

What I need to know if I am considering setting up a DBT Programme in my service

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**on behalf of
The National Office for Suicide Prevention**

What is DBT?

DBT was initially formulated as a treatment for emotionally dysregulated and impulsive disorders such as Borderline Personality Disorder (BPD) and for patients that have suicidal and para-suicidal tendencies. It is a combination of cognitive based therapy enhanced with the addition of mindfulness practice and acceptance based philosophy and practice.

Standard DBT is delivered by a team of mental health professionals (psychiatrists, psychologists, social workers, occupational therapists, nurses etc). It is comprised of individual therapy sessions for each participant, group skills training sessions delivered by two clinicians, crisis phone support, and consultation meetings for the clinicians each week. Individual therapy focuses on motivation and commitment, and use of cognitive and behavioural skills to reduce self harm and other self destructive behaviours. The group skills sessions teach mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness skills. Telephone contact (phone coaching) is used to assist service users in actively using skills learned to manage crises more effectively and less destructively, thus reducing the need for repeated admissions or crisis attendance at outpatient clinics (Linehan, 1993a; 1993b). The phone-coaching contact hours agreement are agreed between each client and their DBT therapist prior to the client's starting the DBT intervention.

It has over time been conceptualised as a useful treatment for a wider range of difficult to treat clients with symptoms theoretically and functionally similar to BPD, such as substance abuse, eating disorders and ADHD. (Feigenbaum, 2007; Lynch & Cheavens, 2008; Brassington & Krawitz, 2006). DBT has been cited by both the American Psychiatric Association and the NHS National Institute of Clinical Excellence as an effective evidence based treatment for persons with BPD (American Psychiatric Association, 2001; NHS, 2009)

How can I and the service consider and prepare for the introduction of a DBT programme?

In establishing any new treatment, careful consideration needs to be given to the treatment environment, the service in which the treatment is going to be set up and run. We refer to this as 'organisational pre-treatment'. The successful implementation of DBT as a treatment approach takes individual and organisational effort (Swales & Heard, 2010, Swales, 2010a; 2010 b).

Am I the ‘treatment champion’ and do I believe DBT can lead to change in how we work?

Every new programme needs a ‘treatment champion’ (Swales, 2010a). This person is often a clinician who will be familiar with the research on the effectiveness of DBT in treating clients with chronic self harm and suicidal tendencies. The champion will need to take responsibility for co-ordinating the organisation in seeking to establish a different approach to working with this client population.

As well as presenting convincing arguments based on research outcomes, the champion will also need to be familiar with existing programmes running nationally and any outcome data they have gleaned from their experience that may relate to how their organisation operates. Reference will also need to be made to national mental health policy (A Vision for Change, 2006) and any other relevant documentation such as Reach Out (2005) and local and national service plan recommendations.

Swales (2010a) highlights a number of additional key features of the role:

- ✚ Taking responsibility for assessing the organisation’s goals and readiness to engage in training (see below)
- ✚ Must have skills necessary to lead a team and maintain the confidence of the organisation especially in the management of a high-risk client group
- ✚ Must elicit commitment from organisational members at all levels (senior management and community mental health team colleagues)
- ✚ Orienting the organisation to the DBT programme at all levels including making presentations outlining a description of the client group and the evidence base for DBT, the main aims and outcomes envisaged by introducing a DBT programme
- ✚ Be mindful of the immediate and ongoing resources required to implement the programme
- ✚ Must foster the commitment of the DBT team to provide treatment that is adherent to the evidence based model, offering all component modes of treatment, group skills training, individual therapy, team consultation, structuring the environment and phone coaching
- ✚ Must champion ongoing advancement in training and staff supervision to ensure effective practice

Preparing your service - Organisational Pre-Treatment

In early meetings with key stakeholders within the organisation such as area management teams, the role of the champion will be to establish the organisation’s goals regarding clients presenting with BPD (Swales, 2010b) .

Organisational Goals:

- ✚ Does the organisation have a role in providing psychotherapy to this client group as part of its remit? Do we treat clients with BPD?
- ✚ If treating complex BPD cases with chronic self harm and suicidality is part of the services remit, then the champion needs to explore how a dialectical behaviour therapy programme offers the service a more effective way to work with this client group.
- ✚ Have other treatment approaches been considered, and why is DBT the best fit for this organisation?
- ✚ Is the organisation looking for a systematic evidence based treatment for working with this population?
- ✚ Is the organisation aware of the high level of utilisation of this client group of existing services and the cost in terms of resources (outpatient attendances, emergency department attendances, admissions and average length of stay)?
- ✚ Is the organisation satisfied with the outcomes for these clients in terms of recovery using existing services (treatment as usual)?
- ✚ Are clients improving and is this evidenced by change in the degree of service utilisation?
- ✚ Is the organisation committed to providing a more cost effective treatment for this client group?

Organisational Readiness:

Having established that the service does have a goal in meeting this complex client group's needs, by introducing DBT, what considerations and commitments will it need to make to ensure successful training of the team and implementation and maintenance of the programme?

- ✚ Is there a management or advisory group representing key stake holders that can help keep the implementation of the DBT programme on track?
- ✚ What is the current culture of our organisation, how do people see their roles and does this fit with the role of a DBT therapist (are we aware of the principles which guide DBT and can we balance working with principles and competing existing service protocols)?

- ✚ Can the organisation facilitate a virtual team, seconded from their existing community mental health team roles coming together to develop, train in, implement and sustain a DBT service?
- ✚ Can a team form with a minimum of 4 staff, one of which must be a clinical psychologist and each member dedicating 1.5 days per week to running DBT? (team composition and qualifications will be vetted by the trainers in British Isles DBT before a team and its members will be able to train)
- ✚ Can team members who train commit to working on the programme for a minimum time period post training to ensure the programme is established and developed (e.g. a 2 year commitment). Will the organisation ensure this?
- ✚ Are team members willing to have 2 hours of team consultation and supervision each week (familiarity with the ethos and structures of this meeting will need to be considered and agreed by all team members) and will the organisation support this?
- ✚ Are there basic resources available to run the programme such as therapy rooms, group rooms, access to hardware such as computers, photocopiers etc?
- ✚ Have we given consideration to ongoing support of the programme, e.g. costs associated with further training, supervision and expert consultation to the team etc?

Team Member Readiness:

In maximizing the likely effectiveness of a new DBT team, the treatment champion and the organization will need to give careful consideration to the make up of the team and the individual characteristics that contribute to successful establishment and implementation. The following are some considerations for those considering team memberships or being asked to consider team membership (Swales, 2010a).

- ✚ Am I familiar with the principles which guide the practice of DBT and do I embrace these?
- ✚ Am I willing to learn and master all the skills components to be delivered and to apply these skills and strategies to my self?
- ✚ Am I willing to continue to develop competence and adherence to therapy model?
- ✚ Am I open to new learning, receiving feedback and supervision regarding my competence in the practice of DBT?
- ✚ Am I prepared to balance training with in-situ (guidance and discussion with my fellow team members) learning to contribute to the cohesiveness of the DBT team?

DBT is an effective evidence based treatment for persons with a diagnosis of BPD. Its effectiveness is based on the full implementation of the treatment as outlined in the research. There is a responsibility on those who champion DBT to ensure that they, the service and the team members are fully aware of the commitment they are undertaking when they choose to introduce a DBT programme. We hope that the information provided above will help those involved in making a fully informed choice about the costs and benefits of setting up a DBT team and service.

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