

GETTING DBT...AND GETTING DBT INTO THE REAL WORLD

NEA-BPD SUNDAY EVENING
CALL-IN SERIES

October 23, 2011 and February 26, 2012

Charles R. Swenson, M.D.

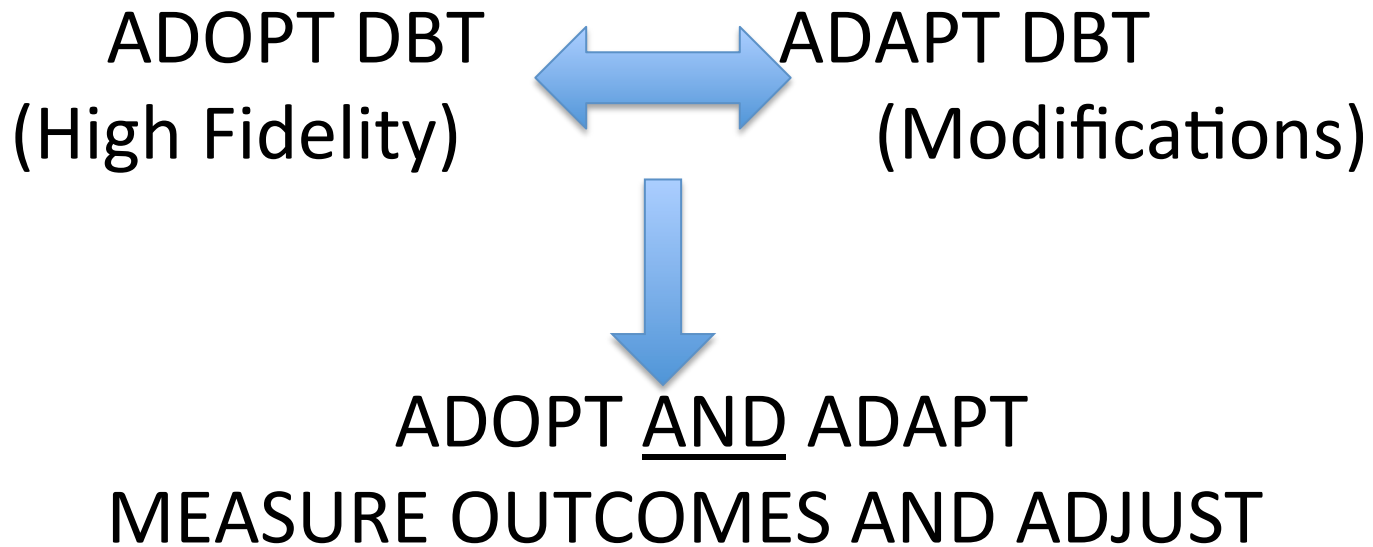
DBT PROGRAM IMPLEMENTATION ...

- IS A PROCESS, NOT AN EVENT (R.WOLBERT).
- IS THE STEP BETWEEN “ADOPTING” A DBT PLAN, AND PRACTICING AND IMPROVING IT
- IS A SAGA AND A WAR
 - THE TERRITORY IS NEVER FULLY SECURED.
- REQUIRES VISION, PASSION, STRATEGY, AND CREATIVITY.
- IS BURDENED AND FACILITATED BY THE FACT THAT DBT IS AN EVIDENCE-BASED PRACTICE.

SUCCESSFUL IMPLEMENTATION REQUIRES “GETTING DBT”

- AS MUCH AS POSSIBLE, THE IMPLEMENTATION TEAM WORKS TO PRESERVE ALL STANDARD DBT ELEMENTS “AS THEY ARE”
- COMMONLY, DUE TO THE CONTEXT, ONE NEEDS TO MAKE MODIFICATIONS OF STANDARD DBT DURING IMPLEMENTATION
- IN ORDER TO MODIFY DETAILS OF STANDARD DBT AS LITTLE AS POSSIBLE, KEEPING TO THE PRINCIPLES, ONE NEEDS TO GRASP DBT

THE PRIMARY DIALECTIC IN IMPLEMENTATION OF DBT



THE BIG PICTURE

- ELEMENTS AND STEPS OF IMPLEMENTATION CAN BE SEEN AS A TREE
 - THE CLIMATE, SURROUNDING VEGETATION, AND SOIL REPRESENT THE “PRE-DBT” CONTEXT OF THE PROGRAM
 - TREE ROOTS REPRESENT DEEP VALUES, PHILOSOPHY, AND PRINCIPLES THAT “DRIVE” IMPLEMENTATION
 - THE TRUNK REPRESENTS THE PURSUIT OF A LIFE WORTH LIVING (THE WHOLE POINT), AND THE BIO-SOCIAL THEORY
 - IDEALLY, PROGRAM LEADERSHIP TENDS TO THE ROOTS AND CONTEXT, EMBRACES THE PURPOSE AND THEORY, AND DEVELOPS THE PROGRAM VIA THE FIVE PRIMARY BRANCHES

THE FIVE PRIMARY BRANCHES OF THE DBT TREE

1. **GOALS, STAGES AND TARGETS** BRING THE “LIFE WORTH LIVING” INTO CONCRETE AND INDIVIDUALIZED FORM
2. **FUNCTIONS AND MODES** DEFINE THE WAY IN WHICH THE TREATMENT IS STRUCTURED
3. **ASSUMPTIONS** SPELL OUT THE ASSUMPTIONS ABOUT PATIENTS AND THERAPY THAT GUIDE THE TREATMENT
4. **AGREEMENTS** SPECIFY THOSE THINGS THAT CONSULTATION TEAMS, PATIENTS, AND THERAPISTS SIGN ONTO, MAKING FOR A COLLABORATIVE FRAMEWORK
5. **STRATEGIES** CONSISTING OF THREE CORE GROUPS, ARE THE INTERVENTIONS USED TO ACCOMPLISH THE TARGETS AND GET A LIFE WORTH LIVING

LEADERSHIP

- EFFECTIVE LEADERSHIP IS CRITICAL FOR SUCCESSFUL DBT IMPLEMENTATION. ONE CAN DIVIDE THE FEATURES OF LEADERSHIP INTO FOUR FUNCTIONS, WHICH IN MEDIUM TO LARGE ORGANIZATIONS CAN BE SEEN AS FOUR “LEVELS” OF LEADERSHIP. PROBLEMS AT ANY ONE LEVEL CAN COMPROMISE DBT IMPLEMENTATION
 - EXECUTIVE LEADERSHIP
 - CLINICAL LEADERSHIP
 - DBT PROGRAM LEADERSHIP
 - OPINION LEADERSHIP

EXECUTIVE LEADERSHIP

- EXECUTIVE LEADERSHIP (E.G., EXECUTIVE DIRECTOR)
 - ATTENDS TO THE ENVIRONMENT EXTERNAL TO THE CLINICAL CONTEXT IN WHICH DBT IS IMPLEMENTED
 - PROMOTES AND DEFENDS THE DBT PROGRAM IN THE EXTL. ENVIRONMENT
 - PROCURES AND MAINTAIN RESOURCE STREAMS FOR PROGRAM
 - CULTIVATES SUPPORT WITH INSURANCE, MANAGED CARE, PUBLIC MENTAL HEALTH AUTHORITIES, ADVOCACY GROUPS, BOARD OF DIRECTORS, OTHER STAKEHOLDERS
 - INSISTS ON MEASURABLE PROGRAMMATIC OUTCOMES
 - MAINTAINS A LONG TERM PERSPECTIVE
 - NEGOTIATES CONFLICTS BETWEEN DBT AND OTHER ORGANIZATIONAL PRIORITIES
 - CULTIVATES SUPPORT WITH INSURANCE, MANAGED CARE, PUBLIC MENTAL HEALTH AUTHORITIES, ADVOCACY GROUPS

CLINICAL LEADERSHIP

- CLINICAL LEADERSHIP (E.G., CLINICAL DIRECTOR)
 - ATTENDS TO THE CLINICAL ENVIRONMENT WITHIN THE ORGANIZATION IN WHICH DBT IS IMPLEMENTED
 - PROMOTES AND DEFENDS DBT WITHIN THAT ENVIRONMENT
 - ALLOCATES AND MAINTAINS RESOURCES FOR DBT PROGRAM
 - NEGOTIATES BOUNDARY CONFLICTS BETWEEN DBT PROGRAM AND OTHER CLINICAL PROGRAMS IN THAT CLINICAL ENVIRONMENT
 - MAINTAINS GOOD COMMUNICATION WITH EXECUTIVE LEADERSHIP
 - OVERSEES START-UP, TRAINING, OUTSIDE CONSULTATION
 - INSISTS ON RELEVANT OUTCOMES, FIDELITY, ADHERENCE
 - EFFECTIVELY MAKES CONNECTIONS BETWEEN DBT PROGRAM AND OTHER CLINICAL PROGRAMS (E.G., CBT TREATMENTS)
 - DESIGNATES A SPECIFIC DBT LEADER

DBT PROGRAM LEADERSHIP

- DBT LEADERSHIP (E.G., DBT PROGRAM DIRECTOR) ATTENDS SPECIFICALLY TO THE DBT PROGRAM
 - DEFINES DBT PROGRAM GOALS AND ORGANIZES CLINICAL RESOURCES TO PURSUE THOSE GOALS
 - SECURES RESOURCES NECESSARY TO MEET DBT PROGRAM GOALS
 - ADVOCATES FOR DBT PROGRAM, AMONG OTHER CLINICAL PROGRAMS, IN THE CLINICAL ORGANIZATIONAL ENVIRONMENT
 - INSISTS ON MEASURING CLINICAL OUTCOMES
 - DEFINES NEEDS FOR START-UP, TRAINING, MAINTENANCE
 - WORKS TOWARD PROGRAM FIDELITY, CLINICAL ADHERENCE
- THE DBT LEADER WORKS CLOSELY WITH CLINICAL LEADERSHIP, BUT IS ALSO SEPARATE
- THE DBT LEADER WORKS WITH A DBT PROGRAM IMPLEMENTATION TEAM

OPINION LEADERSHIP

- OPINION LEADERS ARE STAFF MEMBERS WITHIN THE CLINICAL ENVIRONMENT WHERE DBT IS BEING IMPLEMENTED
- OPINION LEADERS INFLUENCE THEIR PEERS TO A DEGREE THAT IS GREATER THAN THEIR FORMAL AUTHORITY
- OPINION LEADERS CAN MAKE OR BREAK A HIGH QUALITY DBT IMPLEMENTATION
- DBT LEADERSHIP IS WISE TO IDENTIFY THE OPINION LEADERS AND GAIN THEIR SUPPORT FOR DBT IMPLEMENTATION
 - AT TIMES THIS MEANS TO CHERISH THE OPPOSITION

LEADERSHIP VARIATIONS

- IN A MODERATE TO LARGE CLINICAL ORGANIZATION (E.G., HOSPITAL, CMHC), THE FOUR LEVELS MAY EACH BE REPRESENTED BY A ROLE AND A PERSON
 - EXECUTIVE DIRECTOR, CLINICAL DIRECTOR, DBT DIRECTOR, CLINICAL DIRECTOR
- IN A SMALLER ORGANIZATION, THE LEADERSHIP FUNCTIONS/LEVELS MAY BE COLLAPSED INTO A SMALLER NUMBER OF ROLES
 - E.G., IN A GROUP PRACTICE, ONE INDIVIDUAL MIGHT BE THE EXECUTIVE DIRECTOR, CLINICAL DIRECTOR, AND THE DBT DIRECTOR
 - E.G., IN A DBT-BASED PARTIAL HOSPITAL PROGRAM OR ASSERTIVE COMMUNITY TREATMENT TEAM, ONE PERSON MIGHT BE THE CLINICAL DIRECTOR AND THE DBT DIRECTOR
- IN ANY CASE, IT IS IMPORTANT THAT ALL FOUR FUNCTIONS/LEVELS BE REPRESENTED IN LEADERSHIP. FAILURE OF ANY OF THE FUNCTIONS CAN RESULT IN FAILURE OR COMPROMISE

PRE-DBT CONTEXT (CLIMATE, VEGETATION, AND SOIL)

- LEADERSHIP ASKS:
 - ARE WE ABLE TO GROW AND MAINTAIN A DBT PROGRAM IN THIS CONTEXT?
 - DO WE HAVE ROOM FOR ANOTHER TREATMENT MODEL?
 - IS OUR CONTEXT PHILOSOPHICALLY COMPATIBLE WITH DBT?
 - OUTCOMES-ORIENTATION, CBT, MINDFULNESS, DIALECTICAL THINKING
 - WILL DBT BE SEEN AS A VALUABLE ADDITION BY OUR MOST IMPORTANT STAKEHOLDERS?
 - IF THE ANSWER TO ANY OF THESE IS “NO”, CAN WE ADDRESS THE CONTEXTUAL PROBLEMS THROUGH PRE-IMPLEMENTATION STRATEGIES?
 - CAN WE MAKE ROOM FOR A DBT PROGRAM?
 - CAN WE “FERTILIZE” THE SOIL WITH NECESSARY INGREDIENTS TO SUPPORT AND SUSTAIN THE ROOTS OF A DBT PROGRAM?
 - CAN WE ORIENT OUR PRIMARY STAKEHOLDERS AND GET BUY-IN?

WHAT CHANGES AND WHAT STAYS THE SAME

- NOTICE THAT WHEN THERE IS A “NON-STANDARD” DBT PROGRAM, MODIFIED DUE TO POPULATION OR CONTEXT...
- THE PARTS OF DBT REPRESENTED BY THE ROOTS, THE TRUNK, AND THE LARGE BASIC BRANCHES REMAIN THE SAME
- AND THE PARTS OF DBT REPRESENTED BY THE FINER BRANCHS, FURTHER OUT, UNDERGO SOME MODIFICATION...

BRANCH #1: GOALS AND STAGES

- “A LIFE WORTH LIVING” IS PURSUED SEQUENTIALLY IN GOALS
- IN PRE-TREATMENT, THE THERAPIST AND PATIENT WORK TOWARD A STRONGER COMMITMENT TO THE TREATMENT PLAN
- FOLLOWING PRE-TREATMENT, TREATMENT PROCEEDS IN STAGES
 - STAGE I: TO ESTABLISH BEHAVIORAL CONTROL AND THE USE OF SKILLS
 - STAGE II: TO REDUCE SUFFERING, INCREASE EMOT. EXPERIENCING
 - STAGE III: TO WORK ON INDIVIDUAL GOALS AND SELF-RESPECT
 - STAGE IV: TO WORK TOWARDS GREATER MEANING AND JOY

BRANCH #1: TARGETS ARE SPECIFIED FOR EACH MAJOR GOAL (& STAGE)

- FOR INSTANCE, STAGE I TARGETS ARE LAID OUT IN ORDER OF PRIORITY
 - 1. REDUCE LIFE-THREATENING BEHAVIORS
 - 2. REDUCE THERAPY-INTERFERING BEHAVIORS
 - 3. REDUCE QUALITY-OF-LIFE INTERFERING BEHAVIORS
 - 4. INCREASE THE USE OF DBT SKILLS (INSTEAD OF THE USE OF PROBLEMATIC BEHAVIORS)
- IN ADAPTATIONS OF DBT, THE GOALS AND STAGES TYPICALLY REMAIN, BUT TARGETS (THE FINER BRANCHES) ARE CHANGED

BRANCH #1: DIFFERENT POPULATIONS OR CONTEXTS MAY NEED DIF.

TARGETS

- ONE NEEDS TO MODIFY THE TARGETS (AS LITTLE AS POSSIBLE)
- E.G., FOR ADAPTING DBT TO SUBSTANCE USE DISORDERS, SEVERAL SUBSTANCE ABUSE-SPECIFIC TARGETS WERE ADDED TO THE QUALITY-OF-LIFE INTERFERING BEHAVIORS
- E.G., FOR ADAPTING DBT TO ACUTE INPATIENT, GOALS AND TARGETS WERE RE-WORKED
 - GETTING IN, GETTING IN CONTROL, GETTING OUT
 - SPECIFIC TARGETS FOR EACH OF THESE GOALS/
STAGES

BRANCH #2: FUNCTIONS AND MODES

- COMPREHENSIVE DBT ACCOMPLISHES FIVE FUNCTIONS
 - 1. ENHANCE CAPABILITIES
 - 2. IMPROVE MOTIVATION
 - 3. GENERALIZE CAPABILITIES TO RELEVANT ENVIRONMENTS
 - 4. STRUCTURE THE ENVIRONMENT (OF LIFE AND TREATMENT)
 - 5. ENHANCE CAPABILITIES AND IMPROVE MOTIVATION OF THERAPISTS AND STAFF
- SOME PROGRAMS IMPLEMENT A SELECTIVE APPLICATION OF DBT, ORGANIZED AROUND CERTAIN FUNCTIONS AND NOT OTHERS
 - E.G., A SKILLS TRAINING PROGRAM GROUP PLUS COACHING

BRANCH # 2: EACH FUNCTION IS CARRIED OUT THROUGH MODES

- IN STANDARD DBT, THE MODES ARE: SKILLS GROUP, INDIVIDUAL THERAPY, PHONE COACHING, DBT PROGRAM LEADERSHIP, CONSULTATION TEAM FOR THERAPISTS
- IN ADAPTATIONS OF STANDARD DBT, THE SAME FUNCTIONS MIGHT REQUIRE NEW OR MODIFIED MODES
- DBT FOR COGNITIVE DEFICITS MAY MODIFY THE SKILLS TRAINING MODE AND CURRICULUM TO REDUCE “COGNITIVE LOAD”
- DBT FOR ADOLESCENTS AND FAMILIES MODIFIES THE SKILLS TRAINING MODE TO INCLUDE FAMILIES
- DBT FOR INPATIENT ADDS A “COMMUNITY MEETING” MODE, AND POSSIBLY A GOALS GROUP

BRANCH #3: ASSUMPTIONS

- DBT'S ASSUMPTIONS ABOUT PATIENTS BALANCE ASSUMPTIONS BASED ON ACCEPTANCE VERSUS ASSUMPTIONS BASED ON NEED FOR CHANGE
 - (ACCEPTANCE) PATIENTS ARE DOING THE BEST THEY CAN, THEY WANT TO IMPROVE, AND THEIR LIVES ARE HELL AS THEY ARE CURRENTLY BEING LIVED
 - (CHANGE) PATIENTS NEED TO DO BETTER, TRY HARDER
 - (ACCEPTANCE AND CHANGE) EVEN TOUGH IT MAY BE TRUE THAT THE CURRENT PROBLEMS WERE (AT LEAST IN PART) CAUSED BY OTHER PEOPLE, THE PATIENT IS THE ONE WHO HAS TO SOLVE THEM

BRANCH #4: AGREEMENTS

- STANDARD DBT HAS AGREEMENTS FOR THE OVERALL TREATMENT, AND AGREEMENTS FOR EACH MODE
- REVIEWING AND AGREEING ON AGREEMENTS CREATES A WORKING COLLABORATIVE FRAMEWORK AND CLEAR EXPECTATIONS
- TYPICAL AGREEMENTS FOR PATIENTS INCLUDE:
 - ATTENDANCE AGREEMENT, AGREEMENT TO TARGET CERTAIN BEHAVIORS (E.G., LIFE-THREATENING), AGREEMENT TO LEARN SKILLS
- TYPICAL AGREEMENTS FOR THERAPISTS INCLUDE:
 - AGREEMENT TO SEEK CONSULTATION AS NEEDED, MAINTAIN CONFIDENTIALITY, AND DELIVER COMPETENT THERAPY

BRANCH #4: STANDARD AGREEMENTS MAY NEED MODIFICATION...

- WITH A DIFFERENT POPULATION OR CONTEXT
 - E.G., FAMILY SKILLS TRAINING
 - E.G., CRIME GROUP (IN FORENSIC SETTING)
 - E.G., URINE DRUG SCREENING (DBT WITH SUDs)
- WHEN A MODE IS MODIFIED OR ADDED
 - E.G., COMMUNITY MEETING MODE IN INPATIENT

BRANCH #5: STRATEGIES

- NOTE THAT THERE ARE THREE SETS OF “CORE STRATEGIES”, AND THEY PARALLEL THE THREE FOUNDATIONAL PARADIGMS FOUND IN THE ROOTS OF THE TREE
 - MINDFULNESS ROOTS → VALIDATION STRATEGIES
 - BEHAVIORISM ROOTS → PROB.-SOLVING STRATS.
 - DIALECTICAL ROOTS → DIALECTICAL STRATEGIES
- STRATEGIES ARE ADDED OR MODIFIED WITH DIFFERENT POPULATIONS AND CONTEXTS
 - E.G., ATTACHMENT STRATEGIES IN DBT FOR SUDs
 - E.G., NEW SKILLS ADDED FOR DBT FOR SUDs

THE IDEAL IMPLEMENTATION

- WHEN THERE IS GOOD ALIGNMENT
 - OVERALL PROGRAM WITH EXTERNAL CONTEXT
 - CONTEXT WITH ROOTS
 - ROOTS WITH PURPOSE (LIFE WORTH LIVING)
 - PURPOSE WITH GOALS
 - GOALS WITH TARGETS
 - GOALS AND TARGETS WITH FUNCTIONS AND MODES
 - AGREEMENTS/ASSUMPTIONS W/ GOALS, TARGETS
 - STRATEGIES WITH OVERALL PROGRAM
 - OVERALL PROGRAM WITH EXTERNAL CONTEXT
- AND FUNCTIONAL LEADERSHIP,
- IMPLEMENTERS CAN, STEP BY STEP, DEVELOP A PROGRAM
- **VALIDATED FINALLY BY SUCCESSFUL OUTCOMES**