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Towards Triage in DBT: The psychometric profile of female BPD patients referred for DBT treatment in a low secure service

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Outline of Service

- 4 DBT trained staff (Nursing, Psychology)
- Standard 12 month DBT Programme, adapted for inpatients.
- Provider for NHS England / NHS Wales

Current Context

- We know that psychological interventions for 'BPD' are efficacious.
- Development of different models over last 15-20 years all addressing the same issue in different ways:
  - DBT (Linehan.
  - MBT (Bateman and Fonagy
  - SFCT (Young, XXXX, Arntz XXXX
  - TFP

Current Context

- Lana and Fernandez San-Martin (2013)
  - "To what extent are specific psychotherapies for borderline personality disorder efficacious? A systematic review of published randomised controlled trials"
  - 11 outcome studies included out of 211 papers once screening criteria have been met.

- 6 studies evaluated dialectical behaviour therapy (DBT)
- 1 study evaluated cognitive behaviour therapy (CBT)
- 2 studies evaluated mentalisation based treatment (MBT)
- 1 study evaluated schema focused therapy (SFT) 3 studies evaluated transference focused psychotherapy (TFP) -

Conclusions

- High variability in outcome data across the same treatment modalities e.g. suicide attempts (7.4%-33.9%), non-completions (6.7%-47.4%) and treatment refusers (17.6%-63.6%)
- Data does not suggest that Treatments for BPD are not effective but :
- Recommendation of need for process to predict who may find it hard to engage / complete
- Recommendation to "continue to develop interventions for treatment refractory patients"

Political / Financial

- Increasing demand for MH services in UK
- Increasing hospital admissions
- Increasing use of MHA
- Cost pressures and skill mix of mental health workforce
- Service User advocacy and call for treatment choice.
- ‘PD’ Treatments expensive and time intensive

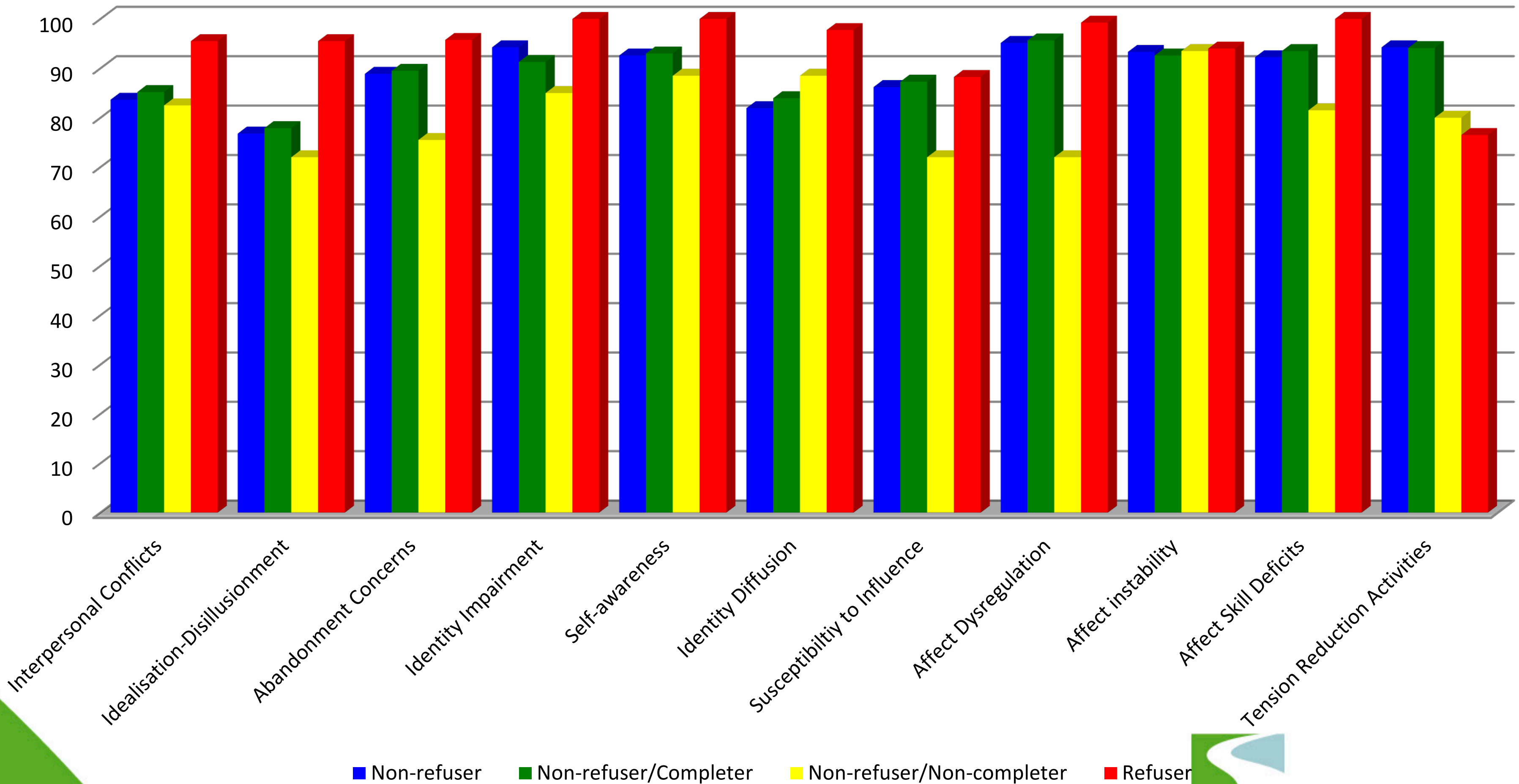
Current Data

- Routine outcome data in Low Secure DBT programme:
  - IASC
  - MCMI-III
  - Behavioural Data (DSH, Violence)
- Not an outcome study – looked at measures taken pre-intervention for those referred for DBT.
- Looked at characteristics of engagement in different groups.

Data

- Total N = 32
- Classified as:
  - Refusers (4)
  - Engagers– Further split into
    - Completers (20)
    - Non-Completers (2)
- Percentages refusers = 12.5%
- Percentage completers = 62.5%
- Percentage non-completers = 6.25%

Data



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Refuser vs Non-refuser	
Scales	Sig. (Two tailed)
Identity_Impairment	0.002**
Self-Awareness	0.004**
Identity Diffusion	0.004**
Affect Skill Deficits	0.002**
Interpersonal_conflicts	0.016*
Idealisation Disillusionment	0.05*

Non-refuser/Completer vs Refuser	
Scales	Sig. (Two tailed)
Identity_Impairment	0.003**
Self-Awareness	0.008**
Identity Diffusion	0.007**
Affect Skill Deficits	0.001***
Interpersonal_conflicts	0.02*

Discussion

- Those who refuse DBT and who drop out of DBT tend to score higher on IASC dimensional subscale scores.
- Refusers have higher scores on all IASC dimensions than drop outs.
- Refusers tend to score lower on 'Tension Reduction Activities' than both engagers and people who drop out.

Discussion

- The more severe the problem, the more likely that people will not engage with treatment.
- People with pre-existing low use of regulation skills are more likely to both drop out and refuse.
- Is there a threshold for current skill use that may predict poor outcome?
- This finding is intuitive but we don't really know why this is in 'BPD'.

- Consistent with Lana and Fernandez-San Martin.

Unanswered Questions

- Is there a need for more tailored intervention for people identified as 'BPD' with 'ultra high severity?" or 'ultra low existing self care skill?'
- What would a structured psychological programme look like for people with this level of distress? (e.g. SCM? (Bateman and Fonagy)
- Could we develop a screening tool that would reliably predict engagement and completion?
- Could it signpost to the right type of treatment?

Why This is Important

- IAPT PD and SMI evaluations ongoing and will aim to develop multimodal treatment options : commissioning needs the data.
- Cost effectiveness and prudent healthcare – how do we avoid wasting resources on treatment unlikely to be effective? When should we stop offering? What is the alternative for those who don’t / won’t / can’t engage in any effective treatment?

Why This is Important

- Are we focused sufficiently on the setting conditions required for engagement and improvement?
  - Recovery Culture (Hope, Possibility of Change)
  - Service User Involvement
  - Staff supervision
  - “Emotional valence” of psychiatric settings (partic. secure?)
  - Trauma informed services
- Ethics – iatrogenesis : an increased focus in psychological treatment – do drop outs get worse than if they had no treatment at all?

Limitations

- Low N for refusers / non completers
- Compromised power due to group disparities although tests for inequality of variance were met.
- Standard outcome measure – not set up as research.

Future Work

- Need for Central database of PD Psychotherapy engagement data in all tiers of healthcare?:
  - IAPT
  - Secondary
  - Tertiary / Secure
- Need for routine collection of quantitative data on outcomes for both drop outs and refusers

Future Work

- Need for routine collection of differential recovery rates for people who move between treatment modalities
- Need for routine collection of qualitative data re:
  - Why a treatment was perceived as helpful (not necessarily same for Service User as Service!)
  - Why a treatment refused / dropped out of.

Challenges

- Sharing clinical data across sectors / organisations / nations.
- Resource to analyse routine outcomes is not prioritised over clinical resource.
- Meaningful Service User involvement in decisions about treatment.
- Ethics re: clinicians' state of knowledge re: what will work for whom.