Community Wide Implementation and Integration of Dialectical Behavior Therapy (DBT) into Adult and Youth Treatment Services in Thunder Bay

PACE Year End Final Report

Project Lead: Fred Schmidt

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Executive Summary
People Advancing Change through Evidence (PACE) Final implementation report

Name of organizations: Children's Centre Thunder Bay; Sister Margaret Smith Centre; Thunder Bay Counselling Centre
Project title: Community Wide Implementation and Integration of Dialectical Behavior Therapy (DBT) into Adult and Youth Treatment Services in Thunder Bay
Project lead: Fred Schmidt, Psychologist

DBT was implemented on a large multi-sector basis in Thunder Bay to meet the needs of complex high need youth and adults. This involved extensive planning by a multi-sector steering committee who oversaw a 15 month training plan. This resulted in cross organization residential and outpatient DBT treatment teams for both adult and youth mental health, substance abuse, and correction programs. Evaluation of the impact that training had on therapist and organizational functioning revealed meaningful and positive effects on therapist functioning, but minimal observed benefits on organization functioning. Many positive lessons learned were achieved through this implementation process including importance of thoughtful planning prior to training, careful selection of therapists, value of multi-sector collaboration, paying attention to fidelity and sustainability of treatment implementation, and the need to compensate for ongoing therapist attrition.

The Purpose and Goals of the Implementation

- To build multi-sector relationships and a shared vision for treatment services of high need and complex clients within the larger community
- To implement an evidence informed treatment model, Dialectical Behavior Therapy, to meet the needs of our most difficult and high risk clients
- To increase organizational capacity and learning on how to implement future EIPs

The Intervention

Through a consultation process, DBT was identified as a treatment program which would best address the needs of the high risk and complex clients served across multiple sectors and organizations within Thunder Bay. This intervention model builds on CBT principles through the incorporation of acceptance/ validation as well as mindfulness strategies. It also contains comprehensive skill modules which can be done on a group basis along with a full individual-based treatment protocol. DBT is an EIP which has demonstrated effectiveness across both youth and adults in the mental health, substance abuse, and youth justice sectors. The flexibility and comprehensiveness of DBT as a treatment model provided the opportunity to simultaneously implement this intervention across multiple treatment teams and organizations.

The Plan

An extensive planning and community engagement process was undertaken by a multi-sector steering committee. This committee took the lead in orchestrating the training process which spanned over roughly a 15 month period of time. The following treatment modules, by DBT trainers Shari Manning and Annie McCall, were conducted: 1) DBT skills training sessions on February 6 – 8, 2013 (370 staff), 2)

individual therapy training for 51 therapists on April 29 – May 3, 2013; September 18- 20, 2013; and December 5-6, 2013. As part of this training, evaluation was completed examining the impact of training on both therapist and organizational functioning. DBT training and implementation was found to have a beneficial impact on therapist functioning but less so at an organizational level.

Wrap up

The cumulative experience of implementing an intensive and complex intervention has required significant resources (both staff time and money) to orchestrate. It has clearly had a formative impact on our respective organizations with many lessons learned including:

- Critical importance of careful and thoughtful planning prior to embarking on any training or service delivery change.
- Need to engage key stakeholders both within each organization and across community stakeholders to achieve a shared collaboration and ownership of implementation.
- The importance of creating a vision of "why" the implementation plan and intervention is needed.
- The value and necessity of a steering group which includes "champions" while simultaneously having the capacity to complement each other in terms of skill sets and responsibilities.
- The need for flexibility and ability to adjust plans as circumstances change.
- Provision of comprehensive training and active learning strategies for therapists.
- Recognition of the challenges involved in sustaining any implementation project and that sustainability requires ongoing attention and effort to avoid treatment drift or drop in services

This DBT implementation experience has also created a significant multiplier effect in terms of the quality and depth of treatment services provided to our most complex and high risk youth in Thunder Bay. It has allowed us to strengthen the level of adult and youth service programs across outpatient, residential, substance abuse, and youth justice program areas. As a result, CCTB and our community partners have formed new relationships which will enhance our collaborations on future treatment services. It has also highlighted the importance and need for ongoing sustainability efforts for an implementation initiative.

Amount awarded: $150,000

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Region: MCYS region

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Background and Introduction to PACE Project

The Children's Centre Thunder Bay (CCTB) has been actively working to enhance the uptake, implementation, and sustainability of Evidence Informed Practices (EIPs) for many years. This process began in earnest following an organizational wide Appreciative Inquiry process that occurred in September 2008. Through this reflective review process, the implementation and use of EIPs, amongst other initiatives, where embraced on an organizational level. One component of this philosophical shift included the institution of the Clinical Research and Development Committee (CRDC). This Committee, comprised of senior clinical staff from across disciplines and programs, as well as managers, provides ongoing clinical leadership and vision for strengthening CCTB's clinical practices. Currently, CCTB has worked to strategically implement and integrate EIPs in a more systemic manner. Over the past seven years, CCTB has integrated EIPs within the organizations service delivery system. This has included a number of EIPs including Second Step, TCI, Assist, Triple P, Circle of Security, Coping Cat, and Family Therapy. There has also been a directed readings group, and subsequent peer development group, focussed on the use of Cognitive Behavioural Therapy (CBT) as a means of developing broader CBT capacity within CCTB. The current PACE project has occurred in the midst of this overall organizational direction to become more effective and use existing EIPs to enhance services.

The goals and objectives of the current implementation project was to implement Dialectical Behavior Therapy (DBT) within the community of Thunder Bay, across multiple partner organizations, as a means of supporting overall organizational growth while addressing needs of high risk complex youth. Investment in DBT as a treatment model was not new to CCTB. In the past, due to clinician interest and request, a small group of clinicians on the outpatient services team were trained in DBT and provided both group and individual services using the DBT model. This was complemented, several years later, with the youth justice team being trained in DBT. However, due to multiple reasons, including staff

attrition, lack of resources, and increasing clinical demands for other services, these initial efforts at implementation were not fully sustained despite significant interest from clinicians.

Through consultation and input from frontline staff, the MLT (Management Leadership Team) and CRDC committee, the expansion and integration of DBT into clinical services was identified as the next stage of organizational development. Within CCTB, previous organizational discussions identified the need to: 1) enhance existing DBT services within the outpatient and youth justice programs and, 2) expand the use of DBT into the residential treatment and parenting programs. Additionally, work with a number of community partners in the youth justice, adult mental health and addictions systems explored the benefits of a more integrated community-wide approach to using DBT. This would provide a more consistent treatment approach across multiple sectors of the organization and complement the use of DBT services within the adult mental health and addictions systems across the community. This has many advantages as it will allow for a consistent and complementary treatment approach for clients involved in multiple service systems and also provide greater support and language for clinicians who work in these respective systems.

From past experience, it was apparent that initial effort to sustain DBT was weak despite the interest and high motivation of front line clinicians. Through this experience and findings from the research literature, it was clear that the PACE model of implementation would be highly beneficial. For example, Durlak and DuPre (2008) found that programs which “re-installed” an EIP with a second round of training were able to double therapist fidelity scores and increase adherence to the treatment model to over 85%. Thus, efforts to develop quality programs and services using DBT must be completed over a lengthy period of time, with significant direction and support from senior management, and intensive training. To undertake this task, a core steering committee, including key representation from partner organizations was struck to move forward with this initiative.

The objective and goals for this PACE project was to comprehensively implement DBT within CCTB, but to also establish community partnerships and treatment program collaborations across organizations. This was seen as being optimal as it not only strengthens the quality of treatment services, but also provides greater continuity and consistency in treatment delivery for shared clients across the mental health system.

Planning Phase

Over the course of the three year PACE DBT implementation process, considerable planning occurred. This involved consistent bi-weekly to tri-weekly meetings of the PACE steering committee. These meetings incorporated multiple tasks including engagement of stakeholders, coordination of a 15 month training plan, coordination of DBT programs and services across the community, and planning for DBT sustainability. Multiple and varied steps were undertaken to ensure positive outcomes.

In the first year of implementation, considerable efforts were taken to engage key champions and middle/senior managers who could make decisions about the adoption of DBT. Some of the key highlights of this planning included the following steps:

- Collaboration with the Clinical Research and Development committee and CCTB Management Leadership Team (MLT) to develop the parameters and obligations associated with the DBT implementation (December 2011)
- Provide information to the CCTB Board of Directors and provide regular updates about process of implementation.
- Identify and finalize key champions and senior leaders to support implementation (January 2012). Ensure commitment from key leaders before moving into the training plan.
- Multiple meetings with key community stakeholders to educate about the DBT intervention model, requirements for training, and setting a community vision for collaboration and cross-

sectoral work with shared clients (three meetings in total). Roughly 25 to 35 key leaders attended each of these three community meetings, representing up to 12 different community organizations.

- Engage Lakehead University students to conduct a DBT literature review and treatment summary matrix table (see Appendices A & B)
- Identify DBT trainers and establish a contract for community wide implementation (i.e., Treatment Implementation Collaboration; Shari Manning & Annie McCall)
- Stakeholder engagement session by TIC trainers with key community leaders to introduce the DBT treatment approach and establish commitment to implement DBT (2 days; October, 2012).
- On-going regular communication both within CCTB and across the community organizations (Intranet Cyber Café; Monthly Town Hall forum; Agency day meetings; regular team meetings; organization E-mail communication; management Leadership team meetings).

As part of this process, it was clear that careful and thoughtful planning was critical and essential prior to moving into a training stage of EIP implementation. Mobilization of organizations required significant buy-in and commitment from senior leadership. While interest and motivation from front-line staff was critical for long term success, initial efforts at implementation required a vision from leaders who had decision making capacity in terms of staff and program priorities, financial resources, and willingness to collaborate at a systems level. This was clearly noted as being necessary in our experience as we engaged in three separate community stakeholder meetings prior to commencement of training. Moreover, this initial engagement step in implementation was also recognized by the DBT trainers who requested a two day community information session about DBT prior to training individual therapists. From our experience, this slower process in the initial stages of implementation was highly productive and resulted in greater take-up and engagement from therapists. For example, roughly 370

therapists completed the DBT skills training session and 50 therapists completed the intensive individual therapy training. This was a significant turnout for a city the size of Thunder Bay.

A significant factor identified in the planning phase of implementation was the establishment of a steering committee that would oversee and support the implementation process. Leaving this role to one or two individuals was seen as inadequate. To conduct proper planning and community engagement, it was critical for representation to come from multiple organizations who were key partners, but also from steering committee members who had a shared vision with diverse and unique roles. For example, membership in the steering committee consisted of senior managers, program managers, frontline therapists, researcher, and students. This blend of members allowed for a rich and comprehensive skill set, allowing each member to contribute in a complementary manner. Based on this experience, future efforts at implementation will give strong attention to the process of planning and identifying key leadership positions and champions who can steer implementation based on real decision making powers and abilities together with a vision for overall EIP clinical services.

Doing Phase

The second year of implementation ostensibly focussed on the doing phase. This consisted of training therapists and establishing DBT services. This phase of implementation largely spanned over a 15 month period of time and included the development and use of DBT interventions in various treatment programs within a number of Thunder Bay community organizations, coordination of DBT Core Teams across service organizations, and completing an evaluation of the training process on therapist and organizational functioning. The core components of the DBT training included. Specific DBT training by TIC trainers Shari Manning and Annie McCall occurred on the following days

- skills training sessions on February 6 – 8, 2013 (370 staff)
- ten days of DBT individual therapy training for 51 therapists

- April 29 – May 3, 2013 (5 day DBT Core Team training)
- September 18- 20, 2013 (3 day DBT Core Team training)
- December 5-6, 2013 (2 day DBT Core Team training)

While considerable energy went into the completion of training therapists across multiple agencies, there were other tasks accomplished as well. This included the formation of DBT consultation teams both within and across organization. As shown in Appendix C, there is a mix of full DBT programs (some across organizations) complemented by the integration of DBT skills only groups into several existing service programs. This represents the initial formation and development of a service delivery model for DBT services which has arisen from the training conducted during the Doing Phase. As part of this implementation, research was conducted to identify possible fidelity measures of DBT service delivery. Feedback from the trainers as well as a literature review, however, did not identify possible measures for DBT treatment fidelity. Rather, what was identified was the need for expert therapists viewing and providing feedback of therapy sessions. Attempting to provide this type of fidelity check for every therapist was onerous and not feasible given existing clinical resources. The only available method was ensuring therapists' participation in a DBT consultation team where there was opportunity for case discussion and active learning from other DBT therapists. This limitation regarding fidelity and lack of expert therapists was flagged as a weakness in the implementation process. It was identified that increasing expertise and capacity of community therapists to play a greater clinical lead role was tabled as an important sustainability need. Efforts to address this issue will be further elaborated on under the Sustainability Phase of our implementation.

In parallel with training and establishing a service delivery system, the impact of training on therapists, DBT consultation teams, and overall organizational systems was evaluated. This involved a partnership with a professor from the Social Work Department (Dr. Jo-Ann Vis) and social work student (Shannon Schiffer) and a psychology student (Carlina Marchese) from Lakehead University. The students

developed an evaluation plan (see Appendix D for copy of measures used), collected data, entered data into SPSS, and completed an evaluation report. This final report is attached as Appendix E and the community powerpoint presentation as Appendix F. This evaluation regarding the impact of DBT training on multiple areas of functioning identified significant gains in overall therapist confidence, team functioning, as well as therapists experiencing less secondary traumatic stress. However, there was no change noted on organizational functioning as a result of the training. These results highlighted important changes that arose from the training and suggested that comprehensive implementation of an EIP program can have beneficial effects on therapists in addition to impacting clients' services and outcomes. As part of completing this evaluation, a community session providing feedback about the results was provided by the student (Shannon Schiffer) in October 2014. This presentation was attended by roughly 30 community members.

A significant learning which arose from the Doing Phase of DBT implementation was the importance of thorough planning and engagement of key leaders and community partners for successful training. These two factors were complementary in our training process and helped to actualize and maximize the potential impact of training beyond what any one organization could do. The power and capacity of community and organizational collaboration was powerful and allowed for a multiplier effect from the training. This has helped to shape and guide the philosophy of our respective organizations and helped to cement the importance of working together and pooling resources. Some of these learnings were shared in at the CMHO annual conference held in Toronto on November 9, 2013. The powerpoint presentation for this knowledge mobilization activity is attached as Appendix G.

An important barrier that was identified during the training process was the limiting impact that therapist attrition/mobility had on forming DBT treatment services. Due to changes, it was difficult to form stable and cohesive consultation teams. This latter finding was also an important lesson which will need careful attention in future training and implementation efforts for other treatment services.

Sustaining Phase

The face-to-face DBT training was completed in December, 2013. This included roughly 14 days of didactic and active training sessions. To complement this training, the DBT trainers provided monthly telephone consultation sessions (1 hour) with each consultation team. This was recommended and part of the training process as a means of ensuring fidelity to DBT interventions, but also to assist with and ensure the sustainability of the DBT services. These monthly telephone sessions ended in the fall 2014 and this ended the formal training of DBT services.

Built within the treatment model of DBT interventions is the requirement of weekly DBT team consultation team meetings to discuss cases but, more importantly, to provide continued therapist skill development for each DBT therapist. Adherence to this DBT approach has been embraced and expected for all DBT therapists. This is a key anchor for ensuring fidelity to the DBT treatment model. However, given the breadth of DBT services enacted by the training, additional efforts to ensure fidelity and therapist development has been implemented in the third year of the PACE project. This has included the continued existence of the steering committee, with key leaders in respective organizations, to be available to address needs as they arose across community programs and treatment services. This provided a mechanism by which system issues could be identified and addressed on an on-going basis. This is seen as critical for the sustainability of DBT services within the community and to facilitate on-going collaboration. This addresses the important need to maintain engagement and participation of key leaders and decision makers.

On the individual therapist level, the steering group identified a sustainability need to promote therapist skills on a broad community level as well as develop strong clinical therapists who provide a clinical lead role for overall DBT services. It is hoped this will provide greater internal therapist expertise which can be used to support existing DBT services on an on-going basis. Given the limited resources of

community organizations, it is not feasible to continually contract out and pay for external consults to provide clinical supervision. Developing capacity to do so on an internal basis is a key need for ongoing sustainability. To that end, several "booster" training sessions have been planned for year four of implementation. This has included two web-based training sessions with a DBT expert which will be provided to all DBT therapists in the community (January 27th and March 9, 2015). In addition, a small group of DBT therapists who wish to develop greater expertise and clinical skills in DBT (and be a resource to the community) will be identified over the coming months. These therapists will be provided monthly therapist "coaching" sessions by a DBT expert based on feedback from recorded treatment sessions. This will occur over the next 12-18 months with an expert DBT therapist (i.e., Randy Wolbert). Finally, there have been efforts at establishing a local community network of DBT therapists. This has included establishing a DBT therapist email list and face-to-face meetings which will be organized roughly two times per year. The first DBT therapist meeting occurred on October 26, 2014 with another planned to occur in the spring of 2015. These community meetings are designed to encourage networking, sharing of treatment strategies, and discussion of topics of professional development. In addition to the regular clinical supports provided to therapists within their organizations, these described approaches will hopefully continue to enhance and sustain the fidelity and effectiveness of DBT services across the community.

A final step in planning for sustainability was the completion of a sustainability report for our DBT services through a website based assessment tool (www.sustaintool.org). This assessment tool was completed by the DBT steering team collectively and provided results on multiple areas of sustainability including Environmental Support, Funding Stability, Partnerships, Organizational Capacity, Program Evaluation, Program Adaptation, Communications, and Strategic Planning. A copy of program results are attached as Appendix H. Significant strengths were identified with Partnerships while sound results were obtained on Support, stability, capacity, communications, and strategic planning. Areas of weakness

included program adaptations and level of client program evaluation consistently across all services. The latter need of program evaluation of client services has been actively discussed by the steering committee. Several of the DBT services and programs are doing evaluation of services, but this is not consistent across all of the program areas. For sustainability, this latter identified need will be an important area to address.

Conclusion, Recommendations & Next Steps

The cumulative experience of implementing an intensive and complex intervention model across multiple sectors and community organizations has been both exciting and exhausting. It has required significant resources (both staff time and money) to orchestrate and follow through to fruition. There are many lessons learned from this implementation project with some of the more salient conclusions including:

- Critical importance of careful and thoughtful planning prior to embarking on any training or service delivery change.
- Need to engage key stakeholders both within each organization and across community stakeholders to achieve a shared collaboration and ownership of implementation.
- The importance of creating a vision of "why" the implementation plan and intervention is necessary and needed.
- The value and necessity of a steering group which includes "champions" while having the capacity to complement each other in terms of skill sets and responsibilities.
- The need for flexibility and ability to adjust plans as circumstances change.
- Provision of comprehensive training and active learning strategies for therapists.
- Recognition of the challenges involved in sustaining any implementation project and realize that sustainability requires ongoing attention and effort to avoid treatment drift or drop in services

Overall, the current PACE support to implement DBT on a community wide basis in Thunder Bay has been an exceptional experience and resulted in meaningful benefits on multiple levels. First, and foremost, it has created a multiplier effect in terms of the quality and depth of treatment services provided to our most complex and high risk youth. It has allowed us to strengthen the level of adult and youth service programs across outpatient, residential, substance abuse, and youth justice program areas. It has also allowed us to coordinate services across program areas so that shared youth can receive consistent and familiar interventions regardless of organization. In addition to enhancing the quality of clinical services, the PACE project has provided invaluable experience and lessons learned regarding how to implement new interventions and service programs. As described above, this requires careful and thoughtful attention to multiple factors if optimal success is to be achieved. As a result of this experience, CCTB and our community will approach and think about implementation of interventions and services in a richer and more complex manner than before. It has been an invaluable and rich learning experience which has created greater capacity on multiple levels within our community.

References

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Appendices

Appendix A

Literature Review of DBT Treatment with Adolescents

Appendix B

Adolescent DBT Treatment Outcomes Matrix Table

Appendix C

Community DBT Service Programs

Appendix D

Evaluation Measures Used to Evaluate Impact of DBT Training

Appendix E

Impact of DBT Training on Therapist and Consultation Team Functioning

Appendix F

DBT training evaluation presentation October 16 2014 (ppt)

Appendix H

Thunder Bay DBT sustainability: Strengths and Needs