

Factors that Impact the Implementation and Sustainability of Dialectical Behaviour Therapy  
Programs: A Qualitative Study of Clinician Perspectives

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### Abstract

Dialectical behaviour therapy (DBT) is a psychological treatment developed for individuals experiencing significant mental health issues along with high-risk behaviours (e.g., suicidal behaviours, self-harm, substance use, aggression, impulsivity). Despite substantial evidence supporting its use, many DBT programs have problems with sustainability, which leaves individuals with severe mental health issues without the treatment they need. The goals of the current study were to: a) identify factors that impact the functioning of DBT programs in Thunder Bay, Ontario; b) identify factors that are particularly relevant for youth DBT programs; c) make recommendations to foster the facilitators of success and address the barriers that hinder the functioning of DBT programs. Clinicians (N=31) trained in DBT completed a semi-structured interview exploring their experiences providing DBT and thoughts on the factors that facilitate or hinder the functioning of the DBT programs. The interviews were transcribed verbatim and then organized into themes using inductive thematic analysis. Three major themes emerged as barriers to the functioning of DBT programs: systemic challenges, conflicts within the consultation teams, and clinician burnout. Factors influencing the success of DBT programs included: systemic support, clinician commitment and “buy in,” and team cohesion. Unique factors specific to providing DBT with youth (i.e., level of commitment, simplifying the language, and parental investment) were also identified. The findings provide novel information on barriers that impact the functioning of DBT programs from clinicians’ perspectives within a Canadian publically funded mental health system. These findings have clear clinical utility and can be used to generate solutions to clinicians’ perceived barriers and to foster perceived facilitators.

Factors that Impact the Implementation and Sustainability of Dialectical Behaviour  
Therapy Programs: A Qualitative Study of Clinician Perspectives

Dialectical Behaviour Therapy is an intensive, evidence-based, outpatient treatment that applies cognitive and behavioural strategies to target problematic behaviours including suicidal behaviours (Linehan, 1993). DBT was originally developed to treat individuals diagnosed with Borderline Personality Disorder given their characteristic chronic suicidality, emotional dysregulation, and associated high-risk behaviours (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993). The core treatment procedures of DBT involve problem solving, exposure techniques, skill training, contingency management, and cognitive modification with an overall emphasis on dialectics which Linehan (1993) describes as a “reconciliation of opposites in a continual process of synthesis” (p. 19). DBT functions to integrate skills in Zen (mindfulness) with contemplative practice (reality acceptance skills) and behaviourism. The treatment encourages dialectical thinking for the client, as well as for the therapist (Linehan, 1993). For the client, dialectics encourage the appreciation of seemingly opposite sides of internal (e.g., what someone wants versus has to do) or external (e.g., with a partner) conflicts, and encourages the client to identify a middle ground when faced with these conflicts (Linehan, 1993).

Over time, DBT has developed into a 4-stage, sequential treatment (Linehan, 1993; Linehan & Wilks, 2015). The first stage of DBT serves to stabilize the client and help him/her to achieve behavioural control (i.e., decrease life threatening behaviours, reduce therapy interfering behaviours, decrease client-guided quality of life interfering behaviours, and increase skillful behaviours to replace dysfunctional behaviours). Stage 2 aims to have the client experience a full range of emotions, and address any lingering symptoms related to various mental health

difficulties (e.g., depression, post-traumatic stress disorder). Stages 3 of DBT aims to support clients in achieving ordinary happiness and unhappiness and reduce ongoing disorders and problems with living. And finally, stage 4 helps clients to achieve joy and resolve any remaining areas of incompleteness. Generally, clients are able to work towards the goals associated with Stages 3 and 4 outside of therapy.

In order to achieve the treatment goals which include behavioural control and experiencing emotions, DBT is a team-based approach that involves four modes: (1) group skills training, (2) individual therapy, (3) telephone consultation, and (4) consultation team which occur concurrently. While the first three modes involve the client, the fourth is specific for clinicians providing DBT services. Weekly group skills training provides clients with an opportunity to learn new skills related to mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (Linehan, 1993). Skills training incorporates various techniques including the provision of didactic information, modeling, stories, role-play, feedback and coaching, and homework assignments. The skills training component of DBT teaches clients to utilize effective behaviours and approaches to problem solving rather than those that are ineffective or maladaptive (i.e., self-harm, substance use, or expressions of violence; Linehan, 1993; Linehan & Wilks, 2015). Weekly individual therapy provides clients with an opportunity to identify, analyze, and find solutions for their specific target behaviours (e.g., cutting). Strategies used include behaviour chain analysis, solution analysis, exposure techniques, and cognitive techniques.

In addition to the co-occurring skills training and individual therapy, the other modes of therapy are telephone coaching and weekly consultation meetings. Telephone coaching allows the client 24/7 phone access to his/her therapist and can serve a variety of therapeutic purposes

such as providing additional support to clients between sessions, skill generalization in different contexts, promoting adaptive interactions in real world settings, as well as repairing alliance ruptures that may have occurred during face-to-face interactions (Linehan, 1993). Specific parameters in DBT outline when phone coaching can and cannot be used (e.g., clients cannot contact their therapist for 24 hours after engaging in a self-harming behaviour). Weekly consultation team meetings are held for all therapists and skills trainers who are involved in providing DBT. Both the consultation meetings and team environment are integral to the treatment's fidelity and success (Linehan & Wilks, 2015) and function to maintain treatment fidelity, manage clinician burnout, and provide support to team members treating high risk clients (Linehan, 1993).

### **Efficacy of Dialectical Behaviour Therapy**

The literature investigating the efficacy<sup>1</sup> and effectiveness<sup>2</sup> of DBT for BPD has come to support this treatment as the standard of care for individuals with BPD (Linehan 1993). DBT is one of the first treatments to be rigorously evaluated as a treatment for BPD, and remains to have the greatest empirical support across several randomized controlled trials, positioning DBT as an evidence-based treatment (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; McMMain et al., 2009; Verheul et al., 2003). Evidence-based treatments are psychological treatments that are well established and efficacious based on the best available research evidence (American Psychological Association,

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<sup>1</sup> Efficacy studies in research provide the most reliable information on treatment outcomes through ideal circumstances in randomized controlled trials (RCTs; Van Der Lim et al., 2012)

<sup>2</sup> Effectiveness studies in research are conducted in clinical practice settings with less stringent exclusionary criteria compared to RCTs (Van Der Lim et al., 2012)

2006; Canadian Psychological Association, 2014). Compared to treatment as usual (i.e., psychotherapy complimented with symptom targeted pharmacotherapy), DBT demonstrates better retention rates and reduced self-harm among clients (American Psychiatric Association, 2001; Verheul et al., 2003).

### **Effectiveness of Dialectical Behaviour Therapy**

Although there is less evidence demonstrating its effectiveness versus its efficacy, which can be explained by interferences or barriers to implementing comprehensive DBT in practice settings, research demonstrates that DBT is superior to treatment as usual in terms of clinical and cost effectiveness (i.e., Pasiieczny & Connor, 2001). While a majority of studies evaluating DBT's effectiveness are difficult to conduct, they continue to find improvements in self-harm and suicidal behaviours, symptom severity, and service utilization (Comtois et al., 2007; Pasiieczny & Connor, 2011).

For example, a naturalistic study with a true experimental design by Turner and colleagues (2000) compared the effectiveness of DBT to a client-centered therapy for clients with BPD. Outcomes of this study showed better improvement for participants who received DBT compared to client-centered therapy on measures of suicide attempts and self-harm episodes. Evidence for similar improvements is demonstrated for youth and young adult populations (Hjalmarsson et al., 2008). Despite the challenges related to implementation in effectiveness studies, the inclusion criteria are less stringent allowing for greater generalizability of the findings (Ben-Porath et al., 2004; Comtois et al., 2007; Kazdin, 2008).

### **DBT as a Transdiagnostic Treatment**

Transdiagnostic approaches to mental illness are defined as interventions that aim to treat underlying processes of an illness rather than a specific disorder, and are becoming increasingly



more prominent in the mental health field (Barlow, Allen, & Choate, 2004; Craske, 2012; Ritschel, Lim, & Stewart, 2015; Wiliamowska, 2012). While DBT was originally designed for individuals presenting with BPD, the modular and flexible structure (i.e., the ability to target behaviours that are impacting clients' quality of life) allow modifications to be made in order to meet the needs of various clinical disorders and presentations (Linehan & Wilks, 2014; Ritschel et al., 2015). Ritschel and colleagues (2015) suggest that DBT's applicability as a transdiagnostic tool is due to the therapy's reliance on effective and accurate case conceptualization strategies, which allow the therapist and client to address multiple issues (sequentially and concurrently) throughout the course of treatment.

DBT's efficacy with clinical populations outside of BPD and chronically suicidal individuals is conceptualized as a result of the focus on targeting emotional dysregulation (Ritschel, Noriel, & Stewart, 2015). Because emotional dysregulation is a prominent characteristic of a number of disorders or clinical presentations, DBT has been utilized outside of the BPD population (Ritschel et al., 2015). For example, populations that DBT demonstrates efficacy for include older adults with depression (Lynch et al., 2003), as well as individuals with eating disorders (Safer & Jo, 2010; Safer & Joyce, 2011), post-traumatic stress disorder (Bohus et al., 2013; Giaconia et al., 1995), and addictions (Linehan et al., 2002). Components of DBT are now being used in work and school systems to teach employees and students coping skills and to build resilience (Linehan & Wilks, 2015). Lynch (2000) conceptualized that the coping skills component of DBT is useful for managing life, independent of diagnosis, which contributed to his application of a modified DBT program for depressed elderly patients.

### **Barriers to Implementation and Sustainability of Evidence-Based Treatment**

Despite identification as an evidence-based treatment, the broad availability of DBT is limited in practice settings (Barlow et al., 2013). This is not specific to DBT, as many well-supported psychological treatments are limited in their impact within public health systems due to interferences and inadequacies in their dissemination, implementation, and sustainability (which can be defined as the ongoing maintenance of components of the program that had been implemented in the treatments initial adoption; Scheirer, 2005). This is a problem that hinders the delivery of many evidence-based treatments, and accounts for the gap between science and practice in clinical psychology (McHugh & Barlow, 2010; Kettlewell, 2004). In regards to DBT specifically, many programs have problems with sustainability leaving individuals with severe mental health issues without the treatment they need (Comtois et al., 2007; Linehan & Heard, 1999).

Common factors that either challenge or influence the successful implementation of evidence-based treatments in the field of mental health services are documented in the literature (i.e., Ben-Porath, Peterson, & Smee, 2004; Herschell et al., 2009; Lehmen, Greener, & Simpson, 2002). Such factors that can present as challenges include: selecting appropriate staff to be trained and anticipating high staff turnover; the ability to maintain treatment fidelity given the available resources; and maintaining support from administration (Lehmen, Green, & Simpson, 2002; Ben-Porath, Peterson, & Smee, 2004). Common factors identified as improving the success of these treatments include: the availability of financial resources that are consistent and long-term; having a sufficient amount of staffing for training and implementation; and a designated leader during the implementation process (Goldman et al., 2001; Torrey et al., 2003; Swenson, Torrey, & Koerner, 2002). In order to promote evidence-based treatments, factors that facilitate or hinder their implementation and sustainability specific to the contexts in which they

are delivered, such as Canadian publically funded mental health systems, need to be identified and understood in order to address the gap between science and practice.

### **Efforts to Promote Implementation of Evidence-Based Treatments**

The study of methods to promote the implementation and sustainability of evidence-based treatments into their respective contexts has become an increasingly crucial area of research in implementation science (Aarons, Hurlburt, & Horwitz, 2010; Gerow & Dorsey, 2014; Mendel et al., 2008). Implementing evidence-based treatments is challenging due to the complex and multilayered contexts involved (e.g. individual clinician, organization, & system; Aarons, Hurlburt, & Horwitz, 2010; Fixsen et al., 2009; Gerow et al., 2015). To summarize the factors that influence the translation of research into practice, models have been proposed based on the contexts in which the interventions are delivered. This exploration phase involves an awareness of issues within their given contexts that need attention or an identification of organizational challenges, in order to effectively move towards a treatment that is implemented and sustained successfully (Aarons et al., 2010; Grol et al., 2007). Following considerations from implementation science that promote an understanding of the barriers or facilitators within the contexts that the service is provided (Aarons et al., 2010, Fixsen et al., 2005; Gerow et al., 2015), previous studies identify the importance of obtaining perspectives from front-line clinicians to identify factors that influence success of the evidence based treatment (i.e. DBT), or represent challenges to the implementation and sustainability of these treatments (Bloch et al., 2006; Carmel, Rose, & Fruzzetti, 2014; Gray et al., 2007).

### **Barriers Affecting the Implementation and Sustainability of DBT**

Carmel, Rose, and Fruzzetti (2014) conducted the first controlled study to examine the system-wide roll out of DBT in a public setting in the United States. This was the first study to

investigate the perspectives of front line clinicians regarding the barriers to implementation and sustainability of DBT for adults. Three themes affecting the successful implementation of DBT emerged as a result of their qualitative study with 19 clinicians across different agencies: (1) program development and recruitment of patients, (2) lack of administrative support or organizational investments in DBT, and (3) time commitment that the treatment requires (Carmel et al., 2014). The first theme (program development) reflected challenges in the large amount of training required for DBT, and that staff turnover or insufficient staffing challenged the sustainability of these programs. With staff attrition, programs had to fill these positions with untrained staff members and a lack of funding affected the ability to train new staff (Carmel et al., 2014). Lack of administrative support was reflected in the prioritization of other programs, limited interest in providing evidence-based treatments, and lack of support for continued training. The final time commitment theme reflected the heavy caseloads the clinicians felt they had as a result of limited staffing on DBT teams, which subsequently limited clinicians' time to attend to other clinical responsibilities in their programs.

Herschell and colleagues (2009) expanded on this research in line recommendations in the literature to gather perspectives from stakeholders at each level (e.g. Gotham, 2006), and conducted semi-structured interviews with 13 administrative staff from nine community based mental health agencies in the United States. Four themes emerged as relevant factors that reflected administrators opinions on the implementation of DBT within their agencies: (1) DBTs fit with the agencies' existing practicing, (2) resource concerns, (3) staff selection for training and staff turnover, and (4) ongoing client referrals. The first theme was related to the administrative staff's perspectives on DBT and if this treatment would fit with the existing practices available in the agencies, generally these views were positive as a majority of

administrators believed the treatment to be complimentary to the agencies' existing practices (Herschell et al., 2009). Resource concerns affecting implementation and sustainability of DBT reflected administrators concerns of funding for clinician training specifically; this intensive training was non-reimbursable for the agencies and would take clinicians away from their current caseloads to participate. Staff selection for training and staff turnover emerged as the third theme. Specifically, the importance of carefully choosing staff (i.e., based on staff seniority, staff that was likely to remain at the agency, staff familiarity with DBT) given the cost of training was highlighted. In some cases, it was presented that although the implementation of DBT was promising following initial training, this would be lost over time due to high levels of staff turnover and limited funds to keep up with ongoing training. Lastly, the fourth theme identified by Herschell and colleagues' (2009) study reflected concerns regarding an insufficient number of referrals, and need for an adequate referral stream; they concluded that this was a factor related to larger system support.

While the literature on factors that facilitate or hinder the delivery of DBT in mental health services is not vast, the research highlights the necessity of exploring factors that are unique to the existing services and delivery models. It is crucial that the information gathered includes perspectives of clinicians who are involved with or experienced in a treatments implementation (Aaron et al., 2010; Carmel et al., 2014; Herschell et al., 2009; McHugh & Barlow, 2010).

The goal of the current study was to: a) better understand the barriers or facilitators that impact the implementation and sustainability of DBT in Thunder Bay, Ontario; b) identify factors particularly relevant to applying DBT within youth populations; c) explore recommendations based on these factors. This study is unique in that it is the first to document

the experiences of clinicians within a Canadian, publically-funded, mental health system. In addition, this study expands the breadth of existing research by gathering information from clinicians who have or currently are providing DBT services with youth and adults, across inpatient, outpatient, and addictions programs.

## **Method**

### **Participants**

Participants in this study were clinicians (i.e. social workers, psychological associates, psychologists, and mental health nurses) working at mental health organizations in Thunder Bay (i.e., St. Joseph's Care Group Mental Health and Addictions Programs, Thunder Bay Regional Health Sciences Centre Mental Health Programs, Thunder Bay Counselling Centre, and Children's Centre Thunder Bay). These organizations provide the majority of mental health care to adults, adolescents, and children in and around Thunder Bay through a broad range of services (i.e., mental health assessment and treatment, addictions treatment) and settings (i.e., inpatient and outpatient, adolescent and adult). Eligibility criteria required that participants had received intensive DBT training within the last 15 years. Participants were eligible to participate whether they were still actively providing DBT services or not, in order to avoid potentially biased perspectives based on the participants current status of involvement (e.g. active or inactive). In order to protect participants' anonymity, minimal demographic information was collected.

### **Procedure**

The lead student researcher collected qualitative data from June 2016 to March 2017. Individual interviews lasted between 20 and 50 minutes, and focus groups often lasted one hour, with the number participants within groups ranging from 2 to 5. Participants were recruited via email, and meetings were arranged for individual interviews at participants' convenience in their

offices. Focus groups were arranged by contacting a designated team leader, and were often scheduled during the team's weekly scheduled consultation meetings within their agencies. During the focus groups and individual interviews, a semi-structured interview guide was utilized (see appendix), whereby participants were asked about their experiences offering and implementing DBT services, factors they believe contribute to or hinder the functioning of DBT programs, and recommendations regarding implementation and sustainability. Within these interviews sustainability was defined as ongoing programming that is supported at various levels including individual clinicians, management staff, and program models. The same semi-structured interview guide was used for both individual and focus group interviews.

### **Data Analysis**

Focus groups and individual interviews were recorded, transcribed verbatim, and coded with QSR NVivo® computer software and then organized into themes using inductive thematic analysis. This approach to qualitative analysis was chosen as it is in line with epistemologies of constructivism where themes are not predetermined but emerge from the data (Braun & Clarke, 2006; Guba & Lincoln, 2005; Neimeyer & Stewart, 1998). In line with the objective of the current study, themes were organized into categories based on whether they were presented as a facilitator or barrier to the functioning of a DBT program. Data (focus groups and individual interviews) collected from clinicians working with either adult or youth mental health or addictions programs were analysed together. However, themes that emerged which reflected factors uniquely related to the provision of DBT with youth were separated. Furthermore, a separate category reflecting the recommendations regarding the implementation and sustainability of these programs that were reported most frequently by participants was identified and included. Overall, major themes and subthemes were identified based on the frequency of

endorsement across participants. This procedure was used to ensure that beliefs or concerns reported repeatedly by one or few participants did not emerge as a major theme if it was not truly representative of the larger sample. This approach was used to avoid an overrepresentation of themes that were mentioned frequently by one or few participants.

Multiple steps were implemented to ensure the trustworthiness of the data (i.e. credibility, transferability, dependability, & confirmability; Irwin et al., 2005; Lincoln & Guba, 1985). Member checking, a technique in qualitative research to establish accuracy and validity of responses (Lincoln & Guba, 1985), was done between questions by reiterating participants' responses to confirm that they were heard and understood correctly by the researcher. In addition to reiterating responses, member checking within focus groups involved calling upon participants who had not contributed, as well as providing opportunities throughout the focus groups for participants to contribute any differing perspectives. This step was completed in order to strengthen the dependability and confirmability of the data, and to ensure that all clinicians were not simply agreeing to the perspectives or experiences of those held by a majority of the group (Lincoln & Guba, 1985). Finally, a second independent researcher reviewed a subset of transcripts to confirm an appropriate level of member checking, as well as the themes and subthemes to enhance the credibility and confirmability of results.

Prior to recruitment, this project was reviewed and approved by the following research ethics boards: Lakehead University, Thunder Bay Regional Health Sciences Centre, and St. Joseph's Care Group. In addition, the project was reviewed and approved by a research advisory group at Children's Centre Thunder Bay and the Thunder Bay Counselling Centre.

## **Results**



A total of 31 participants were recruited for this study. Participants were social workers, psychological associates, and psychologists. Participants could choose how they wanted to share information with the researcher (i.e., individually or in a group format), and the lead student researcher organized the focus group interviews by contacting the team leader of active DBT teams. The team leader informed participants on active consultation teams that they could choose to share their information in the focus group or individually to ensure that participants felt comfortable sharing their experiences, and this opportunity was repeated to participants by the lead student researcher prior to commencing the interview. All participants who were actively providing DBT chose to provide information in a group format (with all members of their consultation team). In total, 12 individual interviews and 5 focus groups were conducted. The majority of participants were female (87%) and 13 (42%) were actively providing comprehensive DBT with either adults (52%) or youth (48%) from a mental health or addiction program.

Participants in the current study were asked to share their thoughts regarding factors (barriers and facilitators) that contribute to or hinder DBT programs, as well as recommendations for enhancing its implementation and sustainability. Themes emerged from the focus groups and interviews pertaining to the barriers that hinder the functioning of a DBT program and were ordered based on the saliency in which they were reported across participants, with the initial barriers or facilitators representing those that were most prominent. These included systemic challenges (B.1), difficulties within the consultation teams (B.2), and clinician burnout (B.3; see Table 1). Themes pertaining to facilitators that contribute to the success of a DBT program were identified including systemic supports (F.1), clinician commitment and “buy in” (F.2), and team cohesiveness (F.3; see Table 2). Examples of participants’ quotes that support these major

themes and subthemes are included in Tables 1 and 2. Additional themes related specifically to providing DBT with youth, and recommendations for implementation and sustainability also emerged and are included in the text below.

### **Barriers that impact the functioning of DBT programs**

**Systemic challenges (B.1).** The first theme involved factors related to systemic challenges including discontinuity of team membership (B.1.1), poor system flow (B.1.2), and lack of fit with an agencies' existing programs (B.1.3). The "system" in the current study encompasses participants' comments related to administration within their agencies, the agencies' existing practices and its larger organization, and the climate of mental health services in Thunder Bay overall. Participants endorsed discontinuity of team membership (B.1.1) as the most common barrier to the success of a DBT program and its sustainability overall. Participants related the discontinuity of their team membership to high rates of job turnover within their agencies, lack of trained replacement staff, and a lack of long-term commitment from trained clinicians. Both the cost and time commitment of sending new staff for training were frequently expressed by participants as an explanation for why replacement staff were not trained in DBT.

Participants frequently reported poor system flow (B.1.2) within and between agencies as a barrier to the successful functioning of their DBT program, and expressed concerns about the accessibility of the treatment to clients that could benefit. For example, participants discussed waitlists and concerns about clients needing to wait a long time (e.g., years) for treatment or having to seek (potentially less appropriate) services elsewhere such as emergency department visits or inpatient hospitalizations. This subtheme was further related to participants' comments on inadequacies within the larger referral stream across mental health services within the system. Participants endorsing this subtheme (particularly relating to long waitlists), frequently

highlighted the negative effects this may have on clients who could benefit from DBT, and that this could be addressed by sending more staff for training.

Challenges related to the lack of fit with the agencies' existing programs (B.1.3) reflected participants' comments on the application and adaption of DBT within specific treatment contexts or to clients that are not a good fit for the treatment. For example, the majority of the participants with experience applying DBT in residential treatment settings (with either youth or adults) felt that this setting was inappropriate as the programs were short in duration, the clients did not have the opportunity to apply skills in their personal lives while in treatment, or the clients were not a good fit for DBT in terms of their symptom presentation. Participants also mentioned challenges related to resistance from staff not trained in DBT with the broad implementation of DBT into their agencies' services as well as difficulties related to reliance on shift-work staff when DBT trained staff were not present. While discussing the application of DBT broadly within residential programs, some clinicians highlighted that the treatment should not be treated as "one size fits all." Participants actively providing DBT services who appeared to believe that the program was an appropriate fit within their agency as did not mention these same concerns. Outside of residential treatment programs, participants reported that working with clients who are not committed to the treatment could be a barrier to the success of the treatment. Participants highlighted the importance of proper screening and preparation for clients prior to entering DBT. However, regardless of whether or not they felt the treatment was an appropriate fit for their agency's existing programs, it should be noted that a majority of participants expressed the importance of having DBT available and accessible for clients in Thunder Bay. Most participants expressed their beliefs that there is a population of

individuals within the community that struggle with highly dysregulated emotions or harmful behaviours that could greatly benefit from DBT.

**Difficulties amongst the consultation team (B.2).** Participants identified certain factors related to difficulties amongst the consultation team as potential barriers for the successful implementation and sustainability of a DBT program. Specifically, participants reported not adhering to the fidelity of the DBT treatment model within consultations meetings (B.2.1), personality conflicts between team members (B.2.2), and lack of trust and safety among team members (B.2.3). Not adhering to the DBT treatment model (B.2.1), included not following the framework of consultation meetings, not consistently attending weekly meetings, or failure to schedule weekly meetings. These were all reported as barriers, and were believed to reflect the degree of team members' investment in the program. Reports of personality conflicts (B.2.2) and lack of trust among members (B.2.3) further supported the barrier related to difficulties amongst the consultation team. These factors were reported frequently to affect team members' ability to share within consultation meetings for fear that they would be judged, or in some cases, that other members would not maintain the confidentiality of their contributions within the meetings, and was referred to as a lack of safety among the team. This fear of judgement and perceived lack of safety were reported to have caused teams to dissolve completely in some instances.

**Clinician Burnout (B.3).** Lastly, some participants reported clinician burnout consistently as a barrier that challenges the functioning of a DBT program. Burnout was identified as a result of the nature of the work itself (B.3.1; e.g., intensity of caseloads, time commitment required), as well as in relation to the systemic challenges faced by clinicians (B.3.2). For instance, participants reported that not only was burnout related to providing

treatment to an intense, high-risk client population, but also to the “uphill battle” against the system in which they had to fight to sustain their DBT program and remain adherent to the model while experiencing a lack of support from the system.

### **Facilitators that impact the functioning of DBT programs**

**Systemic supports (F.1).** The theme reported most frequently as a facilitating factor that helped support the successful functioning of a DBT program was systemic supports. Specific aspects of systemic support that were discussed with respect to the administrators’ familiarity with DBT (F.1.1), time and financial commitment from administrators (F.1.2), and administrators providing autonomy to the DBT teams (F.1.3). Participants found it beneficial when their administrators (managers or directors) had familiarity with DBT as a treatment modality, and therefore understood the type of work that DBT involved, and its cost effectiveness (F.1.1). Relatedly, this commonly included managements’ appreciation of the intensity of the client profiles of those enrolled in a DBT program, and supporting a reduced caseload to offset clinicians providing DBT.

Commitment of time and financial resources (F.1.2) by management was reported frequently as an important facilitating factor. This included managements’ support for time taken for weekly consultation meetings, support for the time away from current caseloads to receive training, and ongoing financial support for training and for costs associated with running the DBT programs. Lastly, provision of autonomy by administrators (F.1.3) was a common subtheme in this category that was supported by the clinicians’ belief that a DBT program has a greater likelihood of success if management has trust in the team, and respects their autonomy to make decisions related to program development and promotes the team’s independence. Participants commonly referred this to as “support from a distance.”

**Clinician commitment and “buy in” (F.2).** The second theme endorsed most frequently as a facilitating factor to the successful functioning of a DBT program was clinician commitment and “buy in”. This theme was characterized by long term commitment from the clinician (F.2.1), embracing or “believing” in the therapy and its effectiveness, and applying the skills in one’s own life (F.2.3). Clinicians that commit to providing DBT services long term after receiving the training was reported consistently as a facilitating factor for the success of a DBT program (F.2.1). In addition to long-term commitment, participants felt that embracing DBT or believing in its process and effectiveness for clients was integral to providing effective therapy (F.2.2). Participants reported that believing in the therapy and its effectiveness for clients was strengthened if the clinician had seen “success” or improvements for their individual clients. Some participants who discussed the importance of embracing or believing in the therapy noted that applying the skills in the clinicians’ personal lives was helpful for clients and within consultation team meetings. That is, participants noted that clients were responsive to learning about their clinician utilizing skillful behaviours in their own lives, and that this was particularly true for youth and parents of youth in treatment. In regards to consultation meetings, some participants endorsed utilizing DBT skills as an important tool for managing any conflict among team members or within meetings. Although a majority of participants stated that the DBT skills were useful to all clients on their caseloads whether they were actively providing DBT or not, “buy in” was specifically related to clinicians who would be ideal candidates to receive training.

**Team cohesiveness (F.3).** Team cohesiveness was discussed consistently as a factor that improved the success and sustainability of a DBT program by many of the participants. Subthemes that emerged in relation to team cohesiveness included strong support, respect, and

trust among team members (F.3.1), and giving and receiving feedback in a supportive, non-judgmental fashion (F.3.2). Participants reported that these factors contribute to a safe environment within the consultation meetings to share their experiences providing DBT. Specifically, participants highlighted the importance of attending to the dynamics of the team (e.g., recognizing and addressing any conflicts or ruptures in relationships). They indicated that this helps not only to provide effective treatment, but also as a means of supporting team members that are providing treatment to challenging clients. Participants often quoted the DBT manual, describing their consultation team meetings as “therapy for the therapist.”

### **Unique factors specific to DBT within youth populations**

Unique themes specific to providing DBT with youth included challenges related to a lower level of commitment from youth and the need to ensure the language used and the materials provided were appropriate for this population. As one participant commented “...it’s not just the kid showing up saying ‘I want help’, it’s the kid’s parent, it’s the kid’s teacher, and the kid might be the last one who wants help right? They don’t want to do it in some cases.” An additional consideration that was reported commonly among participants working with youth was the impact of the parents. Participants indicated that working with youth, and consequently parents, may present a challenge if the parent is not invested in their child’s treatment or lacks involvement. For instance, one participant reported that “There’s less motivation. The parents are sometimes barriers because for a kid to really engage in DBT and be part of our group they need a parent to attend the group with them. If their parent isn’t motivated to go or they’re not motivated to go its not going to work.”

### **Recommendations for Implementation and Sustainability**

Four themes within the interviews were presented as recommendations to help improve the implementation and sustainability of DBT. These themes included: selecting appropriate and committed staff for training; involving the existing team members in decisions for staff selection; ongoing training for staff; and financial support. Ongoing training was suggested for both sending clinicians to receive the comprehensive DBT training within their agency, as well as for active members to receive ongoing education. This ongoing education or training for clinicians was often termed as “refresher” trainings, and was recommended so that clinicians can stay up to date and avoid drifting from the fidelity of the treatment. As one participant commented “I think there is value to that ongoing training and I think that from a management perspective I get the financial piece of it but there’s also some value to making sure that ... that staff are like knowledgeable and that they continue to apply those skills and that things change in the field.” To support the above-mentioned recommendations clinicians frequently reported the importance of ongoing financial support for the sustainability of these programs.

### **Discussion**

The current study both investigated and identified clinician’s beliefs regarding factors that a) impact the implementation and sustainability of DBT programs; b) are unique to applying DBT to youth populations; c) their recommendations for improving implementation and sustainability in Thunder Bay. The data gathered in the current study reflect a narrative of the common challenges and successes clinicians in Thunder Bay have experienced after receiving training in DBT. Based on the commonalities of participants’ responses, several themes emerged that represented either barriers or facilitators that impact the functioning of DBT programs for both adult and youth populations.



The majority of participants in this study expressed the importance of having DBT available and accessible for clients in Thunder Bay regardless of whether or not they felt the treatment was an appropriate fit for their agency's existing programs. Participants frequently expressed their beliefs that there is a population of individuals within the community that struggle with highly dysregulated emotions or harmful behaviours that could greatly benefit from DBT and experience improvements in their quality of life after having participated. Given the importance placed on ensuring availability and accessibility of DBT, the remainder of the discussion will focus on the barriers and facilitators identified and subsequently provide suggestions for improving implementation, functioning, and sustainability.

### **Barriers that impact the functioning of DBT programs**

The main barriers that impact the functioning of a DBT program that emerged included systemic challenges, difficulties amongst the consultation team, and clinician burnout (see Table 1). Based on the views expressed by participants, it appears the barriers identified in this study were not independent, and seemed to influence each other; thus, the interrelation between these barriers, practically speaking, would be difficult to disentangle. Some of these barriers were well documented in the literature and consistent with research surrounding the implementation and sustainability of evidence-based treatments. Other barriers were novel and potentially more specific to DBT, and will be described in detail below.

A lack of resources and organizational support (e.g., due to job turnover and lack of financial support to send additional clinicians for training) is a well-documented barrier to the functioning of evidence-based treatments generally and their sustainability within practice settings (e.g., Swales et al., 2012; Woltman et al., 2008). Results of the current study suggest that lack of resources and organizational support are barriers relevant to DBT as well.

Challenges related to resources and organizational support are reflected in the subthemes of the systemic challenges, particularly the first subtheme, “discontinuity of team membership.” This subtheme was characterized by challenges related to the staff turnover within programs for various reasons including job changes, leaves of absence, or the perceived lack of commitment from clinicians that had been trained, by clinicians who remained in the service. Participants further described that a lack of commitment by clinicians was seen when clinicians agree to attend training without the intention of ever providing DBT, or clinicians feeling that the treatment ultimately did not match with their preferred approach to treatment. These factors are consistent with research suggesting that a poor fit between the principles of an evidence-based treatments protocol and a clinician’s style of therapy presents a challenge to implementing evidence-based treatments (DiMeo, Moore, & Lichtenstein, 2012). Without funding to support the cost of ongoing training to replace clinicians as a result of turnover or lack of commitment, many clinicians explained that their teams struggled or eventually dissolved. The conclusion that a lack of resources and organizational support are common to both evidence-based treatments and DBT suggests that findings and recommendations within the literature on evidence-based treatments overall may be applicable to the context of the current study and could be leveraged on to enhance the programs sustainability within Thunder Bay.

The second subtheme in the category of systemic challenges was related to poor system flow characterized by participants’ comments on suboptimal referral processes or lengthy wait times for clients. It could be assumed that these challenges may be related to the discontinuity of team membership mentioned above, as wait times are likely to increase as clinician availability is reduced. The consequences of low clinician availability will also affect existing clinicians’ workloads, particularly if they experience pressure to take on more DBT clients. Pressure to

increase number of clients on the clinicians' caseload could be problematic as participants commonly identified that DBT clients require more time, and are more demanding than other types of clients due to the intensity of clients' symptomology and treatment needs. Taking on more clients than the clinician feels comfortable and confident treating could potentially lead to poorer client outcomes if doing so affects the clinician's ability to provide DBT that is adherent to the treatment model. The barrier related to system flow and concerns about lengthy waitlists seems to be novel as it opposes the results of Herschell and colleagues' (2009) study that identified insufficient referrals as a factor challenging the success of their programs. It is likely that this barrier may be more relevant for DBT programs that are offered through Canadian publically-funded organizations which generally have longer wait times.

The remaining factor within the category of systemic challenges reflected participants' concerns regarding DBT's fit with the agencies' existing programs. This subtheme is consistent with findings from Herschell and colleagues' (2009) study in which several administrators expressed concerns regarding the fit of the treatment with the agency's existing structure, programs, and populations. In the current study, concerns were specifically expressed regarding DBT in residential treatment settings by most participants. These concerns are in line with the literature examining the implementation of evidence-based treatments into residential programs more generally. For instance, other studies also noted reliance of shift-work staff and high-turnover rates among these staff as barriers within residential treatment settings (Dishion, McCord, & Poulin, 1999; Colton & Roberts, 2007). The reliance on non-DBT trained staff during the evenings to be providing consistent messages in line with the treatment model could be a barrier that is particularly relevant to DBT given that DBT may approach behavioural difficulties (e.g., self-harming behaviours) differently than other treatment modalities (i.e., not

engaging with clients after they engage in self-harming behaviours). If evening staff respond to the client's target behaviours with support and attention, they may inadvertently reinforce these behaviours. These considerations are particularly relevant for DBT clinicians. Overall, our results showed that clinicians believe that DBT is an effective treatment, but that it should not be viewed as a "one size fits all" approach to treating mental illness. Clinicians felt that this should be considered prior to implementation efforts into these programs and agencies.

Results of the current study showed that another commonly mentioned barrier to the successful functioning of a DBT program was difficulties emerging within the consultation teams. The team aspect of DBT is a unique and integral component to its effectiveness (Linehan & Wilks, 2015), and difficulties within this context are likely to challenge its success and fidelity. Not adhering to the treatment model and recommendations for the structure of the consultation meetings (e.g., not consistently scheduling or attending weekly meetings and following the framework as per the manual), personality conflicts between team members, and a lack of trust and safety among members, were frequent concerns among participants in the current study. As consultation team meetings are integral to the treatment (Linehan & Wilks, 2015), and meant to support clinicians who are treating high-risk clients, difficulties that are not resolved by the team can result in negative consequences including the complete dissolution of a DBT program. It could be assumed that clinicians leaving DBT due to such difficulties on the team would impact the other barriers noted earlier (e.g., discontinuity of team membership), creating further systemic challenges.

Clinician burnout was identified as a major theme in the data. Burnout was attributed to the intense nature of the work and navigating the systemic challenges. Clinician burnout from working with suicidal clients is cited throughout the literature (e.g. Linehan & Wilks, 2015), and

the modes of DBT were designed to mitigate this (e.g., creation of a consultation team to support clinicians; Linehan, 1993). The barriers identified in this study indicate that clinicians feel burnt out not only by the work itself, but also as a result of managing the systemic challenges. This “uphill battle” that participants identified highlights the importance of attending to these challenges throughout the implementation process in order to protect clinicians from this burnout and subsequently promote the sustainability of DBT. It is interesting to consider that burnout related to providing therapy to suicidal, highly dysregulated clients can (and should) be addressed within the consultation team, but the treatment does not specifically identify how clinician should manage burn out related to the system.

### **Facilitators that impact the functioning of DBT programs**

Results of the current study highlight many important factors that help to support the successful functioning of a DBT program. In particular, themes related to systemic supports, clinician commitment and “buy in”, and team cohesiveness were identified. Facilitating factors for evidence-based treatments are well documented in the literature (e.g. organizational support and commitment, ongoing funding and training, and monitoring fidelity; Gotham, 2006; Godley et al., 2015; Powell, Hausmann-Stabile, & McMillen, 2013), while those particular to DBT are less known. The latter point makes it difficult to discriminate whether the factors in this study that are different to those cited throughout the literature on evidence-based treatments are uniquely related to DBT or are a product of the organizational climate in Thunder Bay.

Overall, systemic support, particularly relating to ongoing time and financial commitment, is overwhelmingly cited in the literature as a facilitating factor for the implementation and sustainability of evidence-based treatments (Ben-Porath, Peterson, & Smee, 2004; Goldman et al., 2001; Torrey et al., 2003) and was true for the current study as well.

Participants in our study felt that ongoing time and financial commitments from the system have and would be beneficial when issues related to staff turnover arise. Ultimately, support from administration for ongoing time and resources for DBT may have the potential to address many barriers identified in this study including the dissolution of teams, poor system flow, and clinician burnout, which are affected by a lack of these resources. Additionally, participants frequently identified that in addition to sending new staff to receive training, having ongoing training for clinicians actively providing DBT would be a facilitating factor. This additional training was believed to ensure that clinicians remain adherent to the model and avoid drift, which was a concern endorsed by several participants.

One facilitating factor identified in the current study that may be unique to DBT is the importance placed on having administrative staff (e.g., managers or directors) that are familiar with DBT. Participants shared that management having an understanding or familiarity with DBT was beneficial for their team among those who had previously experienced this kind of support. Those who had not experienced this type of support from management also identified that this familiarity would have been beneficial to their DBT program. Participants felt that this familiarity with DBT by their organizational leaders or direct supervisors would allow clinicians to feel more supported, particularly if administrators appreciated the intensity DBT clients and if they were not pressured to carry a large caseload. Ultimately this understanding and support could alleviate some of the barriers that have been identified, such as burnout related to both the inherent nature of the work itself and the system, as it may lead the clinician to feel supported to carry caseloads that they feel they can manage effectively.

Several clinicians noted that it would be beneficial for the larger mental health system to acknowledge the cost-effectiveness of DBT for the community as a whole. Participants

commented that it is common for highly dysregulated individuals, like those on their DBT caseloads, to visit emergency departments and inpatient psychiatric facilities often. This was referred to by participants as the “revolving door,” as these services were either not effective for recovery or reinforced clients’ harmful behaviours, leaving them more likely to seek out these services in the future. Participants believed that the lack of accessibility to DBT programs ultimately costs the system more than the resources necessary to sustain these programs, which is confirmed by economic evaluations of DBT across a variety of contexts in the literature (e.g. Murphy & Bourke, 2014; Pasieczny, & Connor, 2011; Wagner et al., 2014). In the current study, participants with a long history of providing DBT services believed that by providing the right treatment (DBT) for their clients, the financial burden on the system was largely improved as these clients presented to the emergency department in crises much less often. It can be assumed that this understanding further supports the importance of ongoing time and financial commitment from the system to not only sustain these programs for clients in need, but to lower costs for the healthcare system.

The third subtheme of systemic supports was discussed in relation to management providing autonomy to the DBT teams, which included a lack of interference and trusting the team to make decisions related to their own program development. Participants who experienced autonomy within their program explained that this supported the functioning of their team and also left them feeling empowered. Participants that did not have this type of support commented that team autonomy was a factor that might have been beneficial to their programs. Ultimately, these systemic supports have the potential to protect clinicians from burnout related to the nature of DBT itself, and more specifically, the system as previously identified.

Clinician commitment and “buy in” was the second major facilitating theme identified by participants. Having clinicians that were committed to remain on a consultation team and provide DBT emerged as a consistent factor related to the sustainability of the treatment. Having clinicians that were committed to the treatment long term would address or alleviate some of the challenges related to staff attrition. Related to the overall theme of clinician “buy in”, results of the current study highlight the importance of clinicians embracing or believing in the treatment and applying DBT skills in their personal lives. Both embracing the treatment and applying the skills within their own lives represents an internalization of the treatment, which mirrors facilitators identified within the literature on evidence-based treatments. A study by Powell, Hausmann-Stabile, and McMillen (2013), investigated clinician’s experiences implementing evidence-based treatments and found that clinicians who reported intent to provide the evidence-based treatment long term had internalized the treatment as part of their professional identity, and many applied the core principles of the treatment in their own lives. This was termed by the authors as being “sold” on the treatment, which aligns with participants in the current study referring to clinicians’ “buy in” of the treatment. The selection of staff that demonstrate this “buy in” may increase the programs sustainability as these clinicians may be more likely to commit to the provision of DBT long term. Furthermore, selection of clinicians that “buy in” to the treatment may prevent clinicians from discontinuing their membership on the team because of a lack of fit with DBT and their preferred approaches to therapy.

The team component of DBT is integral to the successful functioning of the program as outlined in the treatment manual; because of this, it is understandable that team cohesiveness was endorsed frequently by participants as a facilitating factor. This facilitator may be unique for DBT as there is little evidence that it is relevant to evidence-based treatments more generally. A



mixed method study that analyzed variables affecting the successful implementation of DBT found that team cohesion was related to higher levels of the programs adherence to the DBT model (Ditty, Landes, Doyle, & Beidas, 2015). In the current study, some participants reported team cohesion as the most important factor for the successful functioning of their program. Participants felt that attending to the team and ensuring the team is functioning well is an important step towards increasing the likelihood of DBTs sustainability.

### **Barriers and facilitators for youth populations**

The barriers and facilitators mentioned previously were relevant for clinicians working both with youth and with adult clients. Some specific themes did emerge, however, from clinicians working only with youth. Participants noted frequently that they believed youth were more likely than adults to demonstrate a lower level of commitment, specifically if enrolment in the program was not self-motivated. This lack of commitment was increased in cases where parents lacked involvement in their child's treatment, and was reported as a challenge for participants working with this population. Conversely, results showed that increased commitment from youth and greater involvement from parents would facilitate the successful implementation and sustainability of DBT. These results are novel in the literature, as research up until the time of the current study has not yet investigated barriers or facilitators that impact the functioning of DBT within youth populations.

### **Implications and Recommendations**

While the efficacy and effectiveness of evidence-based treatments, such as DBT, are well known in the literature, less is known about why these treatments are largely underutilized within practice settings. Overall, the factors identified in the current study shed light on the evidence and practice discrepancy by increasing our understating of the system, team, clinician, and client

factors that hinder sustainability. Recommendations based on these findings can be made in an effort to break down barriers and foster facilitators of successful DBT programs as the themes identified reflect a narrative of the challenges and successes clinicians in Thunder Bay have experienced. Below, recommendations are outlined at the: (1) system level, (2) team level, and (3) clinician level.

**System-level recommendations.** Based on participants' responses, administrators may benefit from developing or seeking out additional knowledge about DBT if they believe they are lacking in this area. Administrators could aim to increase this knowledge in a couple of ways. For instance, experienced clinicians would be in a good position to provide administrators with in-service training on the DBT model. This would not only show an openness on the part of management to receive additional training and thereby support their teams, but also acknowledge the expertise of their staff members. Results suggest that managers increasing their understanding of the cost effectiveness of DBT and also the treatment model itself (e.g., components involved, severity of cases) would result in improved functioning of their DBT programs. Ensuring administrators have an adequate understanding of the cost effectiveness of DBT could happen in a number of ways. For instance, experienced DBT clinicians could summarize the literature that outlines the economic benefits of DBT for their managers. Additionally, DBT teams could support management in their understanding of the cost effectiveness by collecting data regarding their programs and conducting ongoing program evaluation regarding its cost effectiveness. This could assist administration in their decisions regarding the allocation or commitment of available resources to the program. Alternatively, administrators could seek out information themselves including research findings and/or data from their programs. Regardless of how the additional knowledge and information is obtained,

acquiring it would allow administrators to best support their teams and contribute to a better functioning DBT program.

The allocation of adequate funding and resources are needed to provide care over the long term, and is another recommendation that could be considered at the system-level to increase the sustainability of DBT programs. Allocating ongoing resources to these programs could allow new staff to be trained and experienced staff to add to their training, thereby increasing the likelihood that programs will be sustainable and clinicians will be able to manage burnout. This could help to alleviate the barriers related to poor system flow and possible pressures for clinicians to increase their caseloads. Additionally, financial support to provide ongoing training would help to mitigate treatment drift or a lack of adherence, which was identified as a barrier affecting the cohesiveness of the teams. All of these considerations would help to address the uphill battle or system burnout participants identified or alluded to and could create a climate in which clinicians are able to work within a system that supports them.

**Team-level recommendations.** Ongoing monitoring of the team dynamics to ensure the successful functioning of DBT programs should be considered and could be done in a number of ways. First, the treatment itself is structured to ensure that the consultation team meetings are a safe space where clinicians can address stressors and concerns related to their work and give and receive feedback with other members (Linehan, 1993). Individual clinicians or the team as a whole could agree to frequently refer to the manual regarding purpose of the consultation meetings, and ensure the meetings are serving this intended purpose. However, in the event that an individual clinician is not comfortable bringing up his/her concerns in the consultation team meetings, he or she could consider consulting with other teams in the community for recommendations on how to approach the matter on their team.

Another approach to support teams in functioning well is to implement a community of practice approach, whereby active DBT teams within the community routinely meet to discuss and share their experiences or challenges related to the broader system, to the work they do, or to the challenges they face. Lastly the availability of an expert in the community that is available for as-needed consultation for DBT teams may also be beneficial. Several participants in the study mentioned this recommendation as they felt that the initial consultation that they received as part of their training was not long enough.

Participants also suggested that including staff who are actively providing DBT into the process of recruiting and selecting new staff members for training could help protect team cohesiveness. Regardless of how it is implemented, attending to the team dynamics is recommended so that the consultation team can serve as a safe space to give and receive non-judgemental feedback and support to other members. This recommendation is supported in the literature surrounding implementation of DBT, as attending to these interpersonal variables is linked to an increase in treatment adherence (Ditty et al., 2015).

**Clinician-level recommendations.** Results of the current study suggest that selection of staff that demonstrate an adequate level of long-term commitment and have a good understanding of the treatment prior to receiving the training in DBT is an important consideration and has the potential to address barriers related to discontinuity of team membership. According to study participants, long-term commitment from staff was believed to support the sustainability of their programs; therefore, asking staff about their longer-term career plans and ensuring adequate commitment will be important. It is recommended that staff chosen for training have an understanding of the type of work this treatment entails. This could be achieved through a treatment orientation similar to the orientation that clients receive or

clinicians who express interest in DBT could be given an opportunity to shadow another DBT clinician for a period of time. Ideally, ensuring clinicians have a good sense of what the treatment involves and what would be expected of them would reduce the likelihood of clinicians being trained and then not offering the treatment.

### **Strengths and Limitations**

Participants expressed consistently the importance of the availability and accessibility of DBT programs within Thunder Bay to service individuals in the community who struggle with highly dysregulated emotions and harmful behaviours. This finding ultimately highlights the need for efforts at each level (i.e., system, individual clinician, and team) to increase the likelihood of the sustainability of DBT programs in Thunder Bay to potentially increase the quality of life for these individuals seeking services.

The findings and recommendations of the current study are uniquely positioned to inform stakeholders at each level (i.e., system, individual clinician, and team), in their decisions relating to the functioning and sustainability of DBT these programs in Thunder Bay for a number of reasons. Not only are the findings of the current study the first to investigate factors that impact the functioning of DBT programs within a Canadian publically funded mental health system, it is also the first to include clinicians working with youth populations adding to the breadth of existing research in the literature. Another strength of the present study is related to its representativeness due to its large sample size (N = 31) of clinicians in the community, which involved clinicians that were inactive or actively providing DBT services at the time of the current study. Including both types of clinicians (i.e., inactive and active) reduces the likelihood of bias of responses due to their current status related to the provision of DBT services. Further,

the findings are specific to the organizational climate of Thunder Bay itself, which enhances the applicability of the findings and recommendations to decision makers in the community.

However, several limitations of the current study relating to the representativeness of the sample should be noted. First, the organizations in which the participants worked were not evenly distributed, as a majority of the participants worked among agencies within a larger organization. This uneven distribution of participants across organizations in Thunder Bay suggests that the results of this study may be nested within the organization(s) where a majority of participants worked. Because of this, the participants' experiences may reflect barriers or facilitating factors that are specific to one organization and be less representative of the community as a whole. Further, the generalizability of the findings may not extend to professions that were underrepresented in the current study (e.g. mental health workers, nurses), as a majority of the clinicians represented in the current sample were social workers and psychological associates. Lastly, a limitation related to the individual clinicians who chose to participate may potentially reflect biased responses or experience and affect the representativeness of the sample. For example, clinicians who chose to participate in the current study when given the opportunity could have differing views of DBT compared those who chose not to participate.

### **Future Directions**

Several recommendations for future research could be made based on the limitations apparent in the current study. First, collecting data via both qualitative and quantitative measures, such as the level of adherence to the model or degree of clinician competence in delivering the treatment, in order to explore the possibilities of extraneous variables contributing to respondent's challenges in implementing DBT will be important. This would aid in the

understanding of whether or not the barriers or facilitators are specific to the organization or system, or result from differing levels of adherence to the model (e.g., by individual clinicians or the team/agency as a whole), or degree of competency.

In order to expand on the findings of the current study, future research should gather data from other stakeholders within the mental health and addictions systems, such as administrators and experts, or patients, to identify any similarities or differences in their perspectives. This direction aligns with suggestions in implementation science to obtaining perspectives of stakeholders to identify any challenges that may exist in relation to training, setting, evaluation of adherence to treatment fidelity, and patient outcomes at all levels (Aaron et al., 2010). Perspectives of multiple stakeholders' would influence a more broad understanding of challenges at each level in order for decision makers to optimally formulate next steps for the translation of the findings into practice (Gerow et al., 2015).

Finally, in order to improve the availability of resources and inform policies and decisions regarding the availability of programs within our community, future research should conduct a cost-benefit analysis of DBT within a Canadian, publically-funded mental health and addictions system. Such research should investigate the costs and benefits of having highly dysregulated clients enrolled in DBT compared to treatment as usual (e.g., frequent emergency room presentations and lengthy hospital admissions). This information could both justify the case made by clinicians requesting additional funding and resources for their programs, or assist administrators in making decisions about the allocation of resources.

### **Conclusion**

Despite substantial evidence supporting its use, DBT programs have problems with sustainability, which leaves individuals with severe mental health issues without the treatment

that works best. This study identified factors that impact the functioning of DBT programs servicing youth and adult populations and its implementation and sustainability within Thunder Bay. Three major themes emerged as barriers to the functioning of DBT programs: systemic challenges, conflicts within consultation teams, and clinician burnout. Factors contributing to the success of these programs included systemic support, clinician commitment and “buy in”, and team cohesion. Lastly factors specific to providing DBT to youth (i.e., level of commitment, simplifying the language, and parental investment), and recommendations suggested by clinicians were identified. The findings of the current study provide novel information that have clear clinical implications, and translate into opportunities for administrators and clinicians to break down the barriers and foster facilitators to increase the successful implementation, functioning, and, sustainability of DBT programs in our community.



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Table 1  
Barriers to functioning of DBT programs

Theme	Sub theme & supporting comments
B.1 Systemic challenges	B.1.1 Discontinuity of team membership
	<p>“So I think that lack of resources, of like actual clinician resources, um to be able to provide that is a pretty significant thing...if we don’t have the staff there to do it, it’s really hard to sustain a program and unfortunately the patients are the ones who suffer from that.”</p> <p>“...we didn’t fall apart completely but it [state what it is referring to] has changed lots so I forgot actually we lost [identifying information omitted] who used to work here [identifying information omitted] yeah and then [identifying information omitted]. So all them switched jobs and we lost them because no one could come in who was trained.”</p> <p>“... the team that I sat on dissolved after the training because most of the people on the team took the training without the intention of practicing individual therapy, so they no longer had a purpose of sitting on the consultation team.”</p> <p>“You get someone who either hates it [DBT?], burnt out, or feels indifferent, or feels a pull, you know? The other people who fall into that kind of indifferent category are the people who have been trained in it and it’s that one modality that they like to use but there are other things they like better.”</p>
	B.1.2 Poor system flow
<p>“[I]n the meantime people, they are struggling, so they keep [going] back to emerge and [go] back to be admitted to the unit both the adult unit and the children’s unit as they are waiting to get into appropriate services.”</p> <p>“... there has to be a way of providing more timely help. I don’t know the current status of the wait period but it was terribly long before. Um the clients would have to wait, oh I don’t know whether it was the year or more, or I think it was pretty long and that bothers me...So I guess if if more people were trained maybe that would help address it [the long wait lists].”</p> <p>“...work with the intended population and not make people wait forever and a day for the programing. I don’t know if that’s going to happen and I, you know, I don’t know all the reasons why we’ve talked about some of my concerns already um but at the end of the day I mean I don’t know. You just have to chalk it up to learned experience, you know?”</p>	
B.1.3 Lack of fit with agencies’ existing programs	<p>“I certainly didn’t agree with it [implementation of DBT] in the [identifying information omitted] program here and in fact it almost collapsed the program here. The residential, the [identifying information omitted] program. I see DBT as a theoretical approach, one of many, and I believe it’s effective for its intended population delivered in its purest form. Um I also believe there is some merit to teaching the skills on an outpatients basis and...it does not belong in a residential treatment program.”</p> <p>“...And they ended it [DBT program] almost entirely realizing [DBT] wasn’t practical, and it actually was, you know, causing programs to be cancelled...You know things were happening that you couldn’t dispute. It was directly related to the impact of DBT, we never seen it before so.”</p> <p>“It was difficult, just the population that we were working with, to actually get commitment because of the transient nature of the population. So those were some of the challenges that we had in order to implement practically...”</p>
B.2 Difficulties amongst the consultation team	B.2.1 Not adhering to DBT model
	<p>“[How the consultation team] should look, and what should happen within kind of that team was not what was actually going on in reality...and so that made it a bit challenging.”</p> <p>“... at that time, my consultation group wasn’t being consistent and people weren’t showing up...I think being more on top of that and ensuring that people are doing what they should be doing in those groups [is important].”</p>



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Theme	Sub theme & supporting comments
B.2.2 Personality conflicts	<p data-bbox="506 342 1008 363">“...it was just some real difficult people to get along with.”</p> <p data-bbox="506 390 1435 436">“Yeah it was a lot of dynamics, a lot of personalities, a lot of different uh approaches different different ways of interpreting things. Um really there was pretty toxic personalities involved I felt.”</p>
B.2.3 Lack of trust & safety	<p data-bbox="506 514 1435 583">“Again I think interpersonally there was a lot of team dynamics that made it really really challenging. There was no trust in that team at all, um so I think that people were really hesitant to talk about the challenges that they have encountered about some of their own experiences like therapy wise.”</p>
B.3 Clinician burnout	<p data-bbox="410 636 711 657">B.3.1 Burnout from nature of work</p> <p data-bbox="506 682 1435 777">“...there was talk, you know, maybe we need a full time. Somebody working full time on this team. And it’s like, ‘why would you do that to somebody?’ And even people who were all gung ho ‘oh I would do it full time’ and it’s like, ‘well okay you are saying this now, but five years from now...you are going to be completely burnt out.’”</p> <p data-bbox="506 804 1435 873">“We have a lot of people in this building trained who aren’t doing it. Why? Probably because they’re burnt out. Because it’s an intensive population to work with. Umm, so I think balance would also be important, for people, in treating this particular population.”</p> <p data-bbox="410 926 643 947">B.3.2 Burnout from system</p> <p data-bbox="506 972 1435 1094">“...someone on the team said, ‘You know, I’m not burnt out by the patients. I am burnt out by the system that isn’t supporting what we are doing.’ And I remember that because now that I am in a [identifying information omitted] role I think about it a lot. That when we talk about therapist burnout maybe what we are talking about isn’t about them not being able to manage the intensity of the clinical work, but them trying to do that in a system that doesn’t support what they do.”</p> <p data-bbox="506 1121 1435 1192">“I really think that that burnout is a lot more, particularly with DBT therapists. [It’s] about them having to have this uphill battle to do the kind of work that they do, to keep clients in care, and to deal with other aspects of systems like CAS and other pieces that make the work pretty tough at times.”</p>

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Table 2  
*Facilitators to functioning of DBT programs*

Theme	Subtheme & supporting comments
F.1 Systemic supports	F.1.1 Administrators' familiarity with DBT
	<p>"I think the administrator needs to understand the impact on the clinicians who are providing care. It is a very tough group to work with. It is very draining emotionally for the therapists, and so, if you have administrators who don't understand that, then they don't understand when a clinician is struggling with caseloads."</p>
	<p>"[W]e have had managers um in the past who are like, 'Well, everyone is getting a caseload of 30.' Well, if you are carrying borderline clients, like 5 borderline clients are like 10, and 10 borderline clients are nothing like 10 clients who just have their first episode of depression or strained anxiety. So, you are comparing apples to oranges and we had to advocate for that."</p>
<p>"If you don't have an administrator that understands that ultimately you are actually saving money because this person isn't coming to the hospital the emergency and getting admitted, which is more expensive, um you're going to be challenged to do that kind of work."</p>	
F.1.2 Time and financial commitment	<p>"...managerial support. [I] have said this already too. I think [it] is important. I think they have to accept that there is an expense to training people in this...They have to accept that there is a time commitment that the clinician will have to give to develop and to learn and to gel as a team."</p>
<p>"...it comes down to its an expensive treatment, and as a system we need to acknowledge and accept that patients are going to be in that care for a long time, and the staff doing that work are doing a lot of it with one person. So, when we look at ratios of client time to staff it's different in DBT...[I]f we are going to be successful, we have to be willing to use some of our resources to do this...because otherwise we are not providing adequate care to a group of patients that need it, and they are just going to keep coming into emerge and then to hospital which is even more expensive...[A]s a mental health and addictions care system, we need to realize we have to be allocating some of our resources to intensive longer term work. Otherwise people aren't getting better."</p>	<p>"You need administrative support because it is on the outside looking in it is... an expensive treatment right? Someone is seeing a therapist for an hour to an hour and a half every week for two to three years and doing group for a year or more is really expensive care."</p>
F.1.3 Providing autonomy	<p>"I think what has been important to me...reviewing our development, is just having the autonomy and insisting with management that we have the autonomy to make decisions for ourselves. And the ability to do program development has been immensely rewarding to me, and I love the fact that we have been in charge of our own development, and we have taken charge of our own development, we have had the autonomy for ourselves... But I think that has contributed to the sustainability of the team because it is innately rewarding to be part of a development of a team on all different levels, rather than having management tell you what to do."</p>
<p>"I think lack of interference [from management] and some cases that means clearing out barriers or not creating barriers."</p>	<p>"Generally, the less management involvement the better we feel."</p>

Theme	Subtheme & supporting comments
F.2 Clinician commitment and "buy in"	F.2.1 Long term commitment from clinician
	<p>"...I think one of the things is...making sure that the staff that are going for the training are actually staff who are agreeable to doing this long term. I think often what can happen is that you spend a lot of money to send people for these this training, but not necessarily everyone is a good fit for the population, or for the work that it entails. So having a bit more of a commitment from people so that we don't have so many staff members who are trained...[and] for various reasons not providing the actual um intervention to patients. I think is where we ran into not having enough staff to actually make that happen."</p> <p>"And I think a part, a big part, is also commitment to this client population and being willing to work with these very sick people. And if you don't have that... if you are not willing to work with this population, I mean, I think that is a basic requirement. Having commitment to our clients, to this population."</p>
	F.2.2 Embraces/believes in DBT
	<p>"I think you have to embrace it...I know just sometimes when we've had...like students...if they're watching their clock or they book something before our consultation is over that's not really embracing what this is all about and I think for clinicians... if you're going to do this, and you're going to do it evidence based, you have to embrace it."</p> <p>"...I think it falls to people that really buy into the program, and the skills, and enjoy doing it... It's just finding those people where it clicks....."</p> <p>"You can't fake DBT you're either in and you believe in doing it and you do it, or you think it's not good and you don't do it... you can't be half way...Because they it will show, they will. So when I say to my clients... 'I believe this is the treatment you need', I thoroughly believe that... There's some people who have been trained who [think] ' I don't really believe that DBT is all that', and I don't think [those people] could be great at it."</p>
	F.2.3 Applies DBT skills in own lives
	<p>"I think that practice what you preach is a big piece...when you do the DBT therapy. You have to kind of accept that you're going to adopt a lot of this way of thinking into your own personal life, and not just compartmentalized at work, right? It's something you bring to every...parenting or...sibling relationship, or [every] parent [and] child relationship, you bring it every where."</p> <p>"Motivation, perseverance, but also willingness to practice what you preach [is important]. So if I have a beef with somebody and I'm not going to handle that using a skillful approach, then I don't think that you're going to have a functioning team or a good program."</p> <p>"You need to be able to practice it right? Especially [for] youth [as they] are so experiential. They are looking for you to provide those examples of how you have used those [in your life], and how they are beneficial as opposed to teaching at. You need to be able to...you have to be able to incorporate it. This happened two days ago and I used this skill and this skill, and this is how it has helped in my lived experience..."</p>

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Theme	Subtheme & supporting comments
F.3 Team cohesiveness	<p data-bbox="386 289 799 319">F.3.1 Support, respect, &amp; trust among members</p> <p data-bbox="483 340 1435 466">“...I think there’s absolutely in my mind two key components. One is cohesion of the team. If you don’t have a cohesive team that works together, gets along, knows each other, wants to be there, knows how to support each other, you won’t get good DBT. These patients are very difficult to deal with as a clinician. I mean you are dealing with...things that push your boundaries all the time as a therapist and you need that support. Cohesion of the team is number one.”</p> <p data-bbox="483 487 1435 646">“One of the things that always stood out for me was that the consultation team is really therapy for the therapist. The check in, the support, because it is a difficult client group to work with. You are dealing with real life and death situations with the client and so that needs to remain important and it is easy [for administrative] stuff [to] really take over the consultation team [meetings] and that’s what we really struggle with, because that is so important too and so is staying true to the DBT. So you’re always pushing because you don’t want to give up how the program is run but [also] balancing that.”</p> <p data-bbox="483 667 1435 751">“...I think it’s the trust and safety within the team and you know that that whole...[idea that] we don’t have to treat each other as fragile, like truly we don’t. And I don’t think that’s the case in every other team or other teams in general right? its I think its that safety is super critical.”</p> <p data-bbox="386 793 734 823">F.3.2 Sharing non-judgmental feedback</p> <p data-bbox="483 844 1435 928">“Respect for each other, respect for the clinicians...sort of letting go of that judgmental piece of course would be a successful program where you aren’t judging [each other] that one [clinician on the team] is less competent than the other.”</p> <p data-bbox="483 949 1435 1033">“...but I also know there was a few people that didn’t necessarily feel, I don’t want to use the word safe, but to challenge their supervisor at the door when they were doing consultation. So I think trust is a huge one and I think being able to be open, honest, and give feedback.”</p> <p data-bbox="483 1054 1435 1138">“...we had case consultation and you know giving DBT feedback [to each other on the team to] make sure we are being dialectical. Offer suggestions those sorts of things, it was a group I had [once]...but uh it was a good team...I guess I think I said it all, those kinds of people on a team, is what makes a good team..”</p>

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**APPENDIX****Interview Guide**

Questions:

*Tell us about your training in comprehensive DBT?*

*a. when did you receive your training?*

*b. where did you receive your training?*

*c. who were your trainers?*

*d. what are some things you recall about your DBT training?*

*e. What led to you receiving the training (prompts: did you request it? were you volunteered/told to by your manager/director?)*

*1. How did you feel about being trained in comprehensive DBT at the time? And now?*

*2. After your training, how were you involved with DBT?*

*3. Are you still involved with DBT?*

*a. If yes, how long have you been involved?*

*b. If yes, how are you involved?*

*c. If no, how long were you involved?*

*d. If no, why did your involvement change?*

*e. If no, what are you doing now?*

*4. What do you think contributes to a successful DBT team/program? (prompts: client factors? clinician factors? system factors?)*

*5. Are there things that you think affect the implementation/sustainability a DBT team/program? (prompts: client factors? clinician factors? system factors?)*

*6. Are there changes to the system do you think would be helpful? important? Essential?*

*7. Are there any organizational/leadership/management factors that you think affect the implementation/sustainability of DBT services?*

*8. Sustainability can be defined as ongoing programming that is supported at various levels including individual clinicians, management staff, and program models. What would your recommendations re: sustainability be?*

*9. Do you see a need for comprehensive DBT programs in Thunder Bay?*

*10. Anything else you would like to add?*