clear evidence of efficacy.

## **BENEFITS TO SERVICES OF IMPLEMENTING A FORMAL DBT PROGRAMME**

### **Financial**

- Less overall staff time spent on crisis management.
- Reduced overall treatment costs of between 33 per cent (Perseus et al, 2004) and 50 per cent (Heard, 2000), typically achieved through an 80 per cent reduction in inpatient days through offering a modest increase in outpatient DBT services. One New Zealand district health board showed a similar change in the pattern of service use, but this was not subject to rigorous cost analysis (Batcheler, 2005).
- Reduction in emergency department admissions and associated medical costs.

### **Staff**

- Increased job satisfaction through increased understanding of the treatment rationale and the clear treatment model to follow, and through familiarity with specific therapeutic strategies.
- Improved staff morale and staff retention, and decreased staff burnout due to unsuccessful or unfocussed interventions.
- Decreased stress amongst staff due to disagreement or lack of clarity about direction of treatment. There are processes within the DBT consultation team that aid in understanding disagreements and lead either to resolution or acceptance of differences.
- Consultation inherent within the model supports staff development. The consultative group process provides staff with an effective and supportive forum for reflective, critical thinking for treatment planning and quality assurance.

## Management

- Measurable changes in service delivery, clinical practices and clinical outcomes.
- Provides a consistent, cohesive and effective service to clients across the region.
- Increased effectiveness in achieving outcomes including client wellbeing, staff wellbeing, workforce development and financial outcomes.
- Focus of treatment shifting from inpatient to community settings through strengthening community treatment and minimising inpatient treatment.
- A service-wide perspective on use of resources with less use of overall service resources (staff time and facilities). This is balanced against an initial increase in individual clinician time (which decreases as the treatment progresses).
- A clear and robust approach to client risk management.
- Service development utilising best clinical practice, supporting a centre of excellence philosophy within the service.
- Benefits for staff retention and attracting skilled staff from other areas.
- Decreased complaints and decreased sentinel events (i.e. suicides).

## A SURVEY OF KEY ISSUES AND ONGOING DEVELOPMENT NEEDS OF SERVICES AND CLINICIANS

### THE NUMBER OF CLINICIANS TRAINED IN DBT IN NEW ZEALAND

Approximately 280 clinicians undertook intensive training in DBT in New Zealand between 2000 and 2008. An additional 60 clinicians participated in a foundational five-day training programme in 2008.

A survey of district health boards, conducted as part of the review of DBT in New Zealand, was unable to determine the number of clinicians that were intensively trained and are still practising DBT in New Zealand. It was evident from the survey however that a number of clinicians have remained working in this challenging area for a long time, with many citing DBT as the main reason they remain (see Use and Perceived Effectiveness of DBT section on page 15).

### DETERMINING THE CURRENT STATUS OF DBT IN NEW ZEALAND

As stated above, a survey was carried out of the current status of DBT within the 21 district health boards. We sought a description of current services and the views of district health board general managers, clinical leaders and some clinicians. We also surveyed the views of some consumer advisors and a number of consumers who had experienced DBT treatment.

The survey was developed in consultation with New Zealand DBT practitioners. The structured interview questions used are listed in Appendix D. Approaches were made to a range of staff in all New Zealand district health boards. This included mental health services general managers, clinical directors and consumer advisors. An adapted questionnaire was given to a group of consumers. Twenty district health boards responded to the survey request. Interviews were conducted by phone or email, usually with a number of follow-up contacts to gain a fuller understanding of the status of DBT in each district health board.

## **ANALYSIS OF SURVEY RESPONSES**

The results of the survey are summarised below.

### **DO ORGANISATIONS PROVIDE SPECIALIST SERVICES FOR BORDERLINE PERSONALITY DISORDER?**

Nine district health boards provide specialist services for people with borderline personality disorder, while 11 have no specialist services for this group.

Eight of the nine district health boards with a specialist service for clients with borderline personality disorder use DBT. Five of them; Counties Manukau, Hutt Valley, MidCentral, Waikato and Waitemata exclusively use DBT. The other four district health boards use DBT less exclusively. Auckland and Taranaki offer DBT alongside other therapy options. Capital and Coast uses DBT in an integrated approach in which DBT is one of a selection of treatments in the range of options they can draw upon as they work individually with clients. Canterbury, the only district health board with a specialist service for borderline personality disorder not using DBT, uses a comprehensive mentalization-based treatment programme.

Of the 11 district health boards that do not have a specialist service for borderline personality disorder, six of them still use DBT to some extent within their general service. This is through having a team member who has attended some DBT training (typically a workshop) and is using DBT with some clients. There is interest from teams who would like DBT skills, but training costs are recognised as being prohibitive.

South Canterbury and Southland DHBs have committed to other treatment alternatives, with staff attending mentalization-based therapy and Clinical Behavioural Therapy trainings in preference to DBT.

### **WHAT LEVEL OF DBT IMPLEMENTATION CAN ORGANISATIONS PROVIDE?**

There are a number of elements required in a DBT programme. Some services start with partial implementation and work towards full implementation. Reliably establishing the level of implementation is complex (see Appendix E) and beyond the scope of this project. However, data currently available, including survey responses and a 2008 report from Dr Robyn McCann, has identified the following:

- four district health boards offer strong and significant implementation of DBT within at least some parts of their services

- five district health boards are progressing with the implementation of DBT
- five district health boards provide partial DBT treatment
- seven district health boards provide no DBT.

Some survey responses from clinicians and managers noted concerns about finding ways to further develop programmes to improve the standard of practice.

[We would benefit from] “...help with outside supervision to assist with next step in developing the DBT programme.”

[Request for] “Some way of practice being reviewed to rate [DBT] adherence.”

[Requests for] “...an external supervisor and consultation group; Individual supervision of therapists.”

### USE AND PERCEIVED EFFECTIVENESS OF DBT

Twenty-one clinicians responded to an email survey about their experiences using DBT. All were working in a DBT team, which may partly account for their interest in responding to the survey.

The training of the 21 respondents varied from very little formal training (a two-day in-house workshop) to having attended the advanced training.

There was resounding enthusiasm from all clinicians about the effectiveness of DBT as a treatment modality. In terms of their clinical practice, typical responses were that DBT training had helped “enormously”, “exponentially” and “across all domains”.

The effectiveness of DBT was recognised as being twofold. Firstly, the behavioural approach and focus on action change was seen as giving consumers proven, effective, prescribed skills and hope for bringing about positive change. The treatment was seen to significantly reduce self-harm and suicidal behaviours. Mindfulness was generally seen to be particularly useful.

“The emphasis on changing behaviour rather than working psychodynamically means that clients have the idea that they can begin to change.”

The clinicians typically believed it to be a sound and ethical way of working.

[It is a] “...safe, sensible, intelligent, respectful way to work.”

Clinicians noted that they used skills in both their professional and personal lives.

“Using the skills has helped me in all areas of my life.”

[DBT is useful]...“for anyone wanting to better connect with themselves and others, and manage emotions and stress with greater ease.”

“DBT provides good basic tools for living that can be adapted to fit many issues.”

Secondly, DBT was valued for the way it substantially supports constructive team work by creating a structure that facilitates feedback and critique. Key components identified as helping this supportive approach were:

- providing team consistency, e.g. team members using the same treatment orientation
- using prescribed team processes, e.g. having prescribed ways for addressing unhelpful team behaviour patterns and conflict. This includes the use of validation, identifying differences of opinion and judgmental behaviour, and fostering awareness of personal limits.

[DBT] “...helps the team remain connected and supportive of one another...”

With DBT skills and backup from the team, clinicians are able to work more confidently with difficult-to-treat problems. Many commented that they felt unwilling and unprepared to work with clients with borderline personality disorder without DBT.

“If not for the DBT framework and treatment formulation I would not be working with this client group.”

“...I can confidently say I would not be able to keep seeing the clients I do if it were not for my DBT training and the support of my DBT team.”

[DBT] “...enables me to see very challenging clients and remain hopeful and (usually) effective.”

### **FUTURE TRAINING NEEDS**

When asked about the need for future training, one respondent summed it up as:

[I want] “...more, more, more!”

All clinicians reported a need for more DBT training for their own advancement or for keeping up to date, as well as training for new staff. Clinicians identified training to be a vital ongoing need, along with DBT-specific supervision.

The levels of training requested included:

- opportunities to do the intensive training
- train the trainer programme to build New Zealand trainer capacity
- there was a perceived need to keep ideas fresh and have personal practice tweaked, preferably at regular (yearly) in-house trainings.

“Two-day annual revision training to continue with the momentum would help.”

“Intensive training as this is vital to ensure we continue to maintain a critical mass. The training is essential if we want clinicians to follow the model. Advanced training for the trained clinicians to support them.”

“Intensive training for new staff, updates on latest developments for staff already intensively trained...two-day orientation for general staff to assist case management and related tasks.”

“The more staff trained at the various levels the better the service offered.”

“Further foundation training, advanced training, anything to sustain the programme.”

“There has been strong interest in providing DBT within CAMHS...but obstacles include lack of training and lack of capacity for the commitment that DBT takes.”

The advanced practitioners wanted specific training for improving their expertise, e.g. adherence coding and critiquing of their own and others' work on video. One expressed a need for making DBT appropriate to the New Zealand cultural context, looking at how “to make it a better fit within the Aotearoa/New Zealand context and biculturalism”.

Another wanted to attend a DBT conference, or to hold a New Zealand DBT conference.

## FUNDING ISSUES

While clearly there has been funding available for DBT training in 2008, clinicians had been advised further DBT funding could not be guaranteed. One commented that due to the high costs of DBT training in 2008, the district health board “would not be likely to be making a big investment again in the future.”

Many clinicians were concerned that current cutbacks would jeopardise further training.

“Yes (we've had funding)...but it may not be ongoing due to severe cutbacks.”

“Due to high costs [of the DBT training] and the current financial climate it is hard to guarantee funding in the future.”

While district health boards have verbalised a commitment to DBT, only one response indicated funding support without qualifying that response. More typical were qualified responses such as, there is “a commitment (from the district health board to assist people with DBT training) but they haven't provided the resources to do it”.

The responses of the various district health boards to future funding for DBT training varied greatly. For some of the rural sector and smaller district health boards the following issues were raised.

“DBT training is expensive.”

“We don't have the kind of financial resourcing to develop DBT in a meaningful way.”

“Training costs us more because of the additional costs (transport and accommodation) of sending staff to the larger centres for training.”

“The financial commitment [for intensive training] is not viable for small district health boards.”

## **HOW TO STRUCTURE, SUPPORT AND PROVIDE A DBT SERVICE WITHIN NEW ZEALAND AGENCIES**

Managers and clinicians noted the challenges of trying to implement DBT within existing services that were structured to provide quite different forms of treatment. There was one report of a regional meeting of neighbouring services to support service development, and a request for external expertise to assist with this.

One service manager expressed concerns that DBT support and training networks had not developed as had been hoped for after the 2006 Wellington intensive training.

One professional leader said, “it is clearly critical for the ongoing success of DBT in New Zealand that a local national training team is maintained... [and that]...costs need to be heavily subsidised”, especially to assist provincial services to participate.

“There is a lack of support to sustain programmes.”

“Some [fully trained staff] have not been able to provide DBT treatment due to organisational difficulties [in structuring the service].”

“They want to train people, but haven’t provided resources for people to do the treatment.”

“How do you resource it operationally? There is some tension around how staff work within teams in terms of time taken for DBT provision.”

“How do you develop a service for rural areas?”

## **BARRIERS TO PROVIDING DBT**

As well as the funding issues noted above, there were some other identified barriers to implementing a DBT programme in services.

One manager noted there appeared to be significant ongoing costs associated with the delivery of DBT, such as further training and the staff costs associated with providing frequent clinical contacts in an intensive treatment. We note that this would be consistent with literature reports of higher community treatment costs, alongside lower inpatient and overall treatment costs, i.e. beds are freed up and community services are utilised more.

One district health board clinician mentioned that clinicians needed a high degree of commitment to DBT, due to the perceived time and personal dedication required for the training. This was seen as an obstacle precluding people from doing the training and providing the treatment.

There is a perceived tension between implementing DBT fully and offering elements of DBT within existing services. One manager said DBT is typically only promoted as high-level, specialist training.

“It is presented by the trainers exclusively as a tightly prescribed specialist service.”

This manager considered that there were opportunities for DBT’s application beyond provision of a specialist service and in a less intense way.

“DBT has much to offer if the clinician can use it in an eclectic way...but it is not presented in this way and has always seemed like working with a religion.”

Some district health boards and clinicians around the country do not want to provide DBT and dispute that there is an adequate evidence base to recommend its provision. As in other areas of psychological treatments, there remains a tension between more psychodynamically oriented treatments and cognitive-behavioural approaches, such as DBT.

### **CONSUMER FEEDBACK**

Due to time restrictions of this project, only a small number of consumers were contacted for feedback about using DBT. Of note was one consumer representative who provided a detailed review of one district health board’s DBT service, noting the transformational impact that DBT has had on both service attitudes and client outcomes. This text is included in full in Appendix . Others provided briefer comments, which are summarised below.

Nine consumers responded, all of whom were currently, or had been, receiving a DBT specialist service. When asked what aspects of their treatment had been helpful, eight of the nine consumers specifically mentioned DBT.

Other modes of treatment mentioned as being helpful by these consumers were counselling (one), ACC counselling (two), individual therapy (one) and medication (two).

The positive impact of being in a DBT residential programme was significant for five respondents:

“... residential DBT was the most effective treatment ... the living together and intensive training, and support services all in one package was life changing.”

“DBT was life changing.”


“My time at [DBT residential service] was life saving and life changing.”

“[Being in the DBT residential programme]...has enabled me to stay alive.”

“DBT skills in a safe environment has basically enabled me to stay alive.”

When asked for their views on what treatments the government should be resourcing for workforce training, the consumers all believed DBT should be supported:

“Definitely DBT skills. They can be of assistance for people with many different issues.”



Other suggestions were for art therapy and for “more psychologists, home-based treatment team, more psychiatrists”.

Given that 14 of the 21 district health boards are using DBT, and that there was a desire expressed by all the clinicians surveyed for more DBT training, there is a role in New Zealand for more DBT training and development, and for sustaining current DBT teams.

## SUMMARY OF DEVELOPMENT AND STATUS OF DBT IN NEW ZEALAND

DBT has the strongest evidence-base for working with service users who have complex, chronically suicidal and multi-diagnostic high-needs.

- Behavioral Tech is the US-based training company, founded by the originator and developer of DBT, and the only training organisation with a direct link to this developer. The company is widely recognised as the international leader in DBT training. Behavioral Tech has provided key trainings in New Zealand that have helped establish New Zealand's current services.
- DBTNZ is a group of trainers who have been supported by Behavioral Tech, Mental Health Workforce Development Programmes and later Te Pou to develop their DBT clinical and training competencies. DBTNZ has made great progress in developing its training capability, but now needs to attend to its lack of organisational capacity and to balancing the competing demands on its trainers. This is required to move DBTNZ forward.
- DBT has been implemented across a number of district health boards in New Zealand to varying levels. DBT is generally (but not universally) well regarded by consumers, managers and clinicians alike. There is merit and demand for increasing the quality and competence of many current DBT programmes.
- There are a range of non-training supports that could be offered to both developing and established services. This includes support around treatment development, service structuring and clinician support.
- District health board mental health service senior managers, clinical leaders, clinicians and consumers surveyed were generally very keen to continue to develop and provide DBT.
- A number of barriers were identified to ongoing DBT training and development in New Zealand. These barriers include; cost, logistical challenges, relying on US training providers, ease of access to consultation and bicultural responsiveness.

## FUTURE DEVELOPMENT

Having reviewed DBT in New Zealand and summarised the survey of district health boards, some options for the direction and development of DBT in New Zealand.

### The Goals

From the above review, future work should do the following:

- Help district health board and non-government organisation services continue to develop their DBT services for identified client groups. This will require access to high-quality training and consultation.
- Help services reduce the barriers (such as the cost and logistical complexity) to accessing high-quality DBT training and consultation.
- Help develop a treatment community that can address some of the outstanding issues, such as the bicultural responsiveness of DBT.

## OPTIONS FOR THE FUTURE DIRECTION AND DEVELOPMENT OF DBT IN NEW ZEALAND

### WHAT ARE THE FUTURE OPTIONS FOR TRAINING?

There is a need and demand for services to continue to access high-quality training and consultation. While not all future options for DBT in New Zealand necessarily rely on DBTNZ or a continued relationship with Behavioral Tech, many do.

Over the past four years Behavioral Tech has emphasised that DBTNZ needs to both improve its training competence and develop a solid organisational capability. DBTNZ has primarily focussed on increasing its training skills and has offered a number of training events. However DBTNZ remains a loose collective and has not yet created an organisation with the necessary structures, processes and capability to act as a consistent training provider in New Zealand. One issue to be worked through is how DBTNZ trainers negotiate unpaid release time from their regular roles in order to deliver DBTNZ training.

Behavioral Tech has recently reminded DBTNZ of the need to make progress on the organisational issue in order to move forward. One option under consideration is for DBTNZ trainers to become Behavioral Tech trainers. The other option is for DBTNZ to form a competent organisation and become an international affiliate of Behavioral Tech. Both of these options are discussed below.

## LOCAL TRAINING WITH NO INTERNATIONAL LINKS

One option could be that a local initiative is developed to deliver DBT training without building or maintaining links with an international organisation. This would be a New Zealand specific approach and would not provide certified DBT trainings. There are a couple of trainers in New Zealand who currently offer DBT-related training, either privately or in association with other training providers. Some current DBTNZ trainers have, in the past, also offered introductory training in DBT. In addition, a few district health boards have developed DBT-related training resources, either independently or in collaboration with other district health boards.

### Benefits

- Potentially less complex and costly. There would be no need to obtain overseas-licensed materials or to maintain relationships with an international partner organisation.
- Opportunity to have a more Kiwi-based, locally responsive programme.

### Disadvantages

- No current training providers are able and willing to offer comprehensive DBT training, using their own DBT resources. What is currently being offered is at an introductory level and does not support programme implementation or provide advanced services.
- All DBTNZ trainers have stated that they would not offer independent DBT training as:
  - they don't have any materials to offer
  - such training would not be as comprehensive and would be less likely to foster high-quality services
  - they personally value their relationship with Behavioral Tech and the developer of DBT, and would not be prepared to act independently from them.
- A local programme would not carry as much international credibility and not have the same level of recognition as an established international training. This has been important for some New Zealand services<sup>1</sup>, which recognise that there are additional quality requirements and potential legal risks when providing complex treatments to high-risk and challenging client groups.

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<sup>1</sup> Some New Zealand-based agencies have previously sought DBT training and stated categorically to the author (MB) that it must be “official” DBT training, due to possible issues of risk and liability that could arise from “partial implementation” (see page 42). Note that 20 per cent of legal proceedings against US clinicians arise from suicidal behaviour (Paris, 2002).

- Similarly, New Zealand consumers should be able to access services with staff who are well-trained in effective, evidence-based treatment. While there are currently no empirical comparisons of DBT training providers and the quality of training that they provide, it is likely that the training approaches developed by the originator of the treatment best represent the treatment.
- It would be costly and time consuming to develop such a resource.

**Summary:** Not likely to succeed. Not recommended.

### TRAINING DIRECTLY FROM BEHAVIORAL TECH USING DBTNZ TRAINERS.

DBTNZ trainers have the opportunity to become Behavioral Tech trainers. Future New Zealand DBT training could be organised directly through Seattle-based Behavioral Tech, perhaps using one or more DBTNZ trainers, to ensure all events meet Behavioral Tech's exacting standards. All DBT training and consultation would be negotiated, organised, purchased and provided by the Behavioral Tech office in Seattle. Trainers would be selected by Behavioral Tech for an event and then turn up on the day. Behavioral Tech would provide all billing and logistics. New Zealand would continue to have access to the highest quality DBT training, with the option of using New Zealand trainers who know our services and culture. There would be no demands on local resources to help facilitate these events.

#### Benefits

- Services continue to get access to internationally recognised training and have one or more New Zealand trainers present to maintain awareness of local service arrangements and responsiveness.
- Behavioral Tech remains responsible for trainers' quality standards and all logistics.
- DBTNZ expertise is maintained and DBTNZ members are able to focus solely on delivering training.
- There is no requirement for further centralised investment or New Zealand based infrastructure.

#### Disadvantages

- There have been logistical challenges to working with an offshore provider, e.g. who and how to contact to discuss needs, costs, logistics etc. These challenges would remain.
- Costs are likely to be higher and supply lower. US trainers would need to travel to New Zealand to deliver training and tutor fees would be charged in US dollars.
- Current DBTNZ trainers would not necessarily be used by Behavioral Tech in providing DBT training in New Zealand as their broader pool of trainers and international focus may lead them to recommend non-New Zealand trainers. It could be that current DBTNZ trainers are underutilised and the investment already made to develop New Zealand based trainers is lost.

- It would not help us address issues of local significance, such as bicultural responsiveness.

**Summary:** A partial solution that is not much of an advance on the present situation. Not recommended.

### **TRAINING BY DBTNZ AS AN INTERNATIONAL AFFILIATE OF BEHAVIORAL TECH**

DBTNZ has the opportunity to become an international affiliate of Behavioral Tech. DBTNZ could become the 'local Behavioral Tech', operating as an independent entity in association with Behavioral Tech and with licensed access to its resources and expertise. All New Zealand DBT training and consultation would be provided by DBTNZ through this arrangement. DBTNZ trainers would primarily connect to DBTNZ, not Behavioral Tech. This would require DBTNZ to become a viable business entity, able to form a contract with Behavioral Tech and run an office that can:

- provide infrastructure to deliver training
- have processes to field enquiries and generate plans and business for delivery of training
- manage oversight and delivery of training (logistical coordination and materials)
- maintain trainers (their expertise, keeping them up to date, recruitment etc)
- set the fees for New Zealand training
- liaise between DBTNZ people, organisations wanting training and Behavioral Tech.

There would be initial costs to this option:

- establishing an office or purchasing access to administrative support
- some form of coordinator to manage the venture
- fees to be paid to Behavioral Tech – determined by the quantity and type of training to be provided
- costs associated with ensuring DBTNZ trainers maintained their standards and attended required Behavioral Tech international trainers meetings.

Benefits

- Maintain access to world leading training standards and materials through a continued relationship with Behavioral Tech.
- Increase local presence and responsiveness, hence reducing many of the current access barriers.
- New Zealand-based with a New Zealand approach and the ability to respond to uniquely New Zealand issues, such as bicultural responsiveness.

- The availability of DBT training will help mental health staff progress their skills and knowledge at the practitioner level of the *Let's get real* Real Skills.
- Have the capacity to organise and to provide training specifically for a purchasing organisation, as well as to provide open enrolment training. Open enrolment training is where individuals and teams can enrol in a public event without requiring large financial and logistical backing from a host.
- A DBTNZ coordinator could attend to related issues such as how DBTNZ commitments would need to be included within trainers' existing work commitments.

#### Disadvantages

- The short term organisational development requirements would be significant. There would be seeding costs before this organisation could be self-sustaining.

**Summary:** Most likely to achieve stated goals. Recommended.

#### WHAT KIND OF TRAINING SHOULD BE OFFERED IN THE FUTURE?

We are fortunate to have DBTNZ trainers who already have established capability and relationships with the world's leading DBT training provider. As a health system we should take advantage of this.

To date, intensive training has been sponsored by some larger district health boards or the Mental Health Workforce Development Programmes initiative, with smaller district health boards and non-government organisations able to purchase places when available. The need for a sponsoring district health board has greatly slowed the provision of intensive training.

Over the past two years, two-day orientations to DBT have primarily been provided by DBTNZ trainers as an event attached to a conference or by getting their own parent district health boards to host the training. These events take open enrolments, meaning individuals have taken places on a first come first served basis. A recent offering was so oversubscribed that a second event was offered and further applications are still being held in case another event can be offered. Some other two-day events have been hosted by district health boards. These have focussed on developing their own services with no spare seat sales. On one recent occasion, a provincial district health board was so short on training money that some medical staff pooled their professional development funds to enable the training to be delivered to their team.

This unplanned and sponsor-reliant system has meant that demand has exceeded supply. Services have not received the training they need and service users are therefore not getting access to the treatment they deserve.

A better system would be for two two-day orientations (see page 10) to be hosted each year, perhaps one in the north, and one in the central or southern region. In addition, an annual intensive event (see page 11) could be offered to services that are wishing to develop a programme, without the need for a health provider to sponsor or underwrite a large event.

# WHAT ARE THE FUTURE OPTIONS FOR OTHER FORMS OF SUPPORT AND COORDINATION OF NETWORKS TO ENCOURAGE AND PROMOTE DBT?

This review identifies three main areas where other (non-training) support and coordination could significantly assist the promotion and delivery of DBT. These are listed below.

## ADVICE AND DIRECTION ON HOW TO DEVELOP THE ELEMENTS OF EFFECTIVE DBT TREATMENT

Many services do not know how to go about developing their DBT services or even what is required to provide more comprehensive treatment. For instance, some services offer only some elements of DBT treatment and have little knowledge of how and why they should extend their capability. Improvements could be made by finding a framework and process that services could use to assess and develop their programmes.

## ADVICE AND DIRECTION ON HOW TO STRUCTURE AND PROVIDE A DBT SERVICE WITHIN NEW ZEALAND

Some service managers are not fully aware of the essential elements of a comprehensive treatment programme and the necessary level of inputs to produce outputs. Services repeatedly reinvent solutions to regular problems, as little guidance and support is available. Improvements could be made by finding a framework that does the following:

- Offers advice and examples of ways to structure services to facilitate good treatment outcomes.
- Offers advice on multidisciplinary inputs and models for running programmes within existing mental health service structures.
- Coordinates a shared approach to outcome evaluation.
- Offers advice and models about the level of inputs required and outputs expected for DBT programmes. Inputs include the amount of training, consultation and programme development that is likely to be effective.
- Offers and shares examples of effective district health board and non-government organisation-based clinical pathways, including wait-listing, intake, assessment, treatment provisions and discharge criteria. Additionally, to offer advice on shared treatment pathways for related and co-morbid conditions, such as substance misuse and eating disorders.
- Report on local models of extending DBT principles to inpatient units which often struggle to provide effective help to this client group.
- Coordinate and share examples of DBT based clinical records.

## CLINICIAN-LEVEL SUPPORT

To stay in this area of work, clinicians require both training and non-training support. This includes:

- having a point of contact for DBT clinicians to access and feel part of a local community
- facilitating a system of external consultations, supervision and, ideally, adherence coding to assist clinical practice
- having a community that can start to address and debate local issues, such as bicultural responsiveness and rural delivery.

## HOW TO PROVIDE SUPPORT AND COORDINATION

While some of the support mechanisms identified above are provided on a haphazard basis through informal community links, it is clear that while the tasks remain no-one's day job, they will not reliably happen. As the delivery of training requires a home and point of contact, it would be most effective for a person to take on both the DBTNZ 'shop front' role, and the support and coordination role. The issue of how this position is funded needs to be considered.

## RECOMMENDATIONS FOR FUTURE DIRECTION AND COORDINATION

- A range of support and coordination tasks would substantially assist services to develop and provide quality DBT services. These tasks will be best performed through a coordinator role.
- Training is best provided by DBTNZ through an international affiliate agreement with Behavioral Tech. DBTNZ is developed into an organisation capable of organising and providing such training.
- Some consideration is given to supporting smaller and regional services to access DBT training and support, and another subsidised intensive event could be offered to kick start some remaining services.

### RECOMMENDATION ONE: NATIONAL DBT COORDINATION

A key recommendation is that of a national DBT coordinator. This role could liaise with district health boards, their managers and clinical leaders, Te Pou, the Ministry of Health, clinicians, consumer advisors, service users and Behavioral Tech.

The main tasks of this role would include non-training tasks and managing the operations required for DBTNZ (as an international affiliate of Behavioral Tech) to provide introductory and intensive training within New Zealand. For instance, training could continue to be provided to organisations requesting it. A schedule of open enrolment training events could also be set which would replace the current need for a district health board (or similar) to heavily underwrite the provision of intensive training. This

would greatly assist district health board and non-government organisation teams to get comprehensive training, with reduced logistical, administrative and financial barriers.

This national DBT coordinator role encapsulates two different sets of competencies which could be met by one or two persons.

1. Leadership and expertise:

- a level of standing and influence in the mental health services community
- a high level of DBT knowledge and an understanding of the structures and processes in mental health services, and how to integrate these domains
- relationships with the funders, providers and broader treatment community
- the ability to run a business, generate work, and grow an organisation to be self-sustaining
- this person would not need to be a DBT trainer.

2. Administrative capability:

- ability to run an office and manage projects
- project management, relationship, entrepreneurial and leadership skills
- field and process enquiries, and learn about the sector
- administer training
- be capable of growing an organisation.

This role would require seed funding with the goals for this organisation to become entirely self-funding within two years through the efficient provision of its training and other services.

### **RECOMMENDATION TWO: HELP DBTNZ WORK**

Consideration be given to identifying what is required for DBTNZ and its ongoing sustainability. This would include identifying how the ongoing relationship with Behavioral Tech is formalised. This could include attendance at an annual meeting, some communication support, and enabling one trainer each year to attend the Behavioral Tech international affiliates meeting (typically held in Europe).

### **RECOMMENDATION THREE: ASSIST SMALL, RURAL AND NON-GOVERNMENT ORGANISATION SERVICES**

There is a need for some assistance to enable small, remote and rural services to get access to DBT. This is likely to include the non-government organisation sector, where considerable interest in DBT exists.

## **RECOMMENDATION FOUR: KICK-START SOME MORE SERVICES**

A further national intensive training, which is subsidised, could encourage some of the remaining services that are not currently using DBT to consider this, and to replenish DBT teams subject to natural attrition.

## **OPTIONS**

The various options for future development are outlined below.

### **OPTION A: NATIONAL DBT COORDINATION**

Option A would prioritise the establishment of a national DBT coordinator, with administrative support, to pursue the non-training tasks associated with supporting DBT services. This role would also be responsible for organising DBT training using DBTNZ trainers in an international affiliate relationship with Behavioral Tech. Training would attract no subsidies and there would be no financial support for DBTNZ to further establish its capability. All DBTNZ trainer and training costs would be covered by training fees. The number of training events offered would increase and be annually planned due to the role of the coordinator. This option would significantly reduce the administrative requirements for DBTNZ trainers allowing them to focus on training competencies.

### **OPTION B: COORDINATION AND DEVELOPMENT OF DBTNZ**

Option B includes Option A and adds material and communication support for DBTNZ trainers. This is to ensure they maintain and develop their capability and remain up to date in DBT principles. This option would involve funding one trainer each year to attend the annual Behavioral Tech international affiliates meeting.


### **OPTION C: ASSIST SMALL, RURAL AND NON-GOVERNMENT ORGANISATION SERVICES**

Option C includes Option B and adds a basic level of training support. This training would be targeted at smaller and rural district health boards and non-government organisations who have been finding it difficult to access training, due to the costs involved and their remote location.

### **OPTION D: INITIATE SOME MORE SERVICES**

Option D includes Option C and adds funding to provide a 50 per cent subsidy for the costs of providing a DBT intensive training programme. This training would be accessible (on first come first served basis) to all New Zealand services who wish to establish a DBT programme. This is similar to the Mental Health Workforce Development Programmes-sponsored intensive training in 2006, which:

- assisted the start of four district health board-based programmes (all of which continue to function)
- provided seeding training to two others (one still offers a partial programme)

- 
- strengthened one district health board and one non-government organisation provider (both of which are still operating strongly).

DBT intensive training programmes are about establishing a sustainable treatment programme and training the staff required. The cost of the intensive training has been a barrier for many organizations to access training. The 2006 intensive programme showed that a subsidy enabled a range of services to get started and provide treatment.



## NEXT STEPS

Te Pou has considered the recommendations outlined in this report. In line with Option A, Te Pou will provide some assistance to DBTNZ, as part of its current work in 2009 - 2010 in talking therapies. This will include the co-ordination of any future DBT training. This will include pursuing an affiliate status with Behavioural Tech in USA. An alignment of *Let's get real* to the current DBT training will occur as part of this work. Te Pou will also work with DBTNZ to identify future development of DBT training in New Zealand.

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## STATEMENT OF POTENTIAL CONFLICTS OF INTEREST

Both Mike Batcheler and John Gawith have direct associations with DBTNZ. Similarly, in producing the report they have relied on the unpaid assistance of a number of volunteers from DBTNZ: David Semp, Emily Cooney, Roy Krawitz, Pip Bradley and Kirsten Davis all used their personal time to assist in the research of the report. Emily Cooney is a Behavioral Tech trainer and both she and Kirsten Davis are investigators on a DBT research trial funded by Te Pou. Mike Batcheler is a therapist in that trial and hence all three parties receive funds in another capacity from Te Pou. All those listed above provide DBT in clinical settings, predominantly district health board settings, and have provided some level of DBT training through DBTNZ.

All took steps to mitigate this conflict by identifying their association with DBTNZ, and reporting survey responses in full. Mike Batcheler advised Emma Wood of Te Pou of these potential conflicts by email and telephone message before undertaking the work.

## BORDERLINE PERSONALITY DISORDER AND DBT

### About Borderline Personality Disorder

Borderline personality disorder is a psychiatric term used to describe long-standing patterns of significant problems related to intense changeable emotions. These can include; chronic suicidality, repeated self-harming behaviour (e.g. overdoses, cutting oneself, burning etc), other impulsive behaviours, anger problems, substance use, relationship problems and an enduring uncertainty about self-identity. About 8 to 10 per cent of people who meet criteria for borderline personality disorder are reported to eventually commit suicide (American Psychiatric Association, 1994). Morbidity and mortality figures for borderline personality disorder match or exceed those for groups usually considered to have the diagnoses of major mental illness, such as schizophrenia and bipolar disorder (Paris, 2002).

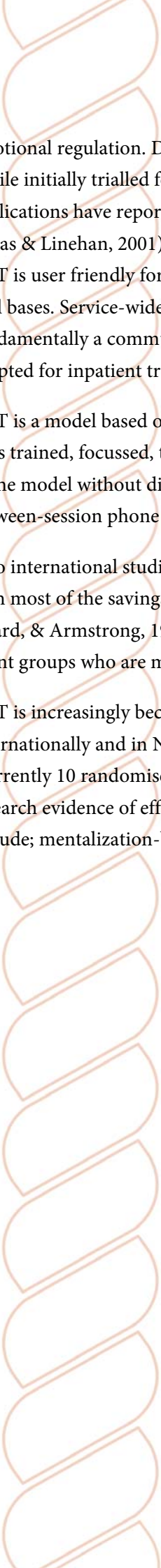
Almost all people who meet criteria for the diagnosis of borderline personality disorder will also meet criteria for one or more other diagnoses; mood disorders, anxiety disorders, eating disorders, substance use disorders and others. According to international literature, about 10 to 15 per cent of clients who are involved in community-based mental health treatment will meet criteria for borderline personality disorder. Usage of general health services is also high, possibly reflecting the consequences of self-harm, impulsive behaviour and substance use (Zanarini, Frankenburg, Hennen, & Silk, 2004). Treatments targeting other diagnoses or problems often are not effective when the problems of borderline personality disorder are also present.

Until 1993 there were no proven treatments available for this client group. Clinicians were generally reluctant to work with such clients, as they had no models of effective treatment and often endured the two factors most associated with clinician burnout – aggression towards their efforts and the constant risk of client suicide (Linehan, 1993). An attitude of therapeutic nihilism developed, where clinicians often regarded such clients as unworthy of service and unlikely to benefit from it. Borderline personality disorder was not seen as a legitimate complaint. Worse, inpatient hospitalisations were often protracted (due to risk issues) and unwittingly would sometimes increase the likelihood of completed suicide (Paris, 2002; Maltzberger, 1994). Clients often felt marginalised and in conflict with the services that were supposed to help them.

While people who meet criteria for borderline personality disorder have found it hard to get effective treatments, they also frequently meet criteria for intensive targeted healthcare services, having complex multi-problem presentations, high rates of suicide, and frequently have social and family difficulties (Bender et al, 2001; Zanarini, Frankenburg, Hennen, & Silk 2004).

### WHAT IS DBT?

Dialectical behaviour therapy (DBT) is an evidence-based, effective treatment model for borderline personality disorder, and other complex multi-diagnostic disorders characterised by problems of



emotional regulation. DBT has the strongest empirical standing in the field for these types of problems. While initially trialled for people with the diagnosis of borderline personality disorder, more recent applications have reported success with drug addictions (Linehan et al, 1999), eating disorders (Telch, Agras & Linehan, 2001) and for presentations in young people (Rathus & Miller 2002), as well as adults. DBT is user friendly for clinicians, comprehensible to clinicians and consistent with multi-disciplinary skill bases. Service-wide training and skill development in DBT is available. While DBT is fundamentally a community treatment model, DBT skills and DBT informed practice are very usefully adapted for inpatient treatment and residential settings (Bohus et al, 2004).

DBT is a model based on teams of trained DBT clinicians working together to effectively treat clients. This trained, focussed, team approach is an essential aspect of the treatment. Maintaining the integrity of the model without diluting it too much is essential. DBT includes individual and group therapy, between-session phone calls to generalise new learning, and consultation teams for the therapists.

Two international studies report that DBT costs about half of the amount of comparative treatment, with most of the savings coming from an up to 80 per cent reduction in inpatient stays (Linehan, Heard, & Armstrong, 1993). This also means that scarce inpatient resources can be redeployed for client groups who are more likely to benefit from such services.

DBT is increasingly becoming a mainstream treatment within mental health services, both internationally and in New Zealand. While DBT has the strongest and most established evidence base (currently 10 randomised controlled trials and numerous other trials), it is not the only treatment with research evidence of effectiveness. Other approaches (all with one randomised controlled trial each) include; mentalization-based treatment, transference focussed therapy and schema therapy.

## PROFILES OF DBTNZ TRAINERS



**Emily Cooney, Ph.D.** received her doctoral degree and diploma in clinical psychology from the University of Otago, New Zealand. Dr Cooney has served as a research therapist on two trials of DBT under Dr Marsha Linehan at the University of Washington. Dr Cooney is currently working as research coordinator and clinical psychologist at the Kari Centre (an outpatient child and adolescent mental health service in Auckland). She is the principal investigator on a feasibility study comparing DBT with treatment as usual for self-harming adolescents. She is also the principal investigator on a small pilot study evaluating outcomes of a DBT skills training group for men with anger problems. She is a DBT trainer for Behavioral Tech and has provided trainings in DBT for substance use disorders, for adolescents and families, and foundation and orientation trainings in DBT.



**Mike Batcheler** has worked as a registered clinical psychologist in health and corrections settings since 1990. He was a founding member of New Zealand's first DBT programme in 1998 and has been the coordinator of that DBT programme since 2000. Mike was intensively trained in DBT in 2000 and continues to work as a DBT therapist and skills trainer in an adult DBT programme. He has considerable experience providing DBT training and consultation in New Zealand health settings, and was the first New Zealander to assist in providing a DBT intensive training (2006 and 2007). He lives in Auckland and is a proud dad of three beautiful children.



**David Semp, Ph.D.** is a clinical psychologist with considerable clinical, teaching and training experience. With a background in adult education, he has worked in alcohol and other drug and community mental health settings since 1996. In that time, he has developed a keen interest in how teams can work together more effectively and how DBT consultation groups can provide a model for that. While drawing on many treatment approaches, in 2000 he was intensively trained in DBT and since then has been active in DBT programmes, primarily in Auckland District Health Board services. David provides individual therapy, skills groups, supervision, consultation and training in DBT. He has developed and provides a mindfulness based group for people currently experiencing depression and anxiety. David recently completed his Ph.D. at the University of Auckland. His research considered how well public mental health services address sexual orientation issues, which is an area he publishes and teaches in. In addition to his district health board work, David has a small private practice.



**Dr Roy Krawitz** is a psychiatrist (Waikato District Health Board) and honorary clinical senior lecturer (the University of Auckland). Roy has specialised for the past 15 years in working with people with borderline personality disorder (as a consultant, supervisor, trainer, researcher, author and DBT therapist). Roy completed his first DBT intensive training in 1999 and subsequently trained to be a DBT trainer affiliated with Behavioral Tech.

Roy has a daily mindfulness practice and has completed several 10-day silent mindfulness retreats dating back 20 years. Roy also has a special interest in working collaboratively with consumers who have recovered from borderline personality disorder. This collaborative work includes; advocacy, case-manager-level training and joint publications (including a book for people with borderline personality disorder).


Roy has provided over 250 days of DBT-informed case-manager level borderline personality disorder training to over 2500 clinicians in New Zealand and Australia. Roy has published research demonstrating the effectiveness of this training, the clinical effectiveness of his therapy, and the clinical effectiveness of the DBT service in which he works. Roy is the author of 11 articles and four books on borderline personality disorder. Books include one commissioned by the New Zealand Mental Health Commission and two by Oxford University Press. One of which has also been translated into, and published in, Dutch and Japanese.

Roy lives on the Coromandel Peninsula.

**Dr Kirsten Davis, Ph.D.** is a clinical psychologist who received a Doctorate in Clinical Psychology from the University of Auckland, New Zealand. She specialises in working with children, young people and their families. Kirsten has been involved in the development and implementation of a DBT programme for young people and their families in a community mental health setting. Kirsten completed her first Behavioral Tech DBT intensive training in 2000. Since that time she has attended three additional intensive trainings, several two-day DBT trainings and Behavioral Tech training for trainers events. She has been either the lead or co-trainer for over 10 DBT workshops. Kirsten has been involved in training and ongoing consultation to support the implementation of DBT programmes in three district health board youth services in New Zealand. She is currently a co-investigator in a randomised feasibility trial for adolescent DBT in Auckland, New Zealand.

**Pip Bradley** has worked as a specialist mental health nurse for the Regional Personality Disorder Service, Capital and Coast District Health for 10 years, specialising in the treatment of borderline personality disorder and other complex multi-diagnostic presentations. She has held a passionate interest in DBT throughout this time and has specialised in DBT practice since completing intensive training in 2006 and subsequent training under the guidance of the Behavior Tech DBT experts.

Since then, Pip has organised formal trainings through Behavior Tech for local and national district health boards and supported the development of DBT in the central region. She has also delivered DBT training locally and has coordinated the development of the DBT programme for Capital and Coast District Health.



Pip remains very excited about DBT and its efficacy as a treatment for complex presentations. She also enjoys the challenges and rewards of being very behaviorally focused in treatment, of developing mindfulness as a clinical practice and the opportunities for personal development inherent in this treatment.

Through her work with the Regional Personality Disorder Service, Pip has strong links with the central region. She is very committed to supporting clinicians regionally in developing their knowledge and practice of DBT and assisting them in developing effective DBT services.

## APPENDIX D

# STRUCTURED INTERVIEW QUESTIONS

Below are the questions that formed the basis of the structured interview of district health board general managers, clinical leaders and consumer advisors. Responses were elicited by phone or email, usually with a number of follow up enquiries to try and develop a fuller understanding of both current services and views.

### QUESTIONS FOR CLINICAL DIRECTOR OF DISTRICT HEALTH BOARD

1. Do you have specialist services for individuals with borderline personality disorder?
2. What treatment models do you use?
3. Do you use DBT? (If yes, go to question 4, if no go to question 18.)
4. Do you have a DBT leader/coordinator with dedicated time for programme development/implementation?
5. How much dedicated time?

### QUESTIONS FOR DBT LEADER/COORDINATOR

6. What current DBT services do you provide?
7. Do you have a skills group at present?
8. Do you have clients receiving DBT individual therapy?
9. Do you provide telephone consultation? If yes, what form does it take?
10. What research measures do you use to evaluate outcomes?
11. Do you have a DBT consultation meeting for DBT therapists?
12. If so, how many clinicians in consult?
13. What training have you received?
14. What training do you want to be available?
15. What training do you do yourselves?
16. Is there funding available for outside training in your district health board?
17. What skills manual are you using?
18. Are you interested in DBT training for your staff? If no, why not?
19. Are there funds available in your district health board for DBT training?
20. Is there a commitment from your district health board to assist people with DBT training?

## HOW TO TELL IF A DBT PROGRAMME IS LIKELY TO BE EFFECTIVE.

The standing assumption is that a DBT programme should have all the vital elements of the treatment and practice, as described in the published treatment manuals. From a scientific perspective this is necessary in order to claim that the treatment offered is likely to have a similar level of effectiveness to that described in the research.

Comprehensive treatment in DBT should achieve five functions (typically in four standard modes):

- Function one – enhance client capabilities. Main mode – skills training.
- Function two – improve motivational factors. Main mode – individual treatment.
- Function three – ensure generalisation to the natural environment. Main mode – in vivo (24-hour coaching).
- Function four – improve therapist capabilities and motivation to provide effective treatment. Main mode – consultation team.
- Function five – structure the environment. Main mode – auxiliary treatment(s), environmental support.

A programme has fidelity only when it meets all the modes and functions of DBT. Conversely, if a programme offers only some of the functions and modes it is said to be a partial implementation. There is currently no evidence that partial implementations are as effective as a programme with full fidelity.

Additionally, the actual practice of the clinicians would need to satisfy a range of principles and protocols outlined within the treatment manual. Practice is said to be adherent only when there is a high degree of alignment between the protocols and the practice. Adherence is not a stable rating of a clinician, but a rating of specific clinician behaviour within a session.

This also means that it is very challenging to answer the question “does this programme and its clinicians offer high-fidelity, adherent DBT?” Systems have been developed for this, but they are very time consuming and beyond both the scope of this report and the capability of its writers.

For the purposes of this report, we have made an estimate of programme adherence from all available Data. These include the self-report responses to our survey and also a confidential report to Te Whare Mahana by Dr Robin McCann, following her visiting and working with a number of DBT providers during her New Zealand locum in 2008.

## A CONSUMER ADVISOR'S PERSPECTIVE ON THE IMPACT OF DBT IN ONE NEW ZEALAND DISTRICT HEALTH BOARD

Below is the full text of the reply from the Waikato District Health Board senior consumer advisor. It is included as it offers a unique perspective on how the implementation of DBT has contributed to both client outcomes and to fostering constructive recovery-oriented organisational change.

### **Dialectical Behavioural Therapy in Waikato District Health Board from a Service user and Family perspective:**

DBT in Hamilton and Thames started in approximately 2001 as a pilot study in conjunction with the Psychology centre. At that time a small number of service users went through the full year to varying level of success. From the service user perspective at that time, DBT was the only hope, and led to be a life saving intervention that had a dramatic impact on shifting maladaptive coping strategies and increasing awareness around borderline personality disorder. Given this treatment was early stage and very new for New Zealand there was a lot of scepticism from staff of the view that people with borderline personality disorder would 'never recover and the best they could do was get through with the least damage possible'. No one thought about how this type of thinking impacted on the people themselves whose sense of self was blurred with self hatred and a perception of being undeserving and just continued to increase the person's own self stigma and feelings of worthlessness. This first study was the start of challenging attitudes and beliefs about people with borderline personality disorder and giving both service users and families hope of a life worth living.

DBT in Waikato went through ups and downs in many areas. Retaining staff that were trained and recruiting staff within mental health services who were interested in this work at times caused many problems. The varying disciplines that took part and continue to take part today is one of the things that make it a success, the broad range of experience and expertise gives the clinicians the ability to share among each other concerns and the options to explore. Disciplines involved included; A&D counsellors, nurses, psychologists, and psychiatrists. The staff that readily chose to be involved in DBT possessed a strong belief in people's abilities that with the right skills and right support people can move on. These clinicians did and must possess an unlimited amount of patience, belief, ability to take risks, continual ability to adapt and learn, and above all to recognise the person behind the behaviours who is worthy of support, trust and warmth.

So where is DBT at now? DBT among even the most pessimistic clinicians is recognised as the preferred model of treatment for people with borderline personality disorder. We have moved to increased staff levels and therefore more ability to offer these services to many more people who need them. Despite the increase in staff who are DBT trained, the ability to work with only one or

at most two clients at a time means that a waiting list is now an ongoing concern.<sup>2</sup> Waiting lists for this programme show its universal portrayal as the best treatment but unfortunately the placing of people on waiting lists results in some of the skills that someone can learn with any other clinician get put on hold. Often what I hear as a service user representative is people putting their progress, recovery and life on hold waiting for DBT expecting it will solve it all. With high expectations it almost definitely means disappointment when the first month or even longer of the programme creates more questions than answers. It is also common that people on the waiting lists are not fully able to realise that their ability to commit to attending the group and individual therapy means if they become despondent about the lack of change DBT is making; especially in those early stages, they are most likely to pull out, miss sessions and inevitably end up back at the bottom of the waiting list. Families whose loved one is not quite in the right place, or not able or willing to fully commit, or who are expecting a quick fix are often the casualties of these programmes. Families become frustrated that the system means their loved one is allowed to sabotage the seemingly only treatment that effectively works for people with borderline personality disorder.

The ongoing success of DBT in Waikato is well recognised with many service users coming out the other end with a life they had never believed possible. These success stories, these people are the stars that keep the pessimists on their toes. Service users who are diagnosed now in comparison to ten years ago are much happier to have the diagnosis – hard to believe I know! They now see a much more positive future, a hopeful future through the changing eyes of our health professionals. As a service user representative we will always have those who choose to clump ‘personality disordered’ people into those stigmatised baskets of ‘manipulative’ and ‘timewasters’ but what we need to focus on is the huge increase of optimists emerging because they see the people coming out at the other end of DBT. Seeing people become more worthy equal members of society; mothers, employees, friends, and positive role models continues to reinforce that people who have borderline personality disorder will and do lead a life worth living.

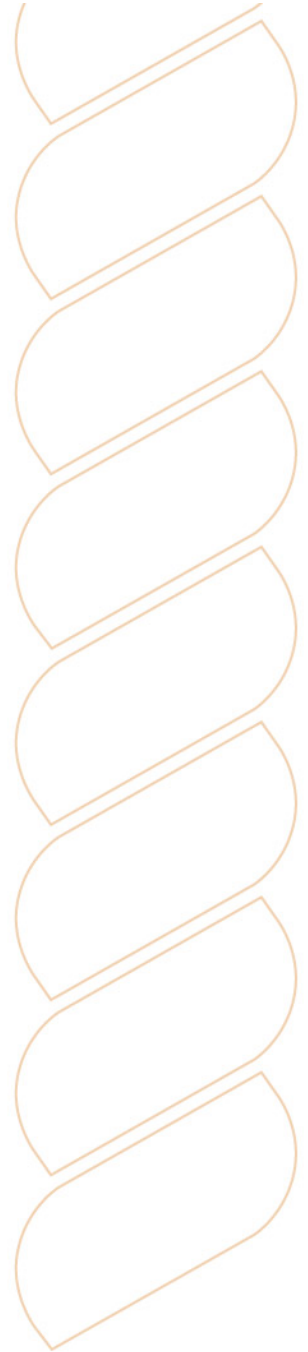
Kelly Ware

Senior Consumer Relationship Advisor

Waikato District Health Board

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<sup>2</sup> Apparently DBT therapists within the Waikato DBT programme are now able to work with up to five DBT clients at a time (Krawitz, personal communication).



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