

Legislative Program Review and Investigations Committee

March 5, 2015

Domiciliary Care Overall:

Staffing: case managers, social workers, employment specialists, behavioral health staff.

Partner with staff from other state agencies, non-profits (DMHAS, DPH, HUD/VASH, DVR, DSS, DOL).

Behavioral health assessment, treatment planning from a Dialectical Behavior Therapy perspective could address mental health concerns and provide a framework to address concerns during length of stay.

Elimination of Veteran Worker and Detail Job program replaced by converting to state employee positions (for Veterans?), paid internships, apprentice positions (Compensated Work Therapy?).

Security concerning perimeter fencing, access to/from the facility, public transportation access.

Separation of Transitional Housing and Permanent Supportive Housing programs; private, semi-private rooms.

Transitional Housing Program:

Resident care fee replaces Program fee annually adjusted for inflation (raised/lowered?).

Permanent Supportive Housing Program:

Adjusted income based fee of 30% (adjusted annually or responsive to interim changes?).

Substance Use Treatment Services:

Partner with DMHAS for service evaluation, program design, staff continuing education; potential to utilize DMHAS data collection criteria and electronic reporting systems to coordinate State estimates of treatment beds/services, outcome measures.

Leadership:

Institutional (seeming) resistance to change relating to focus on overwhelming daily operations at the expense of longer-term planning and implementation. Support for staff to address their personal concerns during a process of change.

Performance Oversight and Monitoring:

Account for Veteran over/under estimation of their own abilities and goal potential, in relation to possibilities of Learned Helplessness from over-institutionalization in treatment planning process.

Assess computer literacy, training process, provision of infrastructure (computers, unfettered internet access) to explore and follow through on housing, jobs, education, healthcare.

Current Rocky Hill VA computer system presents as based upon Windows XP, no longer supported by Microsoft. Consider expense of upgrading OS, computer hardware, networking infrastructure, any Rocky Hill proprietary software; for both State and Veteran access.

Dialectical Behavior Therapy:

See attached.

Lessons from the Community Mental Health initiatives of the 1960's:

Dialectical Behavior Therapy in a Nutshell

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INTRODUCTION

Dialectical behavior therapy (DBT) is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders (Linehan, 1993a,b). Originally developed for chronically suicidal individuals, DBT has evolved into a treatment for multi-disordered individuals with borderline personality disorder (BPD). DBT has since been adapted for other seemingly intractable behavioral disorders involving emotion dysregulation, including substance dependence in individuals with BPD (Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999; Dimeff, Rizvi, Brown, & Linehan, 2000), binge eating (Telch, Agras, & Linehan, in press), depressed, suicidal adolescents (Miller, 1999; Rathus & Miller, 2000), depressed elderly (Lynch, 2000), and to a variety of settings, including inpatient and partial hospitalization, forensic settings (Swenson, Sanderson, Dulit, & Linehan, in press; McCann & Ball, 1996; McCann, Ball, & Ivanoff, under review).

DBT is based on a combined capability deficit and motivational model of BPD which states that (1) people with BPD lack important interpersonal, self-regulation (including emotional regulation) and distress tolerance skills, and (2) personal and environmental factors often both block and/or inhibit the use of behavioral skills that clients do have, and reinforce dysfunctional behaviors. DBT combines the basic strategies of behavior therapy with eastern mindfulness practices, residing within an overarching dialectical worldview that emphasizes the synthesis of opposites. The term dialectical is also meant to convey both the multiple tensions that co-occur in therapy with suicidal clients with BPD as well as the emphasis in DBT of enhancing dialectical thinking patterns to replace rigid, dichotomous thinking. The fundamental dialectic in DBT is between validation and acceptance of the client as they are within the context of simultaneously helping them change. Acceptance procedures in DBT include mindfulness (e.g., attention to the present moment, assuming a non-judgmental stance, focusing on effectiveness) and a variety of validation and acceptance-based stylistic strategies. Change strategies in DBT include behavioral analysis of maladaptive behaviors and problem-solving techniques, including skills training, contingency management (i.e., reinforcers, punishment), cognitive modification, and exposure-based strategies.

As a comprehensive treatment, DBT serves the following five functions: 1) enhances behavioral capabilities, 2) improves motivation to change (by modifying inhibitions and reinforcement contingencies), 3) assures that new capabilities generalize to the natural environment, 4) structures the treatment environment in the ways

essential to support client and therapist capabilities, and 5) enhances therapist capabilities and motivation to treat clients effectively. In standard DBT, these functions are divided among modes of service delivery, including individual psychotherapy, group skills training, phone consultation, and therapist consultation team.

ORIGINS OF DBT

DBT grew out of a series of failed attempts to apply the standard cognitive and behavior therapy protocols of the late 1970's to chronically suicidal clients. These difficulties included:

1. focusing on change procedures was frequently experienced as invalidating by the client and often precipitated withdrawal from therapy, attacks on the therapist, or vacillations between these two poles;
2. teaching and strengthening new skills was extraordinarily difficult to do within the context of an individual therapy session while concurrently targeting and treating the client's motivation to die and suicidal behaviors that had occurred during the previous week;
3. individuals with BPD often unwittingly reinforced the therapist for iatrogenic treatment (e.g., a client stops attacking the therapist when the therapist changes the topic from one the client is afraid to discuss to a pleasant or neutral topic) and punished them for effective treatment strategies (e.g., a client attempts suicide when the therapist refuses to recommend hospitalization stays that reinforce suicide threats).

To overcome these difficulties, several modifications were made that formed the basis of DBT. First, strategies that reflect radical acceptance and validation of clients' current capabilities and behavioral functioning were added to the treatment. The synthesis of acceptance and change within the treatment as a whole and within each treatment interaction led to adding the term "dialectical" to the name of the treatment. This dialectical emphasis brings together in DBT the "technologies of change" based on both principles of learning and crises theory and the "technologies of acceptance" (so to speak) drawn from principles of eastern Zen and western contemplative practices. Second, the therapy as a whole was split into several different components, each focusing on a specific aspect of treatment. The components in standard outpatient DBT are highly structured individual or group skills training (to enhance capability), individual psychotherapy (addressing motivation and skills strengthening), and telephone

contact with the individual therapist (addressing application of coping skills). Third, a consultation/team meeting focused specifically on keeping therapists motivated and providing effective treatment was also added.

BEHAVIORAL TARGETS AND STAGES OF TREATMENT IN DBT

DBT is designed to treat clients at all levels of severity and complexity of disorders and is conceptualized as occurring in stages. In Stage 1, the primary focus is on stabilizing the client and achieving behavioral control. Behavioral targets in this initial stage of treatment include: decreasing life-threatening, suicidal behaviors (e.g., parasuicide acts, including suicide attempts, high risk suicidal ideation, plans and threats), decreasing therapy-interfering behaviors (e.g., missing or coming late to session, phoning at unreasonable hours, not returning phone calls), decreasing quality-of-life interfering behaviors (e.g., reducing behavioral patterns serious enough to substantially interfere with any chance of a reasonable quality of life (e.g., depression, substance dependence, homelessness, chronically unemployed), and increasing behavioral skills (e.g., skills in emotion regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self-management). In the subsequent stages, the treatment goals are to replace "quiet desperation" with non-traumatic emotional experiencing [Stage 2], to achieve "ordinary" happiness and unhappiness and reduce ongoing disorders and problems in living [Stage 3], and to resolve a sense of incompleteness and achieve joy [Stage 4]. In sum, the orientation of the treatment is to first get action under control, then to help the client to feel better, to resolve problems in living and residual disorders, and to find joy and, for some, a sense of transcendence. The overwhelming majority of data to date on DBT has focused on the severely and multi-disordered client who enters treatment at Stage 1.

MOVEMENT, SPEED, AND FLOW

DBT requires that the therapist balance use of acceptance and change strategies within each treatment interaction, from the rapid juxtaposition of change and acceptance techniques to the therapist's use of both irreverent and warmly responsive communication styles. This dance between change and acceptance are required to maintain forward movement in the face of a client who at various moments oscillates between suicidal crises, withdrawal and dissociative responses, rigid refusal to collaborate, attack, rapid emotional escalation and a full collaborative effort. In order to movement, speed, and flow, the DBT therapist must be able to inhibit judgmental attitudes and practice radical acceptance of the client in each moment while keeping an eye on the ultimate goal of the treatment: to move the client from a life in hell to a life worth living as quickly and efficiently as possible. The therapist must also strike a balance between unwavering

centeredness (i.e., believing in oneself, the client, and the treatment) and with compassionate flexibility (i.e., the ability to take in relevant information about the client and modify one's position accordingly, including the ability to admit to and repair one's inevitable mistakes), and a nurturing style (i.e., teaching, coaching, and assisting the client) with a benevolently demanding approach (i.e., dragging out new behaviors from the client, recognizing the client's existing capabilities and capacity to change, having clients "do for themselves" rather than "doing for them.")

RESEARCH IN DBT

The first DBT randomized clinical trial compared DBT to a treatment-as-usual (TAU) control condition (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994). DBT subjects were significantly less likely to parasuicide during the treatment year, reported fewer parasuicide episodes at each assessment point, and had less medically severe parasuicides over the year. DBT was more effective than TAU at limiting treatment drop-out, the most serious therapy-interfering behavior. DBT subjects tended to enter psychiatric units less often, had fewer inpatient psychiatric days per client, and improved more on scores of global as well as social adjustment. DBT subjects showed significantly more improvement in reducing anger than did TAU subjects. DBT superiority was largely maintained during the one-year post-treatment follow-up period. Since then, two RCTs have been conducted evaluating DBT as compared to TAU and one study has been conducted comparing DBT to an ongoing parallel treatment with matched controls. In general, results have largely replicated the initial RCT. Koons and her associates found that BPD women in the VA system assigned to DBT had greater reductions in parasuicide acts and in depression scores than those assigned to TAU and those assigned to DBT (but not to TAU) also had significant improvements in suicide ideation, hopelessness, anger, hostility, and dissociation (Koons, Robins, Tweed, Lynch, Gonzalez, Morse, Bishop, Butterfield, & Bastian, in press). In our recent application of DBT to substance dependent individuals with BPD, DBT subjects had greater reductions in illicit substance use (measured by both structured interview and urinalyses) both during treatment and at follow-up and greater improvements in global functioning and social adjustment at follow-up (Linehan, et al., 1999).

REFERENCES

- Dimeff, L.A., Rizvi, S.L., & Brown M., & Linehan, M.M. (2000). Treating women with methamphetamine and BPD. *Cognitive and Behavioral Practice*, 7, 457-468.
- Koons, C.R., Robins, C.J., Tweed, J.L., Lynch, T.R., Gonzalez, A.M, G.K., Morse, J.Q., Bishop, G.K.,

Butterfield, M.I., & Bastian, L.A. (in press). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy*.

Linehan, M.M. (1993a). Cognitive behavioral therapy of borderline personality disorder. New York: Guilford Press.

Linehan, M.M. (1993b). Skills Training Manual for Treating Borderline Personality Disorder. New York: Guilford Press.

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., & Heard, H.L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *48*, 1060-1064.

Linehan, M.M., Heard, H.L., & Armstrong, H.E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *50*, 971-974.

Linehan, M.M., Tutek, D.A., & Heard, H.L., Armstrong HE. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry*, *151*, 1771-1776.

Linehan, M.M., Schmidt, H., Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug dependence. *American Journal on Addictions*, *8*, 279-292.

Lynch, T. R. (in press). Treatment of elderly depression with personality disorder comorbidity using dialectical behavior therapy. *Cognitive and Behavioral Practice*.

McCann, R., & Ball, E.M. (1996, November). Using dialectical behavior therapy with an inpatient forensic population. Workshop presented at the 1st annual meeting of the International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISITDBT), New York, NY.

McCann, R., Ball, E.M., & Ivanoff, A. (in review). The effectiveness of dialectical behavior therapy in reducing burnout among forensic staff.

Miller, A.L. (1999). DBT-A: A new treatment for parasuicidal adolescents. *American Journal of Psychotherapy*, *53*, 413-417.

Rathus, J.H & Miller, A.L.. (Under review). Dialectical behavior therapy adapted for suicidal adolescents: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*.

Swenson C, Sanderson C, Dulit, R., Linehan, M. (in press). Applying Dialectical Behavior Therapy on Inpatient Units. *Psychiatric Quarterly*.

Telch, C.F., Agras, W.S., & Linehan, M.M. (in press). Group dialectical behavior therapy for binge eating disorder: A preliminary uncontrolled trial. *Journal of Consulting and Clinical Psychology*.