RESIDENTIAL TREATMENT QUALITY

Update on the 2019 Dialectical Behavior Therapy Recommendations

Washington State Department of
CHILDREN, YOUTH & FAMILIES

April 2021

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CHILDREN, YOUTH & FAMILIES

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Introduction

Dialectical Behavior Therapy (DBT) was adopted by Juvenile Rehabilitation (JR) as the main residential treatment model in 2002. The first full **evaluation of DBT** was published in 2019. This document provides a brief update on the status and progress toward the recommendations made in the 2019 evaluation.

In the most recent draft of the **Washington State Department of Children, Youth, and Families Integrated Strategic and Racial Equity Plan 2021-2026**, DBT is identified a few times. First, under the goal of creating successful transitions into adulthood for youth and young adults in our care, one area of work is to "strengthen therapeutic environments" (page 7). Then again, under the goal of improving quality and intention of our practice, the priority is to "build on previous and forthcoming evaluations reports to strengthen staff capability of improving youth mental health outcomes in JR facilities, revise the Quality Assurance (QA) plan to prioritize high-level implementation in the acute mental health units, improve training and staff resources dedicated to each unit to ensure a consistent standard across units." (page 9). The strategic priorities make it clear that improving DBT will be a major area of focus over the next five years. This document gives an updated look at where JR currently stands with DBT in 2021.

To help take stock in where JR is with the recommendations from the DBT evaluation, we include a status determination of either Completed, In-Progress, or Not Started.

Summary of Results

DBT 2019 Report Recommendation	Completed	In-Progress	Not Started
Rec 1: Revise DBT QA protocols			
Sub-rec 1: Living unit assessments once per year	Completed		
Sub-rec 2: Report GHS scores by building	Completed		
Sub-rec 3: Two observations unless three are needed	Completed		
Sub-rec 4: Continue to debrief with staff after observation	Completed		
Sub-rec 5: Modify the EA youth survey	Completed		
Sub-rec 6: Start QA scoring of individual session notes	Completed		
Sub-rec 7: Start QA scoring of skills group session notes		In-Progress	
Sub-rec 8: Discontinue the QA staff, family, and youth surveys	Completed		
Sub-rec 9: Leadership to closely monitor DBT QA reports		In-Progress	
Rec 2: Provide adherent DBT in acute mental health units			Not-Started
Rec 3: Create an achievable DBT training plan			Not-Started
Rec 4: Create a skills group completion definition and process		In-Progress	
Rec 5: Redesign the incident reporting process			Not-Started
Rec 6: Stop practice of tracking sessions that do not occur		In-Progress	
Rec 7: Use findings to inform hiring practices			Not-Started
Rec 8: Establish a committee to review DBT materials		In-Progress	
Rec 9: An updated evaluation every four years		In-Progress	

Update on Recommendation 1: Revise DBT QA Protocols to Include a Measurement of Quality for All Treatment Modes

Sub-recommendation 1: The QA team should reduce the number of assessments per living unit to once per year. Given the resources available to the QA team and the number of areas in the JR ITM that currently have no QA, twice-annual Environmental Adherence (EA) assessments are not an efficient use of resources.

Update: The QA team implemented the recommendation and now observes every living unit in JR once per year. This reduction in observation frequency did allow more time to devote to development of scoring rubrics for the other modes of DBT treatment. **Status: Completed**

Sub-recommendation 2: Reconsider treating each wing at Green Hill School (GHS) as a different living unit for the purpose of reporting DBT QA. Instead, QA should approach the scoring for each building as one living unit. Data indicated that there is very minor variation over time between wings within the same building.

Update: The QA team still conducts observations at the wing-level, but the overall score is aggregated to the building. When conducting EA reviews, we discuss quality improvement recommendations to apply to the entire building. **Status: Completed**

Sub-recommendation 3: The QA Team should start with two EA observations per living unit (more at GHS, we suggest one or two per wing, but that the results get aggregated to the building).

Update: After the initial observations, the assessors meet to discuss the domain scores on the EA scoring tool and see if they can come to a consensus. If the two QA managers score the unit significantly different (more than a .25 difference between scored observations), a third observation is scheduled. Each living unit only gets one score per domain, which is the average of the observation. **Status: Completed**

Sub-recommendation 4: The QA Team should continue to conduct debriefs with staff at the end of an EA observation.

Update: The QA team began testing the process in 2019 of debriefing with staff in the living units at the end of each EA observation. This type of immediate feedback is valuable and important for line-level staff. The QA team continues to conduct these at the end of every EA observation. **Status: Completed**

Sub-recommendation 5: The use of the EA youth survey with some modification.

Update: The QA team worked with Dr. Fox and the Office of Innovation, Alignment, and Accountability (OIAA) to reduce the number of questions related to EA quality and added empirically driven questions related to individual counseling, resident skill acquisition, and skill generalization. This reworking of the youth survey has yielded more information valuable to assessing how young people perceive the treatment received while in JR. **Status: Completed**

Sub-recommendation 6: Begin QA scoring of individual counseling session notes.

Update: The QA team developed a coding form for individual treatment case notes, with feedback from the DBT consultant team. This coding form mirrors the Treatment Planning and Progress Note (TPPN) template within ACT. The goal is for the QA team to utilize this coding form to score individual sessions during the same month that the team is conducting EA observations. The scoring tool that was developed is currently being used to score 100 randomly selected individual session case notes. Findings from this analysis can be found in a later section of this report. **Status: Completed**

Sub-recommendation 7: Begin QA scoring of skills groups session notes.

Update: The QA team has worked with the DBT consultant team to develop a clear scoring tool that mirrors the ACT template for DBT skill acquisition groups. This tool is currently being used by the QA team to score 100 randomly selected DBT skill acquisition groups. A tool has not yet been developed for skill generalization groups. Findings from this analysis can be found in a later section of this report. **Status:** In-Progress

Sub-recommendation 8: Discontinue the collection of the QA staff, family, and youth surveys.

Update: The QA team used to administer these twice per year, however, after understanding that the information gleaned from Performance-Based Standards, which are collected twice annually, was much of the same information, this practice stopped. This process was resource intensive and yielded data that was not always representative, given the collection sampling methods. **Status: Completed**

Sub-recommendation 9: JR leadership should closely monitor DBT QA reports

Update: Two statistical reports have been created and are automatically updated nightly. These two reports provide quantitative metrics related to the number of days it has been since each youth has received an individual counseling session or been involved in a DBT skills group. The reports also provide metrics from the last 30 days and the rate of treatment since they were admitted to JR. These reports are also sent to a variety of JR leaders every month. These reports are used by some facilities and not by others. Monitoring of the data should be more structured and consistent. Additionally, JR leadership should review the QA reports developed by the QA team related to environmental adherence. One strategy might be a monthly meeting where all the DBT data can be presented, to ensure JR leadership understands the status of DBT treatment and can monitor if progress is being made, or not. **Status:** In-Progress

Update on Recommendation 2: Provide Adherent DBT to the Living Units Serving Youth With High Mental Health Needs

Update: Initially, this recommendation was not fully agreed on by JR leadership. There were concerns about how youth are identified for acute mental health units and whether this process could result in racial inequity in treatment quality. However, the submission of funding requests at the start of the most recent legislative session outlined the need for additional resources to be able to designate acute mental health units and ensure high-quality DBT in those units. JR continues to attempt to provide the same level of DBT to all youth in JR residential facilities, however, the issues remain that prevent JR from providing adherent DBT. With high staff turnover, low staffing levels, and the lack of adequate training, staff are not able to meet the JR DBT standards. The result is that the individuals who need DBT the most are not receiving it at the level necessary to improve outcomes. There have been some efforts to improve DBT quality in a few of the acute mental health units, but we have also seen some of those units perform at even lower levels than before. Clear guidance from JR leadership regarding prioritizing this recommendation is essential to move forward. JR should make a clear and explicit effort to improve DBT adherence in the acute mental health units in JR. The agency simply does not have the resources to provide all individuals with adherent DBT, and this is not the treatment that all individuals in JR need, but the young people who do have mental health concerns do need it and they need it to be high quality. Although these DBT skills could potentially help most young people in JR's care, many do not fit the criteria this treatment was originally designed for. DCYF did request additional funding for DBT specialists to be imbedded in acute mental health living units, however, at the time of this writing, the state's next biennium budget has not been finalized, but the funding was included in the governor's budget, as well as both the Senate and House budgets. This is a promising development that has the potential to move this recommendation forward. Also, many individuals in JR's care have different areas of

treatment need, which should be addressed through other treatment options. This continues to be an area of much needed improvement. **Status: Not Started**

Update on Recommendation 3: Create an Achievable DBT Training Plan

Update: In July 2019, JR became part of the Washington State Department of Children, Youth, and Families (DCYF) and the current DCYF Mandatory Training Manual was created, including sections specifically spelling out the training requirements and training timelines for JR staff. There are staff positions established to track trainings at each institution but these staff use various methods to complete this tracking and not all the locations are currently using the DCYF Mandatory Training Manual as a reference.

Tracking if and when JR staff have completed their DBT training is not regularly monitored to ensure staff receive the mandatory trainings before being asked to carry out DBT duties. Without an agency-wide approach to tracking DBT trainings, there are many opportunities for staff to fall through the cracks, missing essential, mandatory trainings for an extended period of time while staff continue to work with the young people in our care without adequate training. Within the first six months of employment, JR staff are supposed to receive a series of trainings, including Coaching on the Floor (which is 16 hours and the training related to environmental adherence). Also, for case carrying staff there is a mandatory training about Case Management (16 hours), which is required "once at hire" (DCYF Mandatory Training Manual, page 11) but the timeframe, when the trainings actually take place varies depending on the staff and the location. These DBT-related trainings are only mandated once, when staff are hired. Residential Counselors (RC) and Counseling Assistants (CA) at our institutions or community facilities are not required to have any additional, ongoing, DBT trainings or assessment. These 32 hours of trainings, occurring once, are inadequate to provide DBT-focused, high-quality, therapeutic interactions in our milieus. **There is currently not any mandatory skills group training,** which leaves some staff being required to facilitate a skills group without formal training on the material or how to facilitate a therapeutic skills group. A skills group training has been developed, but is only optional and the training has not been widespread.

Additionally, supervisors and program managers need to be involved in a recurring DBT training, so that they are both knowledgeable and proficient in the DBT modes. If those who supervise line-level staff are not adequately trained in the treatment model, they will not be able to support and reinforcement the principles for their staff. One option to increase staff expertise that is currently being explored, and one that we strongly support, is the development of a DBT-intensive training for case management staff, specifically those in the acute mental health units. This training would be co-designed and carried out by JR DBT experts with those from an external agency that specializes in DBT. This is a promising development that should be expanded upon.

It is common for individuals in JR to have extensive trauma, mental health concerns, suicidal ideation, substance abuse issues and potentially violent tendencies. Staff are being asked to skillfully address these challenges every day with insufficient training, resulting in staff struggling to stay afloat and inconsistent therapeutic milieus. Staff need significantly more training to adequately sustain a therapeutic milieu, in accordance with DBT principles and standards. Staff also need this training to feel prepared for and successful in their work – a key component of job satisfaction and retention. **Status: Not Started**

Update on Recommendation 4: JR Should Create a Skills Group Completion Definition and Track the Progress a Youth Makes Toward Completion

Update: A completion definition and process has been drafted and the development of a weekly, JR-wide email that outlines the skill, with a link to resources for staff, are welcomed improvements to increase the consistency of weekly skills groups. Much work is needed to first track which skills groups each youth has completed, to agree on a completion definition, and then to implement a system-wide process of graduating youth from DBT skills groups. Questions remain related to how and who will track skills groups completions and eventual graduation from skills groups. This becomes increasingly important since JR has increased jurisdiction to age 25 and will have more youth staying for longer periods of time. **Status: In-Progress**

Update on Recommendation 5: Redesign the Incident Reporting Process

Update: For some time, there have been challenges with the current incident reporting process in Juvenile Rehabilitation (JR). A three-day meeting with approximately 20 JR staff was convened in May 2019 by the Assistant Secretary to attempt to resolve the concerns related to the current incident reporting process and structure. The meeting focused on Value Stream Mapping, guided by LEAN principles. The group identified the current issues with the incident reporting process and outlined a new incident reporting process that would be more accurate and less time-consuming for staff. Unfortunately, the months following revealed that IT did not have the resources to redesign the incident reporting process based on the specifications developed during the three-day event. Based on this revelation, work to improve the incident reporting process has largely stopped.

It is our belief that the challenges related to reporting on incidents are not primarily an ACT or IT issue. Clearly, a redesigned incident report module in ACT could result in a more efficient process, however, there is much that can be done now to improve the process without a new ACT module. Fundamentally, the challenges with incident reporting (IR) boil down to the lack of defined practice and common definitions in the IRs across JR. The primary issues that are contributing to inconsistent data are the lack of common definitions, the absence of a JR incident reporting manual, the lack of consistent training for staff on incident reporting, and an inconsistent quality assurance protocol. **Status: Not Started**

Update on Recommendation 6: Stop the Practice of Tracking Individual Sessions and Skills Groups When They Do Not Actually Occur

Update: The ACT team added a check box in the application that allows staff to create a skills group or individual session note, to indicate that the meeting did not happen. The functionality has been created, but this can be bolstered by adding clarity on the process to the JR standards. For example, explaining why a staff would need to document an individual session or skills groups in the records management system if the treatment session did not actually occur could be helpful. Further clarity around this issue, along with training and tracking are warranted. **Status: In-Progress**

Update on Recommendation 7: Use Findings To Inform Hiring Practices

Update: We are not aware of any progress on this recommendation. JR has very high turnover which adds to the challenge. Improving the hiring process to prioritize staff who have a propensity toward therapy and support, as opposed to punishment, will help improve treatment quality. **Status: Not Started**

Update on Recommendation 8: Establish a Committee, Including Youth and Community Partners, to Review DBT Materials

Update: Internal JR experts have reviewed the DBT skills and continue to add new examples for the application of skills. These new examples are added to the weekly facilitator notes that are made available to staff. This process has not been formalized to include youth or community members, but that would require resources and structure. For the long-term success of the treatment model, it will be important to create a process to ensure the materials are both culturally and socially relevant. **Status: In-Progress**

Update on Recommendation 9: An Updated Evaluation Should Be Conducted Every Four Years

Update: We still anticipate an updated evaluation to be conducted in 2023 by OIAA (unless resources become available for an external evaluation). In the meantime, we need to continue to build feedback loops with the data that are available. Mid-level management and agency leadership alike need to be able to see the status of DBT so that they can make adjustments as needed. A future evaluation should help identify the implementation metrics that are most associated with improved outcomes, so that the agency can focus on improving those metrics, knowing that it will result in improved outcomes for youth. Based on the 2019 evaluation, we know that higher Environmental Adherence scores are related to lower recidivism rates. Based on this, JR should do everything possible to ensure high EA scores in all JR facilities and living units. To date, there continues to be living units with unacceptably low EA scores. **There needs to be clarity on who is responsible for EA improvements and a standardized process to increase scores if they fall below a specific threshold**. **Status: In-Progress**

Update on the Quality of DBT in JR

The DBT QA Team has developed scoring tools for both DBT individual sessions and skills acquisition groups. These scoring sheets were designed to score the documentation of each of those treatment modes and are not used during observations. Technically, these two tools score the individual sessions and skills groups as seen through the documentation from staff. The 2019 evaluation did not find that the number of individual sessions or skills groups were related to recidivism. However, it was noted that the quality of each of those modes varied widely. The development of quality scoring will allow us to determine the percent of each of these modes that meets the adherence standard. To test these new scoring instruments, we took a true random sample of 100 individual sessions and acquisition skills groups for the QA team to score. Below we present the quality of three DBT modes from 2019 in JR, individual sessions, skills groups (acquisition only), and environmental adherence.[1] See Appendix 1 and 2 for coding forms.

Scoring on all three modes is carried out using a 0-3 point scale. For individual sessions and skills groups there are five measures, while environmental adherence has 13 measures. These measures are averaged to get a final score. Individual sessions are at the individual level, skills groups are at the small group level, and environmental adherence is at the living unit level. Here is how the scoring is interpreted:

[1] Scoring has only been developed for skill acquisition groups and not for skill generalization groups. Over 70% of skills groups are acquisition groups and are being addressed first. We selected 2019 for a number of reasons, most importantly, there are many data anomalies in the 2020 data due to COVID-19. In person observations were halted for a number of months and skill group frequency were impacted in 2020. As result, 2019 is the last full year of data available to assess for quality.

Score	Interpretation for individual sessions and skills groups	Interpretation for Environmental Adherence
0	No evidence in file	Anti-DBT
1	Needs attention; does not meet standard	Needs attention
2	Meets standard	Meets standard
3	Exceeds standard	Exceeds standard

Individual Session Quality in 2019

A total of 100 individual sessions were randomly selected from calendar year 2019. The sessions were representative of facility locations and across the 12 months in 2019. Of the five measures scored for quality, review of the diary card scored the highest and treatment plan details scored the lowest. Overall, 8% of individual session notes were categorized as meeting or exceeding the standard (an overall average score of 2 or greater). It is important to note that scoring was only of the sessions that occurred. If a session should have occurred, but did not, it did not receive a score. At this point, the findings either suggest a lack of quality documentation, understanding there may be gaps in training, or it could suggest that the vast majority of current DBT individual sessions do not meet the minimum standard required. This is also a new tool while there have been efforts to ensure interrater reliability, there is additional work to be done related to the validity of the individual session scoring tool and the skill acquisition group scoring tool.

Individual Session Measures 2019	Average
Diary Card Review	1.44
Homework Reviewed	1.41
Treatment Plan Details	1.01
Goals and Motivation	1.23
Treatment Behavior	1.17
Overall	**1.25**

Skill Acquisition Group Quality in 2019

A total of 100 acquisition skills groups were randomly selected from calendar year 2019. Of the five measures scored for quality, mindfulness scored the highest and the review of homework scored the lowest. Overall, 10% of acquisition skills group notes were categorized as meeting or exceeding the standard (an overall average score of 2 or greater).

Skill Acquisition Group Measures	Average
Mindfulness	1.67
Homework Reviewed	1.03
Taught New Skill	1.55
Role Play New Skill	1.19
Assigned Homework	1.38
Overall	**1.36**

Environmental Adherence Quality in 2019

JR has had QA staff observing living units since 2010. The 2019 evaluation showed that this measure is significantly related to recidivism. Youth who experience higher EA scores do better when they are released. There are some areas where living units are doing well, for example, the highest rated measure is whether staff are respectful to youth. There are also a few areas where living units tend to score lower, including, living units effectively reinforcing behaviors and structuring the program to pair privileges with treatment. Overall, the average EA in 2019 was 2.33 with about 75% of living units receiving an average score of 2 or more. It is important to note that some units have consistently received high or even perfect EA scores, while others consistently receive low EA scores. In 2019, the scores ranged from a 1.46 to a perfect 3. Any score of 0 or 1 on any individual measure, or an overall score of less than 2 should be cause for an immediate intervention by agency leadership.

Environmental Adherence Measures	Average
Staff are respectful	2.73
Staff display genuine regard toward youth	2.64
Staff demonstrate that they listen to youth	2.74
Behavior is described in an empathetic way	2.50
Program is structured for treatment	2.48
Structured programming on the floor	2.13
Treatment information is communicated among staff	2.13
Unit effectively reinforces behaviors	1.93
Milieu is structured to actively engage youth in skills	2.07
Program is structured to pair privileges to treatment	2.03
Staff help youth accomplish treatment goals	2.17
Staff apply DBT strategies in the milieu	2.14
Staff support each other to deliver treatment with fidelity	2.58
Overall	**2.33**

The data presented here show that the quality of individual sessions and skills groups needs to be drastically improved. Generally, EA has been improving because it has been consistently measured and communicated to leadership. There are, however, some living units that have consistently received low EA scores for many years. In these cases, leadership should take decisive action, because we know that higher EA scores result in better outcomes for youth. Said differently, it is harmful for youth to be in living units with low EA scores. Some examples of decisive action would include targeted, intensive training for staff in the living unit or change in leadership of the living unit. It is necessary to create quality improvement (QI) plans and to implement change. Within these QI plans there needs to be a standardized feedback and training loop, to foster staff development and improvements in EA milieu scores. Institutions can be harmful, particularly for young people, when the environment is not supportive or therapeutic, and that is exactly what the EA feedback is telling us.

Moving Forward With DBT in JR

Beginning in 2021, the QA reviews, which take place with local administrators, program leaders, and supervisors after the in-person milieu observations are completed, will include more information. QA staff will continue to review all relevant information gathered during EA observations, however, QA staff will also begin to include data collected from the DBT statistical reports that track the rate of individual sessions and skills

groups. The **JR DBT standard** is that each of these should be occurring at least once a week. This will provide local leadership and program personnel additional information regarding the amount of individual counseling sessions and DBT skill acquisition groups residents in the program are receiving. We will use this time to highlight areas where the program is meeting JR standards for DBT treatment, as well as discussing modes of DBT treatment that need attention. Eventually, we will incorporate a comprehensive “report card” that details all of this information on one document, while highlighting areas for quality improvement, and how the program is receiving the corresponding consultation and training.

We still believe the recommendations from the 2019 evaluation are relevant and needed to improve the quality of treatment. There are clearly some structural and organizational issues that are preventing the improvement of treatment. Since the 2019 evaluation, there was also a series of recommendations provided by an external consultant as part of an **assessment of JR’s treatment model** (called the Integrated Treatment Model or ITM). In order to make progress on some of these recommendations, JR needs to clarify the oversight and accountability structure for both the ITM generally, and for DBT more specifically. Currently, accountability and implementation are all pushed to the local level, but this has resulted in a pattern of inconsistent treatment quality, where a youth can receive vastly different treatment quality, not based on need, but based on which living unit they are assigned to. One reasonable option is to task the Clinical Governance Committee with oversight of the ITM, including DBT as the main residential treatment model. That committee would be primarily responsible for monitoring DBT data and key metrics, and would need to have oversight of some resources to assist those living units that are underperforming.

To put it plainly, DBT in JR is currently not designed to be successful. The implementation of DBT cannot be successful under the current resources and structure. Implementation must be reimagined, and oversight redesigned, to create a residential treatment model that can be successful now, using current staff and training resources. JR is simply asking too much of line-level staff and they are not receiving the support necessary, resulting in youth not receiving the treatment they need. DBT has a place in the treatment model, however, attempting to implement it universally is proving to be an enormous challenge and not necessarily what all youth need in JR. It is possible to improve, but JR will need to take the bold action of reimagining what is possible, by emphasizing what works and stopping the practices that are not working.

Appendix 1. DBT Quality Assurance Acquisition Skills Group Coding Form

Components of DBT Skills Acquisition Group

1. Mindfulness Exercise

Principles:

- Mindfulness is a core component of DBT.
- Mindfulness is the foundation of all other DBT skills.
- There is an ideal, standardized structure to a mindfulness exercise. A mindfulness exercise begins with an engaging story and orientation (what you plan to do in the exercise), highlighting a specific skill to focus on, giving time for participation in the exercise or activity, and always including a debrief at the end.
- Mindfulness is a practice of bringing oneself into the present moment. The more repetitions, the stronger the practice becomes.
- A strong mindfulness practice can affect numerous aspects of the youths' lives in our care.

Standardized anchors for 3:
Documented within the ACT Group Case Note

a. Group case note includes information about the mindfulness exercise (title, skill to focus on, and individualized information as needed).
b. Documented mindfulness exercise including reference to story/orientation, skill to focus on, participation, and debrief (can be brief although must cover all components of the mindfulness exercise).

Standardized anchors for a 2:

a. Staff include the title of a specific mindfulness exercise or briefly document an exercise without including a reference to all components of the standardized structure.

Standardized anchors for a 1:

a. Documentation about the mindfulness exercise was incomplete.
b. Documentation suggests an exercise occurred called mindfulness, but this exercise was not included in the "Skill of the Week" list, or there is no evidence included to justify it was an actual mindfulness exercise.

Anti DBT:

a. No content included in the mindfulness exercise section of the group case note.
b. Mindfulness exercise did not occur.

2. Review Homework and Last Skill Taught in Group

Principles:

- Homework and review of last skill taught assists youth in learning and moving toward generalization.
- Homework is assigned at each group, except under specific approved circumstances.
- Homework review is so important that its completion takes precedence over any other group task (Linehan, 1993).
- Homework is reviewed during each group. If homework is not completed, staff assess why it was not by completing a verbal, on-the-fly BCA and get a commitment for future homework completion.
- Staff review last skill taught in each group, asking youth for any further questions and providing clarity before moving on to the next skill.

Standardized anchors for a 3:
Documented within the ACT Group Case note

a. Staff reviewed homework and last skill taught with all youth, including information about the youth's performance with the homework assignment.
b. If youth did not complete the homework, staff assessed what interfered with homework completion; problem-solved with youth, created a plan, and obtained a commitment to have the homework completed for the next group.
c. Staff made efforts to motivate and engage youth that did not want to share homework.
d. If youth had further questions about the last skill taught, staff answer these questions before continuing, unless there are specific circumstances where a particular youth may need additional help outside group.
e. The homework reviewed relates to the last skill taught and encourages practice of the skill.

Standardized anchors for a 2:

a. Staff documented the title of the homework and referenced last skill taught without further description of youths' participation in homework completion.
b. Both homework and the last skill taught are referenced in documentation, even if brief.
c. The homework identified relates to the last skill taught.
d. If homework was not assigned, staff provide brief explanation for these circumstances.

Standardized anchors for a 1:

a. Documentation of information about homework or last skill taught is incomplete (staff documented information in one area but not the other).
b. The homework and last skill taught do not appear to relate to each other and does not encourage youth to practice the last skill taught throughout the previous week.

Anti DBT:

a. No content included in this section of the DBT Group Case note, no evidence it was completed.
b. Staff did not review the homework or the last skill taught.

3. New Skill Taught (Description and Teaching Points)

Principles:

- DBT has five modules – Mindfulness, Middle Path, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. Each module has different skills associated with it.
- DBT Skill Acquisition Groups take place each week, where youth learn skills relating to a specific module. JR has created a standardized list of skills and the order these skills are taught (Skill of the Week).
- Following the structured sequence of the "Skill of the Week" allows staff to track what groups a particular youth has attended and what groups they still need to receive.
- The material within the "Skill of the Week" includes descriptions and teaching points for each skill, creating continuity among facilitators and groups, allowing all youth to receive similar information about each skill as youth transition through JR's continuum of care, encouraging seamless transitions between JR locations.

Standardized anchors for a 3:

Documented within the ACT Group Case note

a. Staff included a relevant description of the new skill taught.
b. The case note included the major teaching points from the "Skill of the Week" discussed during the group.
c. Group leaders highlighted why the skill was relevant to the youths' lives and how it could benefit them.

Standardized anchors for a 2:

a. Staff identified the new skill of the week taught.

b. Documentation included a brief reference to the major teaching points discussed in group.
c. Teaching points were relevant to the new skill taught.

Standardized anchors for a 1:

a. Information documented about the new skill taught was incomplete, not giving a description or not referencing any teaching points.
b. Documentation suggests the new skill taught was taught incorrectly.

Anti DBT:

a. No content included in this section of the case note.
b. Staff did not teach a new skill.

4. Role-Playing/Putting Relevant Behavior to New Skill

Principles:

- DBT involves creating a "life worth living" and helping youth to see how skills are relevant to their individual lives, highlighting situations they experience in their lives will increase motivation in treatment.
- Trying new skills through relevant role-plays (behavioral rehearsal) and real-life examples allows youth to move toward generalization, helping youth to associate the new skill to their life experiences.
- Role-plays (behavioral rehearsal) and putting relevant behaviors to new skills aids in the learning process, and makes the learning more concrete.

Standardized anchors for a 3:
Documented within the ACT Group Case note

a. All youth were engaged in behavioral rehearsal to practice newly learned skills during group.
b. Staff encouraged youth to apply relevant behaviors to the new skill taught. If there are difficulties with role-plays, staff address these, including dialogue about feedback given to youth on how to make necessary adjustments for effective skill usage (ideally, youth try again while applying new feedback).
c. Information included about behavioral rehearsal or applying relevant behaviors to individualized life experiences and how youth practiced/applied the newly learned skill.
d. Behavioral rehearsal and dialogue on applying relevant behaviors are effectively related to the new skill taught.

Standardized anchors for a 2:

a. Staff engaged youth in behavioral rehearsal and put relevant behaviors to the new skill.
b. Behavioral rehearsal and dialogue about relevant behaviors involve the new skill taught.

Standardized anchors for a 1:

a. Documentation about the behavioral rehearsal and putting relevant behaviors to the new skill was incomplete.
b. Documentation suggests the behavioral rehearsal incorrectly practiced the new skill or irrelevant behavior rehearsal was related to the new skill taught.

Anti DBT:

a. No content included in this section of the case note.
b. Staff did not role-play or put relevant behaviors to the new skill.

5. Homework to Practice Newly Learned Skill

Principles:

- Homework is an essential part of "Acquisition Skills Groups," creating additional practice for youth throughout the week between group sessions.

RESIDENTIAL TREATMENT QUALITY
• Assigned homework is relevant to the new skill taught and initially practiced in group. • Behavior and changing established habits can be challenging, repetitive practice of newly learned skills can assist youth in moving toward generalizing these skills into their individual lives.
Standardized anchors for a 3: Documented within the ACT Group Case note a. Staff oriented youth to relevant homework assignment, encouraging youth to practice new skill. b. Staff gathered commitments from youth to complete the assigned homework by the next group. c. Staff related the skill and homework back to individual youths' lives, increasing motivation for homework completion.
Standardized anchors for a 2: a. Documentation includes the name of homework assigned. b. Homework is relevant practice for the newly learned skill.
Standardized anchors for a 1: a. Documentation to practice new learned skill is incomplete. b. Assigned homework is not relevant or does not relate to the newly learned skill.
Anti DBT: a. No content included in this section of the case note. b. No evidence to suggest staff assigned homework to practice the newly learned skill.

Appendix 2. DBT Quality Assurance Treatment Planning and Progress Note Coding Form

Setting the Agenda

1. Diary Card Review

Principles:

- Diary cards are used to set the agenda for the counseling session.
- Diary cards track and provide valuable information for the resident and counselor regarding thoughts, urges, behaviors, and skill usage the resident had throughout the week.
- Individual therapy in DBT requires individuals to self-monitor their behavioral urges, actions, and skills on a diary card as well as to practice using skills in place of problem behaviors (Rathus and Miller, 2014).
- Behaviors that are being tracked change faster than behaviors that are not tracked.
- Diary cards help the youth remember their week and important items to discuss with their counselor.
- The more individualized the diary card is, the more likely the youth will find it relevant and complete it.
- It is imperative that staff communicate the importance of Diary Card adherence and how tracking specific behaviors can lead to positive outcomes and completion of personal goals.

Standardized anchors for a 3:
Documented within the ACT TPPN:

a. Staff identified the youth's performance with their diary card (full completion, partial, or none), and if youth did not fully complete their diary card, staff assessed why and problem-solved with them what they would do to complete it daily the next week.
b. Staff included relevant and specific information about the youth's diary card tracking from the past week, which could include thoughts, urges, changes in baseline, vulnerabilities, drivers, and functions of behavior, skill practice or generalization, etc.
c. The diary card contained information specific to the youth's targeted behaviors and goals.

Standardized anchors for a 2:

a. Staff identified whether or not youth completed their diary card during the week, and if youth did not complete it, then staff gathered a commitment from youth to come prepared next session with their diary card completed.
b. Staff included a brief summary about the youth's tracking from the past week.
c. The diary card contained information relevant to the youth's targeted behaviors and goals.

Standardized anchors for a 1:

a. Staff did not specify whether youth completed their diary card during the week.
b. Staff included incomplete information about the youth's tracking during the week.
c. Diary card tracking was not related to the youth's targeted behaviors and goals.

Anti DBT:

a. Staff convey that diary card completion is unimportant or not necessary.
b. No content included in this section.

Components of Individual Session

2. Homework

Principles:

- Each week at the end of the individual session, at least one new homework assignment is assigned and documented in the "Homework" section of the TPPN.
- Staff are encouraged to use diary cards in conjunction with other treatment assignments (Example: Youth is provided an assignment to practice the GIVE skill in a certain setting, and youth tracks on DC how many times they used it throughout the day).
- Homework assignments extend treatment beyond the one-hour individual counseling each week.
- Homework assignments may help to generalize skills and concepts taught in session.
- Homework assignments should be made or modified for the individual's needs.
- Reviewing homework with the youth conveys that the counselor cares about youth's goals and treatment progress.
- Staff provide reinforcement if homework is completed.
- Staff use problem solving and commitment strategies if youth's homework was not completed, the skills were not practiced correctly, or problems in using the skills were identified.

Standardized anchors for a 3:
Documented within the ACT TPPN

a. Documentation included titles for "Homework assigned in previous session" and "Homework assigned for next session," as well as specific information regarding what the homework had the youth work on (skills practiced, tracking, question and answers, etc.).
b. Staff reviewed youth's homework with them, and staff included specific information regarding the youth's behavior (entries on the diary card, highlighting specific times youth practiced the skill and how the youth thought these interactions went), as well as dialogue or feedback given to the youth.
c. If youth did not complete their homework, staff assessed why and problem solved with the youth to help them come to the next session prepared with homework completed. Staff seeks commitment from the youth to do so.
d. Youth's assignments were relevant to their targeted behaviors and goals.

Standardized anchors for a 2:

a. Documentation included titles for "Homework assigned in previous session" and "Homework assigned for next session.
b. Staff included a brief summary of the youth's attempts to complete the homework from the previous session.
c. If youth did not complete their homework, staff assessed what got in the way and gathered commitments to complete their homework next week.
d. Youth's assignments were related to their targeted behaviors or goals.

Standardized anchors for a 1:

a. There was no information included for one or more homework sections.
b. Staff briefly indicated whether youth completed homework without any further content about what was reviewed.
c. If youth did not complete homework, staff did not address this or gather commitments to complete it next session.

d. Youth's assignments were not related to their targeted behaviors or goals.
e. Staff did not assign homework or review homework with youth.

Anti DBT:

a. Staff conveyed that homework was unimportant or unnecessary.
b. No content included in this section.

3. Treatment Plan Details

Principles:

- Behavior Chain Analysis is one of the most important DBT strategies.
- Staff use BCAs to assess and understand the behaviors of the youth in order to guide effective therapeutic responses.
- A pattern of behavioral responses can be elicited when BCAs are done on an ongoing basis.
- Significant change in behavior can be accomplished by attending to small increments of improvement.
- Counselors document in this section their efforts to work on targeted behaviors, teach youth new skills, shaping steps, and engage youth in behavioral rehearsals/role plays.

Standardized anchors for a 3:
Documented within the ACT TPPN

a. Staff selected "yes" that they completed a BCA in session and identified the specific behavior(s) that was chained.
b. Behavior(s) chained were relevant to the treatment process.
c. Documentation contained relevant and specific information from the completed BCA(s) that included cues, vulnerabilities, risk and protective factors, drivers, and functions of behavior.
d. Staff included detailed information about additional treatment-related topics discussed during the session (work on targeted behaviors, new skills taught, behavioral rehearsals, role-plays, etc.)

Standardized anchors for a 2:

a. Staff selected "Yes" that they completed a BCA in session and briefly identified the behavior that was chained.
b. Staff briefly summarized what was identified during the BCA.
c. Documentation included a list of other treatment-related topics that were discussed during the session.

Standardized anchors for a 1:

a. Staff select "No" that they did not complete a BCA in session.
b. Documentation about the BCA or other treatment-related information discussed is incomplete or missing information (no information included in one or more sections).
c. Documentation in "Other treatment-related information discussed in session" section was not relevant to the individuals' goals or treatment planning.

Anti DBT:

a. Staff conveyed that BCAs were unimportant or unnecessary.
b. No content included in this section.
c. Topics discussed were harmful to the therapeutic process.

4. Goals/Motivation

Principles:

- The core of DBT is building a "life worth living.

RESIDENTIAL TREATMENT QUALITY
• Teaching youth to be goal driven and effective problem solvers may help them build and maintain a life that they deem worth living - youth may not have caused all of their own problems, and they have to solve them anyway. • DBT is focused on the youth's goals; it is all about helping them move toward the goals they have identified for themselves. • Youth's motivation and commitment in DBT is an important part of treatment that serves as both prerequisite for effective therapy and a goal of the treatment. • Focusing on youth's goals may increase motivation and commitment, especially with youth who are not voluntarily in a treatment setting. • Youth are experts on themselves and their goals, and staff are the experts on the DBT model.
Standardized anchors for a 3: Documented within the ACT TPPN a. Staff asked the youth to rate their motivation to work on their goals, and staff included this rating. b. Documentation included relevant and behaviorally specific information that described the youth's motivation to work towards their goals. c. Staff documented the current status of youth's progress toward their goals. d. Staff listed specific goals the youth worked towards and associated accurate "active dates" and "completed dates."
Standardized anchors for a 2: a. Rating was included to indicate the youth's motivation to work on their goals. b. Documentation included a brief description about the youth's motivation to work towards their goals. c. Staff included at least one goal the youth was working towards as well as associated "active dates" and "completed" dates.
Standardized anchors for a 1: a. Rating was included to indicate the youth's motivation to work on goals, but this number did not align with the description provided about the youth's motivation to work on goals. b. Documentation about the youth's motivation section was incomplete or missing information (no information included in one or more areas). c. Documentation indicated that goals had not been identified for an extended period, documented "active" goals were inactive as evidenced by an outdated active date, or there were no references to the youth's performance working towards their "active" goals.
Anti DBT: a. Staff conveyed that the youth's goals were unimportant, unnecessary, or that the youth was incapable of accomplishing goals. b. No content included in this section.

Treatment Planning

5. & 6. Target Behavior #1 & #2

Principles:

- Individual therapy in Juvenile Rehabilitation is structured to focus on the JR hierarchy of treatment targets.
- DBT conceptualizes treatment in stages that correspond to the severity and complexity of the client's problems (Rathus and Miller, 2014).
- Each youth has individual behaviors they need to improve and/or remove to build a life worth living.
- Treatment is focused on shaping steps toward youth goals, reinforcing incremental steps toward these goals: including skill(s) taught to youth, how youth will practice skills, how this will be tracked, and how new behaviors will be reinforced.

Standardized anchors for a 3:
Documented within the ACT TPPN

a. Staff identified a relevant and specific behavior they were targeting with the youth, included it in the correct level on the hierarchy, and indicated the start date of this target behavior.
b. Documentation included a description of the skills the youth had previously worked on regarding the targeted behavior; if youth had not previously worked on skills related to the targeted behavior, staff briefly explained this.
c. Staff identified specific shaping steps to address the targeted behavior; including what behavior would specifically be targeted and what reinforcement youth would receive for practicing these behaviors.
d. At least one BCA was attached to the targeted behavior that included a narrative, as well as relevant cues, vulnerabilities, protective factors, consequences, drivers, and functions of the behavior.

Standardized anchors for a 2:

a. Staff identified a youth's target behavior, including the correct level on the hierarchy, and indicated the start date of this target behavior.
b. Documentation included a list of skills the youth had previously worked on regarding the targeted behavior.
c. Staff briefly identified a plan to address the targeted behavior that included skills, strengths, and goals.
d. A BCA was attached to the targeted behavior that included a narrative, as well as the suspected drivers and functions of the behavior.

Standardized anchors for a 1:

a. Staff use vague language to identified treatment targets like "self-harm or aggression" versus identifying a behaviorally specific target.
b. Documentation was incomplete regarding skills the youth had previously worked on for the targeted behavior.
c. Staff included information about a plan to address the targeted behavior, but the plan was incomplete or missing components such as skills, strengths, or goals, or the plan was not relevant to decreasing or increasing the targeted behavior.
d. A BCA was attached to the targeted behavior, but there was missing information such as the narrative, drivers, or functions, or the staff incorrectly identified treatment information.

Anti DBT:

a. No content included in this section.

RESIDENTIAL TREATMENT QUALITY
b. Documentation frequently contained judgmental language or suggested that the youth was incapable of increasing or decreasing their targeted behavior.
7. Reentry Planning
At this time this domain will not be scored.

Current TPPN standard - effective 3/15/2019

8. Counselors must document details of the session in the Treatment Planning & Progress Note (TPPN) within 72 hours of the session.