Dialectical Behavior Therapy (DBT): Implementation in an Inpatient Setting

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Financial Disclosure

- We do not have any relevant financial relationships with any commercial interests.

Mindfulness Activity

Objectives

- To provide a brief overview of DBT as a treatment
- To describe Napa's process of implementing DBT on an inpatient unit
- To discuss the challenges that arose throughout the implementation process
- To discuss the way challenges were addressed
- To make recommendations to facilities regarding implementation

Overview of DBT Treatment

- DBT is a psychotherapy that combines standard cognitive-behavioral techniques for emotion control, tolerating distress and reality testing, with more eastern Buddhist approaches
- A focus is placed on dialectics with a balance between acceptance and change processes
- Teach patients how to balance their thoughts, emotions and behaviors

Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. The Guilford Press: NY.

Goals of DBT: "What"

- Decrease life threatening behaviors
- Decrease therapy interfering behaviors
- Decrease quality of life interfering behaviors
- Increase behavioral skills:
  - Mindfulness
  - Distress tolerance
  - Interpersonal
  - Emotion regulation

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Goals of DBT: "How"

- Skills groups to enhance capabilities
- Individual therapy to improve motivation
- Homework assignments and milieu coaching to assure generalization
- Milieu interventions and policy changes to structure the environment
- Consultation and training to enhance and improve therapist abilities and motivation

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DBT Implementation at NSH

- At NSH, DBT has been implemented three different ways to address different clinical issues.
  - In July of 2012, DBT was implemented in a "clinic" model, in which patients from various units attended a DBT skills group on an "outpatient" basis and DBT was introduced to help them meet discharge criteria to the community, and decrease their length of stay in the hospital
  - Components of DBT were provided on other units
  - A comprehensive DBT model was implemented on a single unit

Evolution of Implementing NSH's Comprehensive DBT Unit

- In Fall of 2012, a comprehensive form of implementation was developed for a specific unit
- A DBT skills group and individual therapy were provided to these patients in October, 2012 along with consultation groups for the therapy providers.
- In March, 2013, all staff working on the unit received a 2 day, 8 hour training in DBT principles
- A consultation group for all unit staff was introduced
- Constant-in-sight nursing observations (CIO) changed

Treatment as Usual:

- Group therapy
- Individual treatment focused on trauma work, cognitive behavioral therapy, token economy
- 1:1 observations following behaviors (reactive rather than proactive approach)
- Behavioral Plans
- Multilevel reviews through various committees at the state hospital level (treatment as usual continued as the recommendation)

Why DBT Now?

- Individual interventions were not effective
- The need for a holistic and milieu approach was identified
- Prior treatment was only partially and/or temporarily effective

Targets of Treatment When Implementing DBT at NSH:

- Patients were engaging in recurrent and severely dangerous behaviors
- Patients were diagnosed with Borderline Personality Disorder and/or impulsive behaviors that were not being fully addressed
- Staff injuries and assaults were on the rise
- DBT was suggested as a method to not only provide direct treatment to patients, but to provide a more therapeutic milieu to help provide stability to the unit.

What Patients Get This Treatment?

- Civil unit: Patient's were LPS conserved
- 6 Female patients
- Age Range: 18-49
- *Primary Diagnoses*: Borderline Personality Disorder; Oppositional Defiant Disorder; Bipolar I Disorder, Severe without Psychotic Features; Major Depressive Disorder, recurrent, severe with psychotic features; Schizoaffective Disorder; Reactive Attachment Disorder
- *Secondary Diagnoses*: Cannabis Abuse, Alcohol Dependence, Amphetamine Abuse, Borderline Personality Disorder, Schizoaffective Disorder, Post Traumatic Stress Disorder

What Unit Gets This Treatment?

- Staff injury was high
- Staff burn out was high
- Staff felt unsafe
- Staff felt hopeless about the future of their patients
- Low staff morale

General Theory of DBT at NSH:

- What parts of the theory apply to our setting?
  - Individual therapy
    - Diary Card
    - Behavioral Chain
  - Skills group
  - Homework group
  - Milieu/telephone consultation
  - Consultation group
  - ALL PARTS!!!!

Who is Involved in Providing Active Treatment?

- All level of care staff and program management
- "Everyone is a therapist"

How Did Staff Receive Training?

- Initially a grass roots approach, bottom up!
- Began training/consulting during morning meetings and shift exchanges (was not enough)
- More training was necessary
  - Staff training occurred over 3 rounds of 2 day staff trainings (total 8 hours per training)
  - Mandatory
  - Commitment required
- Quick reference cards made for the unit
- Each staff member received skills handouts
- Peer review/observation
- Evaluation of progress and needs

Interventions on Unit:

- Milieu interventions
  - Structured staff check ins/ "phone consultation"
  - Coaching and milieu interventions (whenever necessary)
- Individual therapy (30 minutes-1 hour per week)
- Consultation
  - Email consultation and correspondence between "consultants"
- Groups
  - Mindfulness group (Intro/DBT "lite")
  - Skills group 2x per week (2 hours total)
  - homework group (1 hour per week)

Interventions in the Environment:

- Plan developed to discontinue constant in-sight nursing observations for patients in DBT program, replaced by having nursing staff monitoring of all private areas (bedrooms, bathrooms)
- Staff training for policy for initiating 1:1 observations
- Staff training for staff providing 1:1

Administrative Interventions:

- There are a number of administrative activities regarding DBT implementation that continue on a regular basis
- There is a DBT administrative coordinator
- The hospital DBT administrative committee meets at least monthly to discuss issues relative to DBT implementation at NSH
- Finally, there is unit administrative meeting that meets weekly to discuss issues specific to implementation of DBT on the unit we are discussing

Challenges During Implementation:

- Unit and staff buy in
- Unit and staff commitment to treatment
- Patient buy in and commitment
- Administrative buy in
- Administrative commitment
- Administrative support

Specific Challenges During Implementation:

- Staff resistance-
  - Inconsistent staff "buy in", with some confusion about program and some "sabotage"
    - Patients getting inconsistent messages about staff support of program
    - Staff concerns about increase in violence on unit if treatment fully implemented
  - What if staff don't want to be on a DBT unit?
    - Staff who were not supportive of DBT program were moved to other units
- Problems with accurate implementation of the model:
  - Treatment was not being run in a valid and reliable way
  - There was only one skills group
  - Treatment providers were unsure of the model
  - There was no consultation group

Specific Challenges During Implementation:

- Training coordination:
  - With morning, evening and night shifts how do you train everyone? Who gets trained?
- Resources:
  - Who is going to do the treatment?
- Time:
  - When does the unit get exposed to the skills and theory?
- Applying the model:
  - Outpatient model on an inpatient unit

How Do We Measure Change/Effectiveness?

Patient Outcomes:
- Decrease in self injurious behavior
- Decrease in 1:1 observation
- Decrease in PRN usage
- Discharge from hospital

Staff Outcomes:
- Staff call in rates
- Staff injuries
- Improved morale

Patient Outcomes:

- **Frequency of patients engaging in dangerous behavior:**

Physical Assaults on Others:

Patient Population	Mean incidents pre DBT	Mean incidents post DBT
Patients in DBT	6.0	1.5
Total Patients on unit	19.3	5.3

Self-Injurious Acts:

Patient Population	Mean incidents pre DBT	Mean incidents post DBT
Patients in DBT	8.2	3.5
Total Patients on unit	8.0	4.7

Episodes of Seclusion or Restraint*:

Patient Population	Mean incidents pre DBT	Mean incidents post DBT
Patients in DBT	8.4	1.7
Total Patients on unit	15.4	4.8

Patient Outcomes:

- **Discharge:**
  - 4 patients were discharged from the program
  - 1 patient returned to NSH after 13 days
  - 1 patient resided in the community for over 6 months before returning to the state hospital
  - 2 patients have remained in the community (over 5 months and 2 months)

Staff Outcomes:

- For Nursing Staff:
  - 86% said “I feel safer on A-1 since the unit began using DBT”
  - 80% said “I feel more hopeful about patients’ progress since A-1 began to use DBT”
  - 80% said “I like working on A-1 more since the unit began DBT”
  - 20% said “My job is harder since A-1 began to use DBT”

Staff Outcomes:

- For Ancillary Staff:
  - 100% said "I feel safer on A-1 since the unit began using DBT"
  - 100% said "I feel more hopeful about patients' progress since A-1 began to use DBT"
  - 100% said "I like working on A-1 more since the unit began DBT"
  - 0% said "My job is harder since A-1 began to use DBT"

Conclusions and Recommendations

- Although grass roots implementation was required to gain support, investing up front may make training and implementation easier and more effective (no repeating of issues)
- Current data is not large enough to be generalizable
- Need to implement sustainable program for an indefinite period of time
- Forensic commitment related concerns may arise that are not accounted for at present with a civil population

Conclusions and Recommendations

- Expanded consultation groups to meet needs of various populations and growing DBT program
- Consultation with outside agencies to evaluate competencies of practicing clinicians at NSH

Future Directions

- Hospital wide training (began February 2014)
- Unit based implementation on acute PC 1026 and PC 2972 unit (forensic units) beginning in March 2014
- Follow up studies of efficacy based on patient movement to lower acuity units (i.e. intermediate and discharge units)
  - Measurements of decreased behavioral problems
  - Measurements of decreased PRC and higher level reviews for patient behaviors
  - Measure staff satisfaction
  - Measure staff burnout
  - Measure staff injury

Future Directions

- Within hospital proctoring to assist hospital staff in adhering to the model
- Within hospital evaluation to ensure model does not become diluted
- Follow up training for new staff hired to ensure implementation is consistent
- Addressing forensic issues (e.g.: court or hospital mandates) that may arise if treatment is not completed by the patient (i.e. early discharge)
- Liaison work with the hospital and external agencies to adhere to model of DBT

Questions?

References

- Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. The Guilford Press: NY.

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