Dialectical Behavior Therapy Program Fidelity Checklist (DBT PFC)

Training Manual

(Harned & Schmidt, 2022)

OVERVIEW

The Dialectical Behavior Therapy Program Fidelity Checklist (DBT PFC; Harned & Schmidt, 2022) has been developed as a brief, pragmatic measure for programs to self-evaluate their fidelity to DBT and identify potential areas for improvement. The measure is used to rate the extent to which a program is structured to include the critical elements of comprehensive DBT (Linehan, 1993). Although program fidelity does not guarantee the quality of treatment provided, it does ensure that a program is structured to enable DBT to be delivered in a manner consistent with the comprehensive evidence-based model. The DBT PFC includes 16 items that were adapted from the 29-item DBT Program Fidelity Scale (DBT PFS; Schmidt, Ivanoff, Linehan, Korslund, & Wolbert, 2015), the measure developed by the DBT-Linehan Board of Certification. The DBT PFC draws from each domain included in the DBT PFS but is not meant to be a complete list of all elements required to be a full fidelity comprehensive DBT program. The DBT PFC can be completed by therapists, team leaders, or teams as a whole.

Guidelines for Rating

The DBT PFC is intended to be used to rate a single, structured DBT program, which involves a team of therapists who work together (typically in the same setting) and follow a common set of policies and procedures when implementing DBT. The DBT PFC should not be used to rate DBT teams that do not work together in the same program (e.g., teams consisting of solo practitioners who work in different settings and follow different policies and procedures). Additionally, some programs may offer comprehensive DBT (i.e., individual therapy, skills training, between-session consultation, and therapist consultation team) as well as non-comprehensive DBT (e.g., a DBT skills group only track). In these cases, the DBT PFC items should be rated as they pertain to the comprehensive DBT program. If an organization offers multiple comprehensive DBT programs (e.g., adolescent and adult programs), each program should be rated separately.

Importantly, the DBT PFC is not meant to be a measure of therapist adherence. The items assess the structure and functions of a comprehensive DBT program, but not the degree to which therapists in the program deliver DBT with adherence to the manual. As such, ratings should be based on the program's general structure and approach to delivering DBT, and do not require review or knowledge of therapists' degree of adherence in individual or group sessions.

Items and Response Scale

Each item on the DBT PFC represents an element of program fidelity to DBT. Of the 16 items, 14 are required elements of all comprehensive DBT programs. Required elements (items #1-14) are labeled as such, both in this manual and in the DBT PFC, where they are identified with an asterisk (*). The remaining 2 items (#15 and 16) assess program elements that are required only if working with certain client populations (e.g., minors) or in certain treatment settings (e.g., inpatient).

Each DBT PFC item is rated on a 3-point scale.

0 = Below fidelity
1 = Meets the threshold for fidelity
2 = Exceeds the threshold for fidelity

For each item, behavioral anchors are provided for "0", "1", and "2" that specifically define each level of fidelity for that program element. Although a score of "1" is sufficient for fidelity, a score of "2" is considered ideal and programs should strive to achieve this higher level of fidelity whenever possible. Items with a score of "0" indicate that changes are needed to reach the level of fidelity.

DBT PFC Versions

The DBT PFC has a basic and extended version. The basic version includes the 16 primary items as well as 3 overall evaluation items. The extended version adds text boxes after each of the 16 primary items to provide space for comments (e.g., to explain why the element was rated as above or below fidelity).

Scoring the DBT PFC

There are two options for scoring the DBT PFC.

Total fidelity score. A total fidelity score can be created by determining the percentage of relevant items that meet or exceed the threshold for fidelity (possible range = 0-100%). This is computed as the total number of items scored as "1" or "2" divided by the total number of items relevant to the program. The number of relevant items will range from 14 to 16 depending on the program; i.e., the 14 required items (#1-14) plus up to 2 context-dependent items (#15 and 16). A score of 100% indicates that the program is viewed as meeting the threshold for fidelity on all elements in this measure. A score less than 100% indicates that one or more elements of the program need improvement to reach the level of fidelity.

Average fidelity score. An average fidelity score can be created by calculating the average score on all items relevant to the program (possible range = 0-2). This score can be interpreted using the rating scale for the items. For example, a score less than 1 indicates that, on average, the elements of the program are below the threshold for fidelity, whereas a score greater than 1 indicates that the program elements meet the threshold for fidelity on average. Scores closer to 2 indicate that many program elements exceed the threshold for fidelity. It is important to note that a program may have an average fidelity score of 1 or higher and still have some program elements that are below fidelity (i.e., scored as "0").

Psychometric Properties

To date, the psychometric properties of the DBT PFC have been evaluated in a sample of 50 DBT therapists and 46 linked team members working in DBT programs in routine practice settings. In this study, therapists and another member of their team read the DBT PFC training manual and then independently rated their program's fidelity. The primary psychometric indices that were evaluated include: (1) internal consistency (i.e., the degree of interrelationship among items in the measure) and (2) inter-rater reliability (i.e., the degree of agreement between the two raters).

Internal consistency. The DBT PFC was found to have acceptable internal consistency ($\alpha = 0.76$).

Inter-rater reliability. The average item-level agreement rate between therapists and their team members was 83.4% (SD = 15.4, range = 52.5% - 95.0%). Overall, inter-rater reliability was excellent for the average fidelity score (ICC = 0.76) and good for the total fidelity score (ICC = 0.60). This indicates that therapists and their team members generally rated their program's fidelity in similar ways. Importantly, the validity (accuracy) of the DBT PFC scores generated by therapists and team members was not

assessed (e.g., by comparing them to an expert rater). Thus, DBT PFC scores should be interpreted with some caution.

Recommended Uses

Based on the available research, the recommended uses of the DBT PFC are described below.

Potential Use	Description	
Program Development	When developing a new program, use to determine how to structure the program to maximize fidelity.	
Quality Improvement	For existing programs, use to identify program elements in need of improvement and discuss with the team.	
Formal Assessment of Program Fidelity	Use to make reliable and valid determinations of whether a program meets the criteria of a full fidelity DBT program.*	

*This is not a recommended use given that (1) the DBT PFC does not evaluate all required elements of a comprehensive DBT program, and (2) the accuracy (validity) of the DBT PFC when rated by DBT providers in routine care has not been established.

How to Use this Manual

- We strongly suggest reading through this entire manual prior to completing the DBT PFC, as the manual includes more detailed descriptions of the meaning of each item.
- Examples in the manual are meant to be illustrative rather than exhaustive. There are numerous examples that could be used to illustrate any given element of fidelity.
- DBT PFC items are grouped by treatment mode, overall structure, population, and setting. Not all items will be relevant for all programs.

Citation

Harned, M. S. & Schmidt, S. C. (2022). *The Dialectical Behavior Therapy Program Fidelity Checklist (DBT PFC).* **https://www.dbtadherence.com/**

I. INDIVIDUAL THERAPY

This set of items assesses the extent to which the DBT program upholds the structure and function of the individual therapy mode of treatment. If the DBT program does not assign a primary provider (typically an individual therapist) to each client, check the box at the top of this section, enter "0" for items 1 and 2, and continue to Section II.

- *Note: If the program provides both comprehensive DBT and non-comprehensive DBT (e.g., some clients only receive a DBT skills group), rate the items in this section as they pertain to the comprehensive DBT program.*

***1. DBT program provides a primary provider for each client who is responsible for clinical decision-making that impacts the client's treatment plan.**

Item description: In essence, the primary provider functions as the "backbone" of the client's DBT treatment and is thus responsible for all clinical decision-making for that client. This means that decisions related to the client's treatment plan are referred to the primary provider who is responsible for developing the treatment plan, modifying it when needed, and organizing other providers (e.g., group leaders) to help implement the treatment plan as appropriate. The treatment plan may be a formal document or a more informal plan that includes the goals of treatment and the interventions that will be implemented to achieve these goals. Importantly, although the primary provider is ultimately responsible for their client's treatment plan, this does not mean that clinical decision-making is made in isolation. The primary provider can seek consultation from team members or others, but final decisions about the treatment plan are left to the primary provider. An exception may occur if the primary provider is unlicensed, in which case a supervisor who is legally and clinically responsible for the client may work in tandem with the primary provider to make decisions about the client's treatment plan.

ITEM RESPONSES:

Below fidelity (0): Primary provider is not responsible for clinical decision-making that impacts the client's treatment plan (e.g., treatment plans are managed by the DBT team as a whole or a non-DBT provider).

Meets threshold for fidelity (1): Primary provider is responsible for most but not all clinical decision-making that impacts the client's treatment plan (e.g., implementing but not developing or modifying the treatment plan).

Exceeds threshold for fidelity (2): Primary provider is responsible for all clinical decision-making that impacts the client's treatment plan, including developing, modifying, and implementing the treatment plan.

***2. The primary provider has individual sessions with the client that occur at least weekly and focus primarily on helping the client to replace maladaptive behaviors with skillful responses.**

Item description: The primary function of the individual therapy mode of DBT is to help clients replace maladaptive behaviors with skillful responses. This requires individual therapists to assess and problem solve motivational and other factors (e.g., emotions, cognitions, environmental factors) that may inhibit effective behaviors and/or reinforce maladaptive behaviors. For example, this may be done by building clients' motivation to change, conducting chain analyses of the factors leading up to and following maladaptive behaviors, and/or problem-solving factors that get in the way of skillful behavior. If individual sessions are primarily used for other purposes (e.g., individual skills training) or therapists are required to regularly use session time to do unrelated tasks (e.g., complete agency-required paperwork), then the program would not be structured in a way that meets the intended function of individual therapy. Importantly, this item is intended to measure whether the individual therapy mode of DBT is structured in a way that makes it possible to achieve the function of replacing maladaptive behaviors with skillful responses, and not the extent to which individual therapists are adherent or effective in doing so. To ensure the function of this mode can be sufficiently met, individual therapy sessions typically occur at least weekly. However, session frequency can vary based on clients' needs (e.g., increasing frequency in times of significant stress and decreasing frequency late in treatment if clients have fewer needs).

ITEM RESPONSES:

Below fidelity (0): Primary provider meets with the client less than weekly *and/or* sessions do not focus primarily on helping the client to replace maladaptive behaviors with skillful responses.

Meets threshold for fidelity (1): Primary provider meets with the client at least weekly and most but not all sessions focus on helping the client to replace maladaptive behaviors with skillful responses.

Exceeds threshold for fidelity (2): Primary provider meets with the client at least weekly and all sessions focus on helping the client to replace maladaptive behaviors with skillful responses.

II. SKILLS TRAINING

This set of items assesses the extent to which the DBT program upholds the structure and function of the skills training mode of treatment. Skills training may be delivered in a group or individual format. If the DBT program does not provide skills training, check the box at the top of this section, enter "0" for items 3 and 4, and continue to Section III.

***3. DBT skills training occurs at least weekly and focuses on teaching DBT skills in a systematic way.**

Item description: Skills training in DBT encompasses the following modules: (1) Mindfulness; (2) Emotion Regulation; (3) Interpersonal Effectiveness; and (4) Distress Tolerance. Skills training is typically conducted in a weekly group format, though other formats (e.g., individual skills training) may also be acceptable provided skills training occurs at least weekly and there is a systematic way for doing so. This means that there is a standard protocol for delivering skills training including following a set schedule that specifies the order of skills being taught and the time it will take to complete all of the skills

modules. In addition, skills training should focus only on teaching skills from DBT and should not include skills from non-DBT treatments.

ITEM RESPONSES:

Below fidelity (0): Program offers DBT skills training less than weekly, not in a systematic way *and/or* skills training includes teaching of non-DBT skills.

Meets threshold for fidelity (1): Program offers DBT skills training at least weekly that teaches a subset of DBT skills (e.g., just emotion regulation) in a systematic way, but does not offer comprehensive skills training.

Exceeds threshold for fidelity (2): Program offers weekly DBT skills training in a systematic way that includes all standard DBT skills modules (mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness).

***4. DBT skills training is conducted in a psychoeducational format that primarily focuses on building clients' capability to engage in skillful behavior.**

Item description: The primary function of DBT skills training is to increase clients' capability to engage in skillful behavior by teaching them new skills. Skills training should be conducted in a psychoeducational format (i.e., using a didactic teaching style) that includes teaching new skills as well as assigning and reviewing skills practice homework. Although clients may raise other topics (e.g., talking about stressful events they experienced in the past week), the primary focus of the discussion should be on skills (e.g., how the skills being taught could be applied to a specific situation). If skills training time is regularly used to do things other than teach, review, and practice skills (e.g., do "check-ins" with each client at the start of group or conduct chain analyses of clients' target behaviors), then the program would not be structured in a way that meets the intended function of skills training. Importantly, this item is intended to measure whether the skills training mode of DBT is structured in a way that makes it possible to achieve the function of building clients' capability to engage in skillful behavior, and not the extent to which skills trainers are adherent or effective in doing so.

ITEM RESPONSES:

Below fidelity (0): DBT skills training is not conducted in a psychoeducational format *and/or* skills training often focuses on issues other than teaching and practicing new skills.

Meets threshold for fidelity (1): DBT skills training is conducted in a psychoeducational format that primarily focuses on teaching new skills but does not consistently assign and/or review skills practice homework.

Exceeds threshold for fidelity (2): DBT skills training is conducted in a psychoeducational format that primarily and consistently focuses on teaching new skills and assigning and reviewing skills practice homework.

III. BETWEEN-SESSION CONSULTATION

This set of items assesses the extent to which the DBT program upholds the structure and function of the between-session consultation mode of treatment. If the DBT program does not offer skills coaching and crisis intervention outside of scheduled sessions, check the box at the top of this section, enter "0" for item 5, and continue to Section IV.

***5. DBT program ensures that skills coaching and crisis intervention is available to clients at all times outside of scheduled sessions.**

Item description: The functions of between-session consultation are to: (1) decrease suicide-related crisis behaviors; (2) increase generalization of skills to the outside environment; and (3) repair the relationship between the client and the provider. A DBT client should have access to between-session consultation that is consistent with DBT principles and procedures (e.g., offers coaching in specific DBT skills). If the program does not offer 24/7 between-session consultation, they may use a DBT or non-DBT after-hours service to fulfill this function. If a non-DBT after-hours service (e.g., a suicide crisis hotline) is utilized, to meet the threshold for fidelity it would need to have access to an individualized crisis plan for each client in the program that includes information about specific DBT skills to suggest and how to most effectively intervene in a crisis. To exceed the threshold for fidelity, the program would either need to provide 24/7 between-session consultation or utilize an after-hours service with DBT-trained staff.

ITEM RESPONSES:

Below fidelity (0): DBT program offers between-session skills coaching and crisis intervention that is less than 24/7 *and* utilizes a non-DBT after-hours service that *does not have* access to clients' DBT crisis plans.

Meets threshold for fidelity (1): DBT program offers between-session skills coaching and crisis intervention that is less than 24/7 *and* utilizes a non-DBT after-hours service that *has* access to clients' DBT crisis plans.

Exceeds threshold for fidelity (2): DBT program offers skills coaching and crisis intervention 24/7 *or* utilizes an after-hours service with DBT-trained staff.

IV. CONSULTATION TEAM

This set of items assesses the extent to which the DBT program upholds the structure and function of the therapist consultation team mode of treatment. If the DBT program does not have a consultation team, then check the box at the top of this section, enter "0" for items 6-9, and continue to Section V.

***6. DBT consultation team meets weekly and all DBT providers are required to attend.**

Item description: The expectation is that the DBT consultation team meets weekly, and all DBT

providers are required to attend. This does not mean that a provider cannot periodically miss a meeting (e.g., due to sickness or being on vacation), but that the general expectation is that DBT providers attend DBT consultation team each week. A provider should not miss DBT team to meet with clients or for other program-related issues (e.g., a crisis on another unit) except in rare or unusual circumstances. In addition, attendance should be tracked and addressed when needed.

ITEM RESPONSES:

Below fidelity (0): Consultation team meets less than weekly *and/or* not all DBT providers are required to attend.

Meets threshold for fidelity (1): Consultation team is scheduled to meet weekly but can be preempted by other program meetings *and/or* all DBT providers are expected to attend but some regularly miss meetings.

Exceeds threshold for fidelity (2): Consultation team meets weekly, all DBT providers attend consistently, and attendance is tracked and addressed when needed.

***7. DBT team members commit to delivering DBT and following team agreements, and non-DBT providers do not regularly participate in team meetings.**

Item description: Prior to joining team, providers should make a clear commitment to delivering DBT and abiding by team agreements. Standard commitments can vary by team, but these may include agreeing to deliver DBT in a way that is consistent with the treatment manual, to be willing to give clinical advice to others on team, and to be nonjudgmental towards clients and fellow therapists. Once providers are on the team, there should be methods in place to ensure ongoing review and monitoring of these commitments. For example, a team agreement may be read at the beginning of each meeting and/or if a team member is not abiding by a particular agreement (e.g., is not actively delivering DBT to clients in the program) this is identified as a problem, assessed, and solutions are offered. In addition, while non-DBT providers (e.g., administrators or other providers not engaged in the delivery of DBT) may periodically attend the team for a specific function (e.g., for informational or training purposes), they should primarily be observers and should not regularly participate in team meetings.

ITEM RESPONSES:

Below fidelity (0): Providers can join the team without a clear commitment to delivering DBT and adhering to team agreements *and/or* non-DBT providers regularly participate in team meetings.

Meets threshold for fidelity (1): Only providers who commit to delivering DBT and following team agreements can join and regularly participate in the team, but these agreements are *not* consistently reviewed or monitored once providers are members of the team.

Exceeds threshold for fidelity (2): Only providers who commit to delivering DBT and following team agreements can join and regularly participate in the team, and these agreements *are* consistently reviewed and monitored at team.

***8. There is a designated DBT team leader who functions as the head of the DBT team.**

Item description: Each DBT team should have a designated team leader. Specific tasks of the team leader can vary in accordance with the team's needs; for example, team leaders in DBT programs embedded in larger systems (e.g., hospitals) may have more administrative duties, whereas a team leader of a group of private practitioners may not. The general principle is that the team leader is generally responsible for the overall structure of the team (e.g., meeting format; team composition) and addressing problems with team functioning. The DBT team leader is also expected to be well-trained in DBT and actively delivering DBT to clients. Sometimes, the team leader is a person who has more expertise or training than the other members of the team, but this does not have to be the case. Of note, the team leader is different from the DBT team meeting leader (i.e., the person who facilitates the DBT consultation team meeting). The DBT team leader is typically a consistent position, whereas the DBT team meeting leader may rotate.

ITEM RESPONSES:

Below fidelity (0): There is no designated team leader *or* the designated team leader is not adequately trained in DBT and/or does not deliver DBT to clients.

Meets threshold for fidelity (1): There is a designated team leader who is well-trained in and delivering DBT to clients but does not effectively manage the team and/or address obstacles to team functioning.

Exceeds threshold for fidelity (2): There is a designated team leader who is well-trained in and delivering DBT to clients, effectively manages the team, and addresses obstacles to team functioning.

***9. DBT consultation team primarily focuses on increasing providers' capabilities, motivation, and adherence, and ensures that each provider obtains sufficient consultation.**

Item description: This item is assessing the extent to which the DBT consultation team is meeting the function of the team mode of treatment, which is to increase provider capabilities (i.e., skill in delivering the treatment across all modes), motivation (i.e., willingness and desire to deliver DBT), and adherence to DBT (i.e., delivering DBT in a manner consistent with the treatment manual). Overall, the goal of consultation team is to provide "therapy for the therapist;" that is, to ensure that providers' needs and behaviors that interfere with delivering DBT effectively are addressed. This includes ensuring that there is sufficient time for providers to obtain consultation when needed and that all providers actively participate in team meetings. "Active participation" means that each member of the team is expected to regularly speak and contribute rather than sitting silently. There is no set amount of time that must be allotted for each team member to obtain consultation, as this is dependent on providers' specific needs during each meeting. However, there must be sufficient time to allow most members to participate most weeks. The general principle is that of reciprocal vulnerability; i.e., each team member must participate in both giving and receiving consultation. Ideally, each provider offers at least some consultation to other team members each week and asks for consultation as often as is needed (and at least some of the time). Teams that primarily focus on clients' needs and behaviors and/or administrative issues instead of providers' needs and behaviors would not be structured in a way that meets the intended function of DBT consultation team.

ITEM RESPONSES:

Below fidelity (0): DBT team often primarily focuses on clients' needs or administrative issues *and/or* there is insufficient time to help each provider to increase capabilities, motivation, and adherence.

Meets threshold for fidelity (1): DBT team primarily focuses on increasing providers' capabilities, motivation, and adherence, but team members are allowed to sit silently and/or not obtain consultation for weeks.

Exceeds threshold for fidelity (2): DBT team is organized to allow each provider opportunities to obtain consultation to increase capabilities, motivation, and adherence, and all team members actively participate in meetings.

V. GENERAL TREATMENT STRUCTURE AND APPROACH

***10. There are contingencies in place that make it clear when a client is no longer in treatment (e.g., 4-miss rule) and to avoid reinforcing suicidal behavior (e.g., 24-hour rule).**

Item description: There are two rules in standard outpatient DBT with adults that function as contingency management strategies: the 4-miss rule (i.e., if clients miss 4 sessions in a row of individual or group treatment they are out of DBT) and the 24-hour rule (i.e., if a client engages in suicidal or self-harming behavior, they may have no between-session contact with their provider for the next 24 hours). However, not all programs can abide by these specific rules (e.g., a residential treatment unit with multiple treatment sessions daily; a school-based or adolescent program whose providers are expected to immediately assess any disclosure of self-harming behavior). Thus, the principle here is that there needs to be (1) an agreed upon objective criterion for determining when a client is no longer in DBT, and (2) procedures in place to avoid reinforcing suicidal behavior with unscheduled therapist contact. These contingencies should be applied consistently across clients.

ITEM RESPONSES:

Below fidelity (0): Program does not have contingencies in place that make it clear when a client is no longer in treatment *and/or* to not reinforce suicidal behavior.

Meets threshold for fidelity (1): Program has contingencies in place to make it clear when a client is no longer in treatment and to not reinforce suicidal behavior, but these procedures are not consistently enforced.

Exceeds threshold for fidelity (2): Program has contingencies in place to make it clear when a client is no longer in treatment and to not reinforce suicidal behavior *and* these contingencies are consistently enforced.

***11. DBT program continuously monitors client progress.**

Item description: Ongoing monitoring of client progress is critical for ensuring that the DBT program is achieving desired outcomes. While the primary way most programs do this is via DBT diary cards, ongoing monitoring of client progress can also include other methods such as collecting self-report data or conducting diagnostic interviews. The critical piece here is that progress monitoring cannot solely be determined by data provided by individuals other than the clients (e.g., clinical observation, informant report). Diary card data is generally monitored daily/weekly, while other relevant outcomes can be assessed at whatever intervals make the most sense for the program.

ITEM RESPONSES:

Below fidelity (0): Program does not monitor outcomes, assesses irrelevant outcomes, *and/or* relies solely on data not provided by clients (e.g., parent report).

Meets threshold for fidelity (1): Program inconsistently monitors outcomes (e.g., does not routinely collect diary cards or other relevant outcome measures).

Exceeds threshold for fidelity (2): Program routinely monitors client outcomes, including tracking of targeted behaviors daily/weekly (e.g., via a diary card) and other relevant outcome measures if indicated.

***12. DBT program adheres to an agreed to length of treatment and extensions depend on evidence of client progress and recommitment.**

Item description: A client who commits to DBT should know exactly how long they are agreeing to do the treatment and the length of treatment should be agreed to during pre-treatment. While a client may initially agree to a certain length of treatment, there are times when extending the treatment contract may be indicated. Continuation in DBT beyond the initially agreed upon treatment contract should be contingent upon client progress (i.e., clients must show some signs of progress to extend a treatment contract). Therapists should have a rationale for extending treatment that is discussed with the team, including clearly explicated goals for the extension period on which the client has agreed to work. For example, a client who has recently completed PTSD treatment may want to extend their treatment contract to work on goals related to finding employment, which they were unable to do when PTSD was still active. If treatment is extended, clients are required to recommit to engage in DBT for the agreed to extension period.

ITEM RESPONSES:

Below fidelity (0): There is no length of treatment agreed to at the beginning of therapy.

Meets threshold for fidelity (1): There is an agreed to length of treatment, but extensions are allowed without evidence of client progress, a solid rationale for continuation that is discussed in team, and/or recommitment.

Exceeds threshold for fidelity (2): There is an agreed to length of treatment and extensions require evidence of client progress, a solid rationale for continuation that is discussed in team, and recommitment.

***13. The DBT program follows the principles of behaviorism, dialectics, and acceptance across all modes of treatment.**

Item description: The theoretical underpinnings of DBT consist of behavior therapy, dialectical philosophy, and acceptance-based practices derived from Zen. Thus, principles of behaviorism, dialectics, and acceptance should underlie all modes of DBT and form the theoretical foundation of the treatment. For example, during consultation team meetings providers should provide validation, search for dialectical balances, and use behavioral strategies to change team members' behavior when needed. Similarly, skills groups leaders should apply validation, change, and dialectical strategies in the process of teaching clients' new skills, and so on for the other modes of treatment. Ideally, other theoretical approaches (e.g., psychodynamic) should not be followed in the program and, if they are, should clearly be secondary.

ITEM RESPONSES:

Below fidelity (0): The DBT program does not adopt the principles of behaviorism, dialectics *and/or* acceptance as the theoretical foundation of treatment.

Meets threshold for fidelity (1): The DBT program follows the principles of behaviorism, dialectics, and acceptance, but not across all treatment modes *and/or* other theories (e.g., psychodynamic) are also followed.

Exceeds threshold for fidelity (2): The DBT program only follows the principles of behaviorism, dialectics, and acceptance, and these theories form the theoretical foundation of all modes of treatment.

***14. The DBT program only adapts the treatment when needed and, if adaptations are made, they are consistent with DBT principles and assumptions and clearly documented.**

Item description: Whenever possible, DBT programs should deliver the standard DBT treatment model without adaptation or utilize existing evidence-based adaptations (e.g., for adolescents). However, there are times when programs may decide that novel adaptations to the standard treatment are needed. This may be done for a variety of reasons, including system-related regulations, program structure, and population-specific needs. The principle here is that adaptations should only be made when needed (e.g., when adopting standard DBT is ineffective or not possible) and any adaptations must be consistent with DBT principles and underlying assumptions. For example, if a DBT program is embedded in a larger hospital system that requires providers to contact clients within 24 hours of any suicide attempt (i.e., to violate the 24-hour rule), but the program has identified providers outside the DBT team to make these

mandated contacts with DBT patients, this would be a needed adaptation that would be consistent with DBT principles. However, if a DBT program decided that they did not want to utilize the 24-hour rule because they felt it was overly harsh, and they were instead going to increase contact with clients immediately after a suicide attempt, this would be both inconsistent with DBT principles as well as not needed.

ITEM RESPONSES:

Below fidelity (0): Adaptations were made without a sufficient rationale for changing standard DBT, that violate the principles of DBT, *and/or* when a relevant evidence-based adaptation already exists.

Meets threshold for fidelity (1): Adaptations were necessary and are consistent with DBT principles and assumptions, but the adaptations are not documented in sufficient detail.

Exceeds threshold for fidelity (2): No adaptations were made *or* adaptations were necessary and are consistent with DBT principles, clearly justified and documented, and well-integrated with other DBT elements.

VI. PROGRAM POPULATIONS: MINORS AND VULNERABLE/DEPENDENT ADULTS

If the DBT program does not treat minors or vulnerable/dependent adults, then check the box at the top of this section, rate item 15 as "NA" (not applicable), and continue to Section VII.

15. When working with minors or vulnerable/dependent adults, outreach is made to include caregivers (e.g., parents, other family members, or supportive individuals) in treatment.

Item description: In general, caregivers should be included in treatment when working with minors or vulnerable/dependent adults. However, this may not be the case for each client, and there are a variety of factors that one needs to consider when determining the extent of caregiver involvement in treatment including the age of consent for mental health treatment in one's state/country, the client's wishes, and the degree to which involving caregivers is likely to be helpful or harmful to the client and treatment as a whole. Thus, this item is assessing whether the DBT program – on principle – adheres to these guidelines when working with caregivers but is not meant to be proscriptive across all clients. For minors, parents are typically included in DBT treatment via participation in multi-family or parent only skills groups and regular family sessions. Many programs also provide parent skills coaching by providers other than the teen's individual therapist. Of note, "exchange of information" does not include confidential information for individuals who are able to provide consent to mental health treatment. In general, therapists should meet with caregivers with the client present and rely on the strategy of "consultation-to-the-client" (rather than acting as an intermediary between client and caregiver) whenever possible.

ITEM RESPONSES:

Below fidelity (0): Program works only with the identified client and does not include caregivers in treatment when indicated *or* only meets with caregivers as requested by the client.

Meets threshold for fidelity (1): Program meets with caregivers to exchange information, but caregivers are not systematically included in treatment when indicated (e.g., parents of minors do not receive skills training).

Exceeds threshold for fidelity (2): Program systematically includes caregivers in treatment by providing skills training and/or coaching to caregivers and having regular joint/family sessions when indicated.

VII. PROGRAM TYPES: MILIEU TREATMENT/DAY PROGRAM/INPATIENT/RESIDENTIAL

If the DBT program is not milieu/day/inpatient/residential, then check the box at the top of this section, rate item 16 as "NA" (not applicable), and continue to Section VIII.

16. Milieu staff in the DBT program help to promote skills generalization and prepare clients for the external environment.

Item description: As skills generalization is a major component of comprehensive DBT treatment, programs in which clients spend most or all of their days away from their home environment must structure treatment to still facilitate generalization of skills. Thus, there should be a thorough assessment of a client's cues for engaging in target behaviors in their usual external environment, and strategic targeting of these cues while the client is in the milieu/day/residential/inpatient program. For example, this could include creating distress tolerance kits, developing cope ahead plans, identifying situations in which to practice exposure to cues for target behaviors. As these assessments are typically conducted by the primary provider, communication with the milieu staff about target-relevant behaviors and associated cues can be helpful. Milieu staff should also be trained in the DBT skills and able to provide coaching to clients when needed.

ITEM RESPONSES:

Below fidelity (0): Milieu staff do not know the DBT skills *and/or* there is no effort to support cue exposure or generalization of DBT skills.

Meets threshold for fidelity (1): Milieu staff coach DBT skills in a rote manner, without emphasis on cue exposure or the larger goal of generalizing skills to the client's home environment.

Exceeds threshold for fidelity (2): Milieu staff actively coach clients to use DBT skills and there is evidence that primary providers communicate relevant skills and cues to staff (when appropriate).

VIII. OVERALL EVALUATION

17. Total fidelity score:

The total fidelity score is calculated as the percentage of relevant items that meet or exceed the threshold for fidelity (possible range = 0-100%). (See scoring section on p. 3 for information on how to compute and interpret this score.)

18. Average fidelity score:

The average fidelity score is calculated as the average of all relevant items (possible range = 0-2). (See scoring section on p. 3 for information on how to compute and interpret this score.)