

JAIL-BASED DIALECTICAL BEHAVIOR THERAPY PROGRAM FOR INMATES AT RISK FOR SELF-HARM AND SUICIDE

by

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Second Annual Academic and Health Policy Conference
on Correctional Health
Quincy, MA

March 27, 2008



A DBT PROGRAM IN JAIL ?

WHO ?

Who are we? Who are they? Who are all stakeholders?

WHAT ?

What does the jail program entail?

WHERE ?

Jail's Crisis Intervention Unit (CIU)

WHEN ?

Step by step program planning timeline

WHY ?

Why DBT? Why continue or terminate DBT?

Objectives

Participants will:

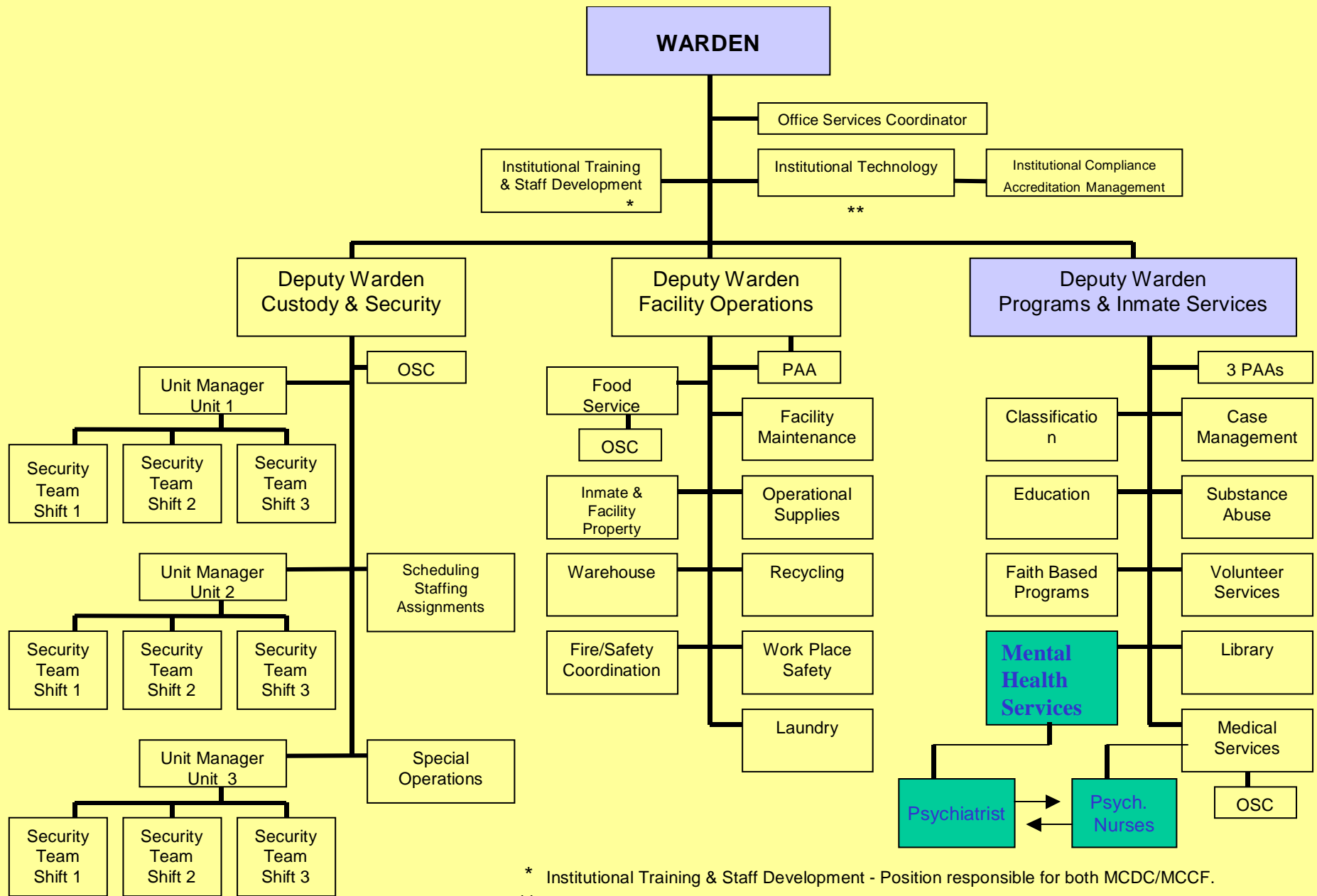
- learn why DBT replaced CBT as primary therapeutic modality at the Montgomery County Correctional Facility (MCCF)
- learn to identify key components of a DBT Program
- learn step by step strategies to develop a DBT program in a jail setting
- identify stakeholders and resources required to develop a DBT program in a jail setting
- learn about essential program modifications made at MCCF (detention facility)

WHO ARE WE ?

MONTGOMERY COUNTY CORRECTIONAL FACILITY Boyds, MD

- Under Mo. Co. Department of Correction and Rehabilitation
- State of the Art facility in full compliance with accreditation standards including NCCHC - 2007 "Facility of Year Award"
- Employs 250 staff (uniform/non-uniform)
- Boasts multiple Inmate Programs run by staff and volunteers
- 18-month detention facility that houses up to 1000 Pre-Trial Defendants/Offenders (double occupancy)
- average population 750

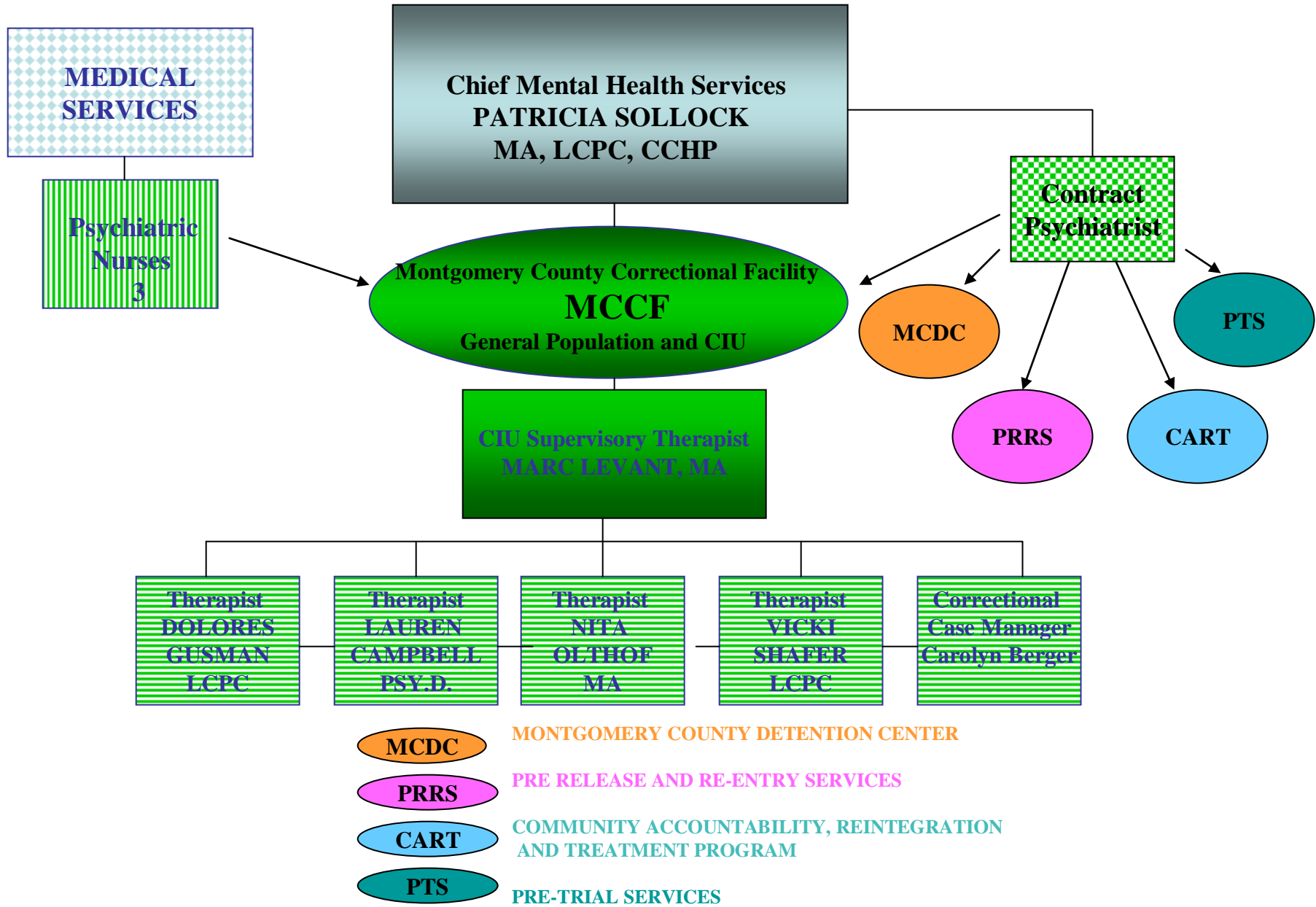
MONTGOMERY COUNTY CORRECTIONAL FACILITY



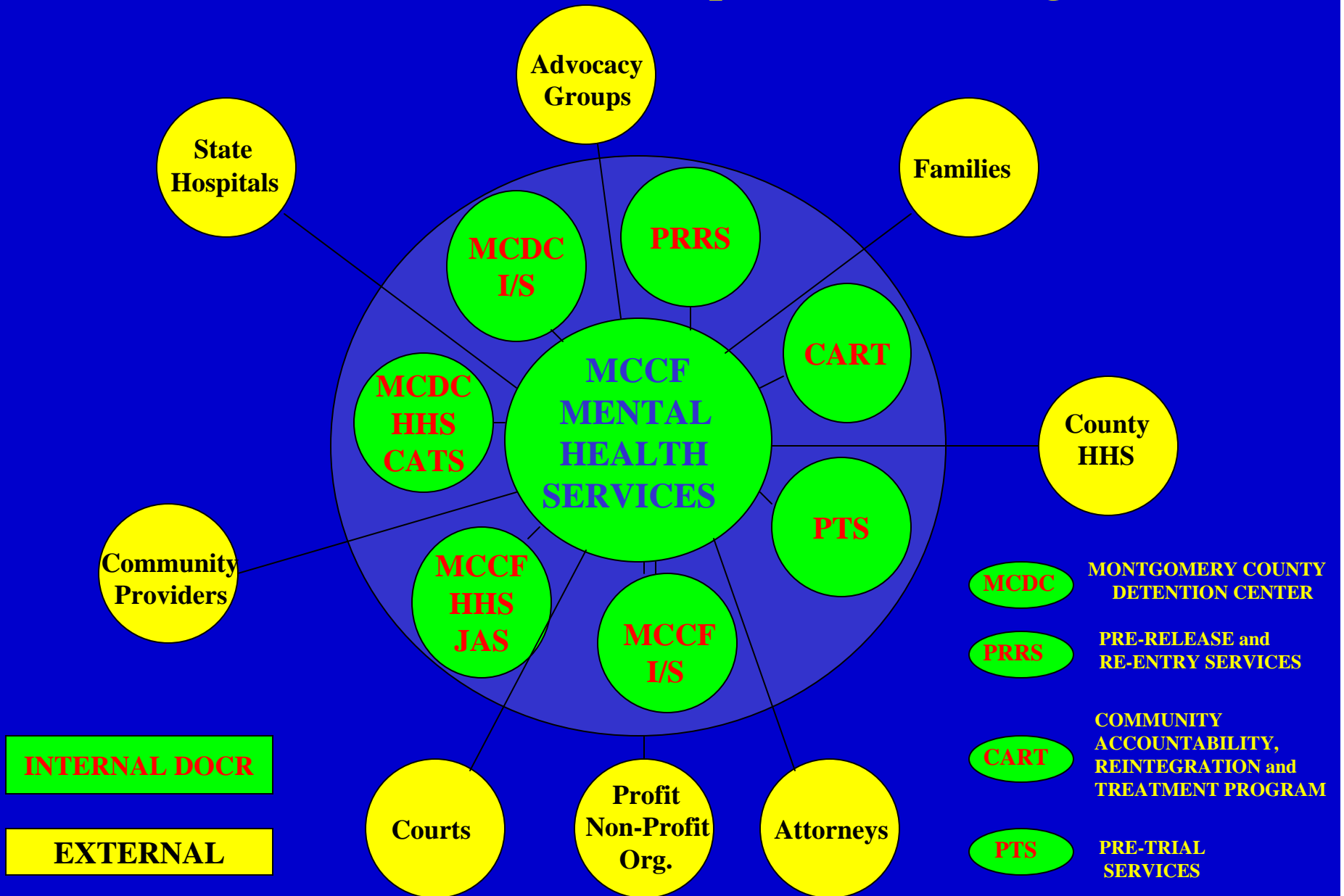
* Institutional Training & Staff Development - Position responsible for both MCDC/MCCF.

** Institutional Technology – Denotes function, not actual personnel compliment.

DOCR MENTAL HEALTH SERVICES



Montgomery County Correctional Facility Mental Health Services: Operational Linkages



Who are They?

The Mentally Ill at MCCF

SCOPE OF THE PROBLEM

- 18% of the population has some form of Psychiatric Disorder
- 2000 referrals/yr to Mental Health Services
- 100 to 170 inmates/day on psychotropic medications
- Additional number NOT on meds also under mental health care
- 40 bed Crisis Intervention Unit (CIU) = humane treatment and housing for inmates whose mental illness precludes them from General Population (GP) housing.

Mentally Ill and Scope of Problem (cont.)

- CIU is largest in-patient Psychiatric Unit in Montgomery County
- CIU: only unit at MCCF where security risk matrix is bypassed
Offenses range from misdemeanor offenses to felony crimes.
- Disorders in CIU range the scope of DSM, from anxiety disorders (phobias, PTSD); mood disorders (Major Depression, Bi-Polar Disorder); thought disorders (Schizophrenia and other psychotic presentations); and co-morbidity (Axis I, II, and III).
- Inmates prone to self-injury, suicide attempts or impulsive behaviors
- pose major challenges to the institution, providers and custody staff, overwhelm staff resources, burnout.

Thus... MCCF's DBT Program...

But Why DBT?

Simple...

Treatment As Usual (TAU) wasn't effective with inmates presenting with

- pervasive behavioral dyscontrol
- emotional dysregulation
- self-injurious behavior

Self Injury, hospitalizations, and disciplinary infractions were on the rise

Something else had to be done !

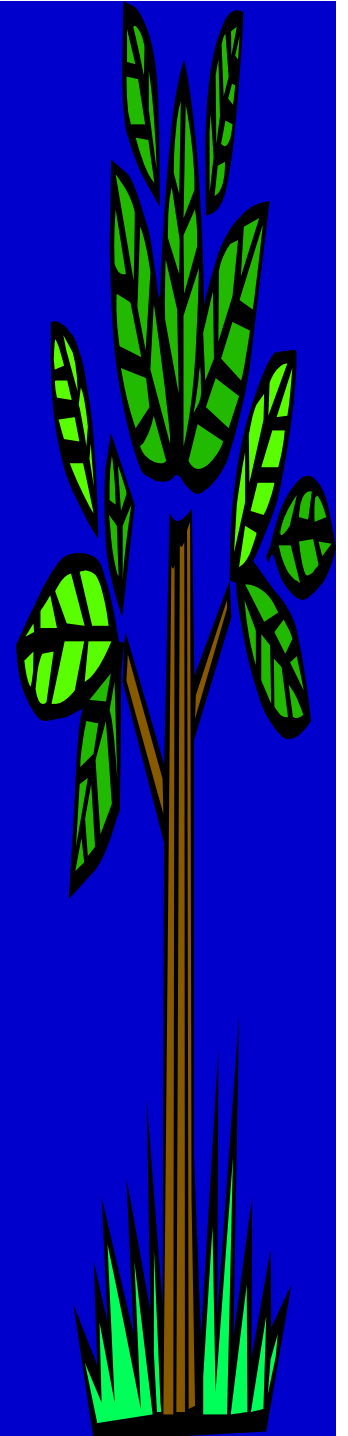
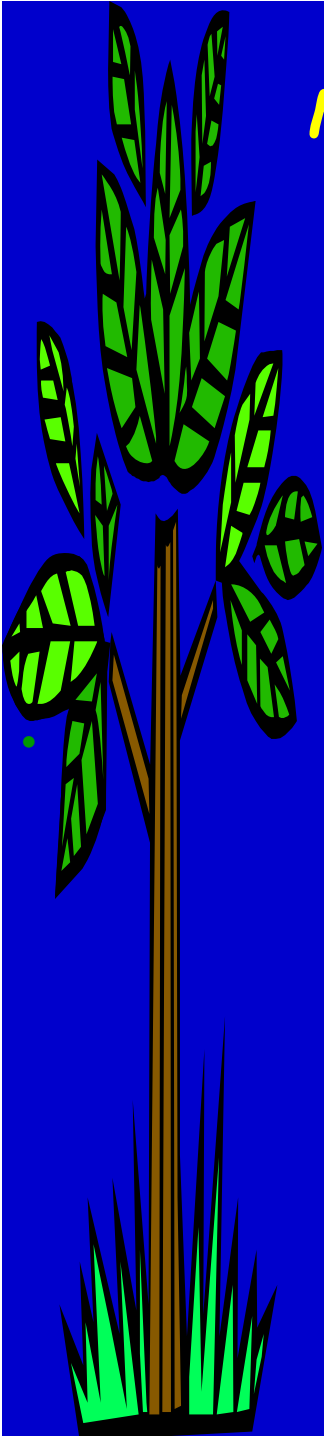
And the "something" had to be
evidence/principle-based..

So, decided to pilot a DBT
Program

Montgomery County Correctional Facility
Crisis Intervention Unit

The Jail's DB-Tree (DBT) Program

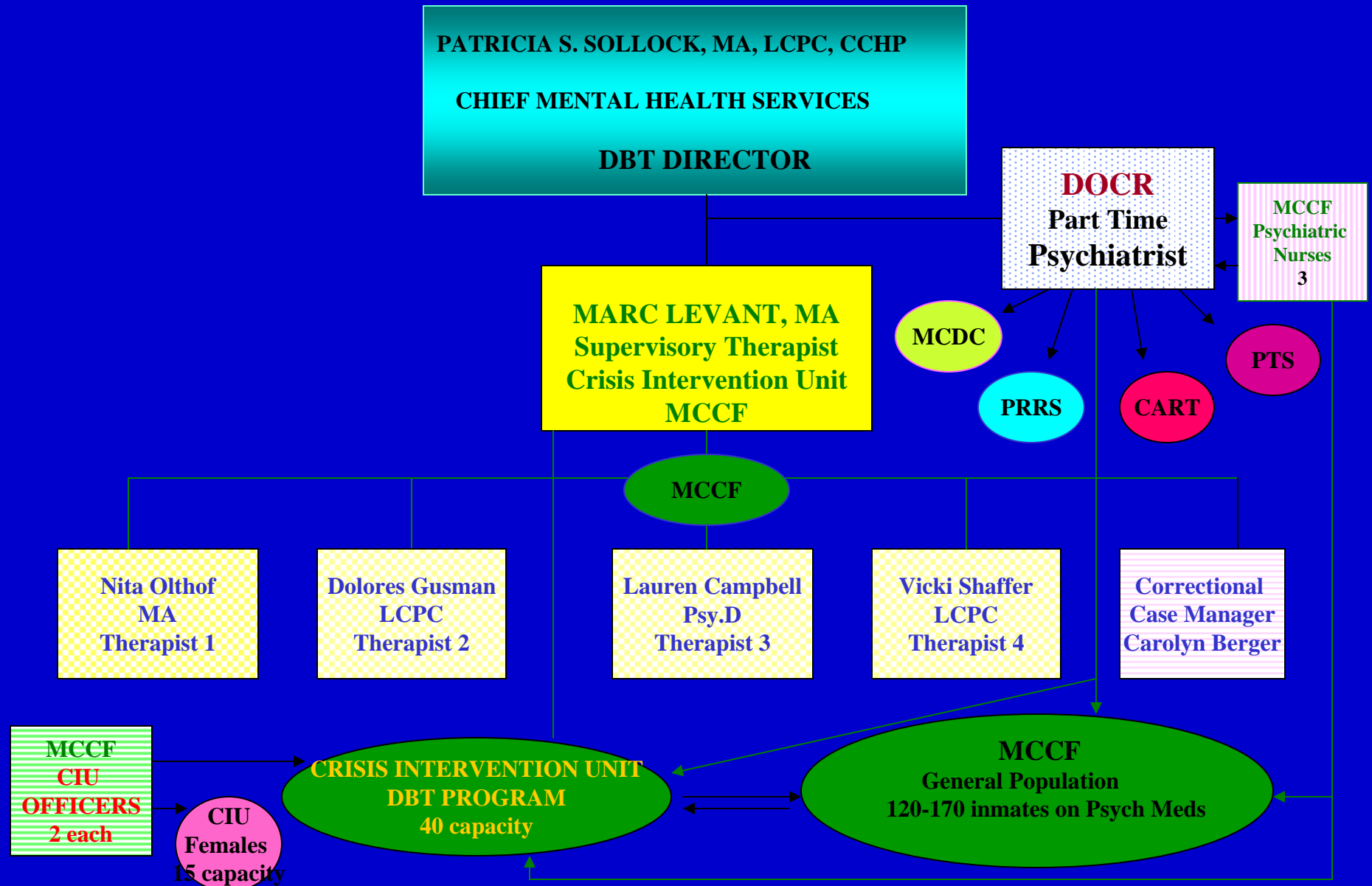
Elements Addressed
Step by Step...



IDENTIFYING RELEVANT ISSUES TO ADDRESS OR MASTER

- I. PROGRAM RESOURCES**
- II. LEADERSHIP: SPEARHEADING DBT**
- III. KNOWLEDGE AND APPLICATION OF PHILOSOPHICAL ASSUMPTIONS**
- IV. DIALECTICAL PHILOSOPHY**
- V. BIOSOCIAL THEORY OF BPD**
- VI. FUNCTIONS OF PROGRAM**
- VII. MODES (Modified for MCCF) OF PROGRAM**
- VIII. STAGES AND LEVELS OF TREATMENT**
- IX. TARGETS OF TREATMENT**
- X. AGREEMENTS (PATIENT'S AND THERAPISTS)**
- XI. DBT ASSUMPTIONS ABOUT PATIENTS**
- XII. PROGRAM ELEMENTS IN PROGRESS AND/OR AREAS NEEDING ASSISTANCE/IMPROVEMENT**
- XIII GOALS AHEAD**
- XIV. EVALUATION METRICS**

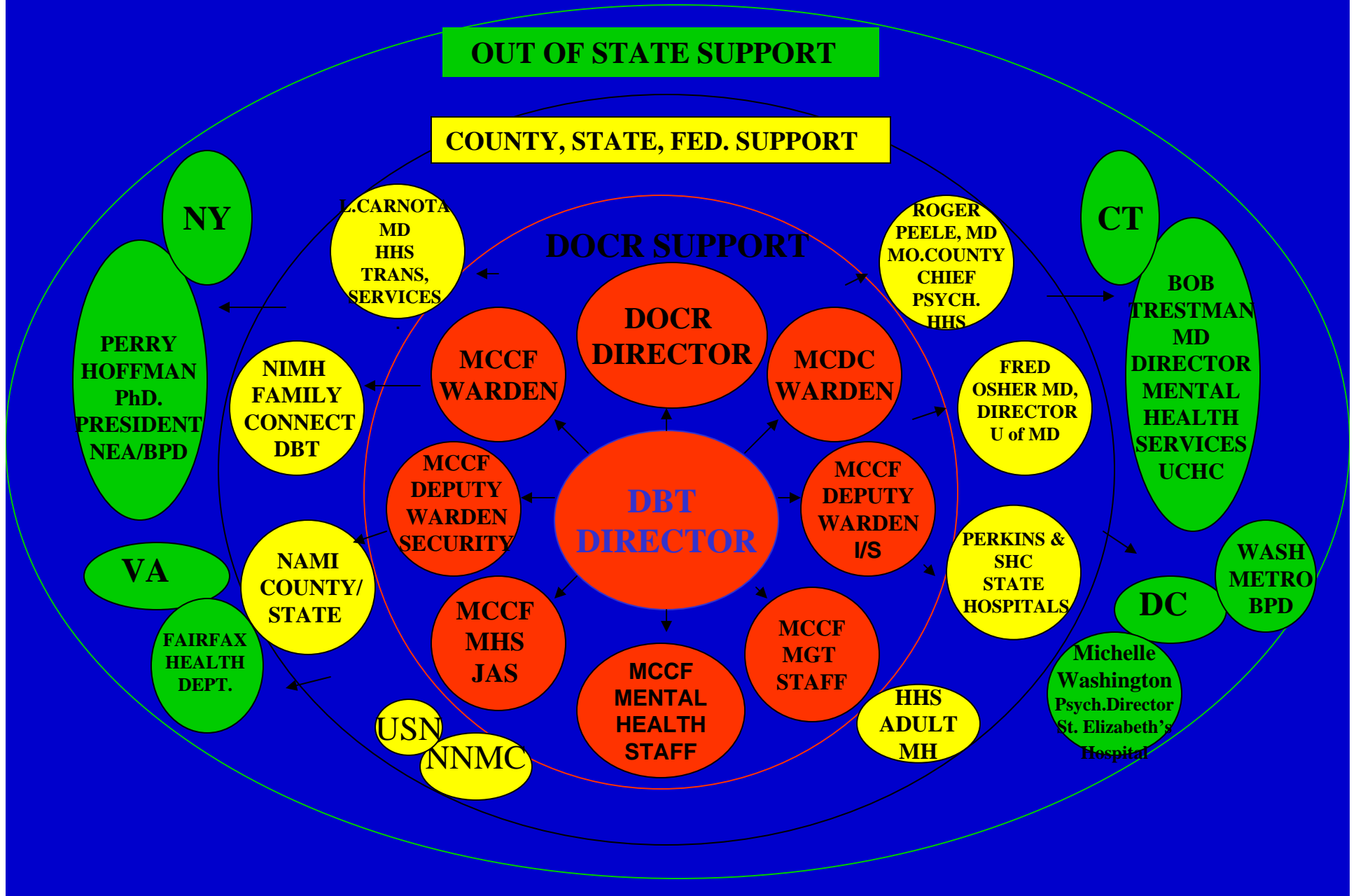
DOCR MENTAL HEALTH SERVICES & DBT RESOURCES



II. LEADERSHIP: SPEARHEADING DBT, A CHRONOLOGY

- **Chief, Mental Health Services, DBT Director, conceived idea and spearheaded comprehensive plan to develop DBT Program within MCCF (6/03)**
- **Submitted DBT as part of MHS goals for FY2004. Plan included detailed steps including trip to CT with key Staff to visit Dr. Bob Trestman's program/**
- **Obtained letters of support for DBT program (from County, State and Out of State providers)**
- **Disseminated DBT information to all levels of Management within DOCR and HHS colleagues**
- **Submitted formal DBT Program proposal and received full support by Warden, Deputy Warden for Inmate Services and all MCCF managers (11/03)**
- **I invited Perry Hoffman, President of National Education Alliance for Borderline Personality Disorder to present on the "Biosocial Theory of BPD" to all MCCF staff and HHS providers (12/03)**
- **Obtained support from DOCR Director to procure outside trainer for Overview of DBT Principles for all DOCR providers including PRRS, CRES. PTS, CART (12/03)**
- **Enlisted support from all Therapists within MCCF including Health and Human Services (HHS) Jail Addiction Services (JAS) and Clinical Assessment and Triage Services (CATS). Began internal DBT study and practice.**
- **Obtained approval from Warden to develop "Pilot DBT Program" and officially started 3/04**
- **Procured funding for six MCCF Managers to travel to CT and meet with Dr. Robert Trestman and staff (11/04)**
- **Successfully advocated for and obtained training funds to send MCCF Team for DBT Intensive training (3/05)**

LEADERSHIP: ENLISTING SUPPORT FOR DBT



III. KNOWLEDGE AND APPLICATION OF PHILOSOPHICAL ASSUMPTIONS

COGNITIVE-BEHAVIORAL PRINCIPLES:

- **Therapists agree on CB principles as a full system response to conceptualize case, they also use diary cards, chain analysis and develop detailed “Special Handling Plans” (behavioral) for Officers to manage Level 1 clients who require close observation.**
- **DBT Unit is structured to reflect a therapeutic milieu conducive to treatment. The Unit’s physical layout visibly “ identifies” Levels of Disorder. There is a “unit within a unit” to house Level One clients so Officers can more readily identify clients needing greater supervision.**

MINDFULNESS/ACCEPTANCE PRINCIPLES:

- **Mindfulness group is for all inmates in the CIU. Participation may be continuous. Other “Creative Leisure Time” activities in CIU reinforce mindfulness practice with the aid of high quality professional relaxation videos portraying relaxing but sensory stimulating audiovisuals.**

IV. DIALECTICAL PHILOSOPHY

- **Therapists practice and model acceptance/change strategies not just with inmates participating in DBT, but with inmates throughout the facility in any jail crisis situation.**
- **Other providers and some DOCR staff accept / understand the concept at a cognitive level but have yet to translate it into behaviors that support validation/acceptance principles.**

V. BIOSOCIAL THEORY

- **Biosocial theory of personality function is fully accepted by Therapists as basis for treating clients.**

VI. FUNCTIONS

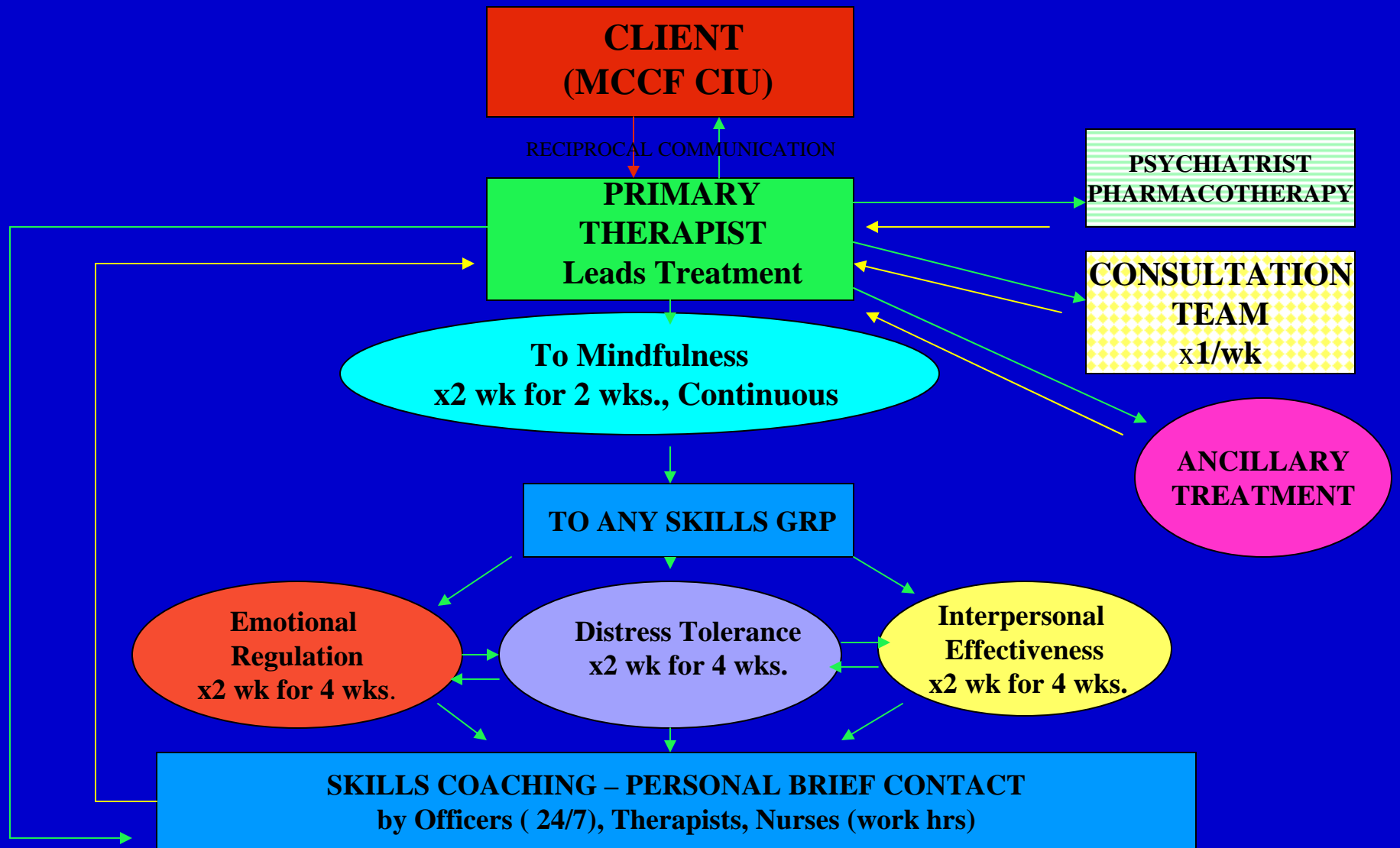
- **Enhancing capabilities**
- **Improving motivational factors**
- **Generalizing the environment**
- **Developing therapists capabilities and structuring the environment are all addressed.**
- **but functions have been modified to best adopt DBT philosophy and treatment principles to the jail setting.**

VII. SPECIFIC MODES MODIFIED FOR MCCF (Correctional Facility)

1. INDIVIDUAL THERAPY

- **A Primary Therapist is assigned to each incarcerated offender/client housed in CIU and:**
 - **develops client's treatment plan**
 - **monitors execution of treatment plan**
 - **conducts weekly individual psychotherapy with client**
 - **reviews Diary Cards and conducts chain analysis with client**
 - a. **to evaluate acquisition of skills and/or**
 - b. **review repertoire of cognitive, emotional, physiological and behavioral responses**
 - **formulates with urgency Special Handling Plans for Level One behaviors for dissemination to CIU Officers outlining client management**

**Dialectical Behavior Therapy Program
Montgomery County Correctional Facility
MODES OF TREATMENT**



VIII. STAGES AND LEVELS OF TREATMENT

- **Therapists utilize DBT “language” of stages and levels of treatment.**
- **Officers in the unit follow Special Handling Plans developed by Therapists**
- **The Montgomery County Correctional Facility’s Crisis Intervention Unit (CIU) “visibly” identify areas where inmates with specific Levels of Disorders are housed. Ex. Level I area houses inmates requiring Special Handling Plans due to severity of disorder/behavior.**
- **Due to institutional constraints, Level 1 is pretty much “all or nothing” management especially when client is suicidal or threatens suicide and/or is labeled a threat to self or others.**

IX. TARGETS

- **In practice target behaviors are prioritized by therapists only and there is no central or visible target list. Life threatening behaviors are always priority.**

CRISIS INTERVENTION UNIT (CIU) MCCF THERAPEUTIC MILEU AND LEVELS OF DISORDER

UNIT WITHIN UNIT: LEVEL 1

PRESENTATION

1. THREAT TO SELF OR OTHERS
2. EXTREME ANGER / RAGE
3. PSYCHOSIS (FLORID)
4. MAJOR DEPRESSION
5. CONFUSED, ERRATIC, UNTREATABLE

GOAL

1. BEHAVIORAL CONTROL

MANAGEMENT

1. 15 MIN OBSERVATION
2. CONTINGENCY PLANS
3. INVOLUNTARY COMMITMENT
4. STRIPPED DOWN CELL/SINGLE CELL
5. RESTRAINT CHAIR
6. E.R.

**LEVEL 3 and LEVEL 4
(INCOMPLETENESS)**

PRESENTATION

1. EMPTINESS
2. MALAISE
3. EXISTENTIAL CONCERNS

GOAL

1. CAPACITY FOR JOY AND FREEDOM

Officers' Station

Therapists' Offices

CIU POPULATION MANAGEMENT

- THERAPEUTIC MILIEU
- SINGLE OR DOUBLE CELL
- COMMUNITY MEETINGS
- RECREATION POD
- CREATIVE LEISURE ACTIVITIES
- INDIVIDUAL THERAPY
- DBT SKILLS GROUPS
- BRIEF PERSONAL COACHING "BPC"
- PHARMACOTHERAPY
- ANCILLARY TREATMENT

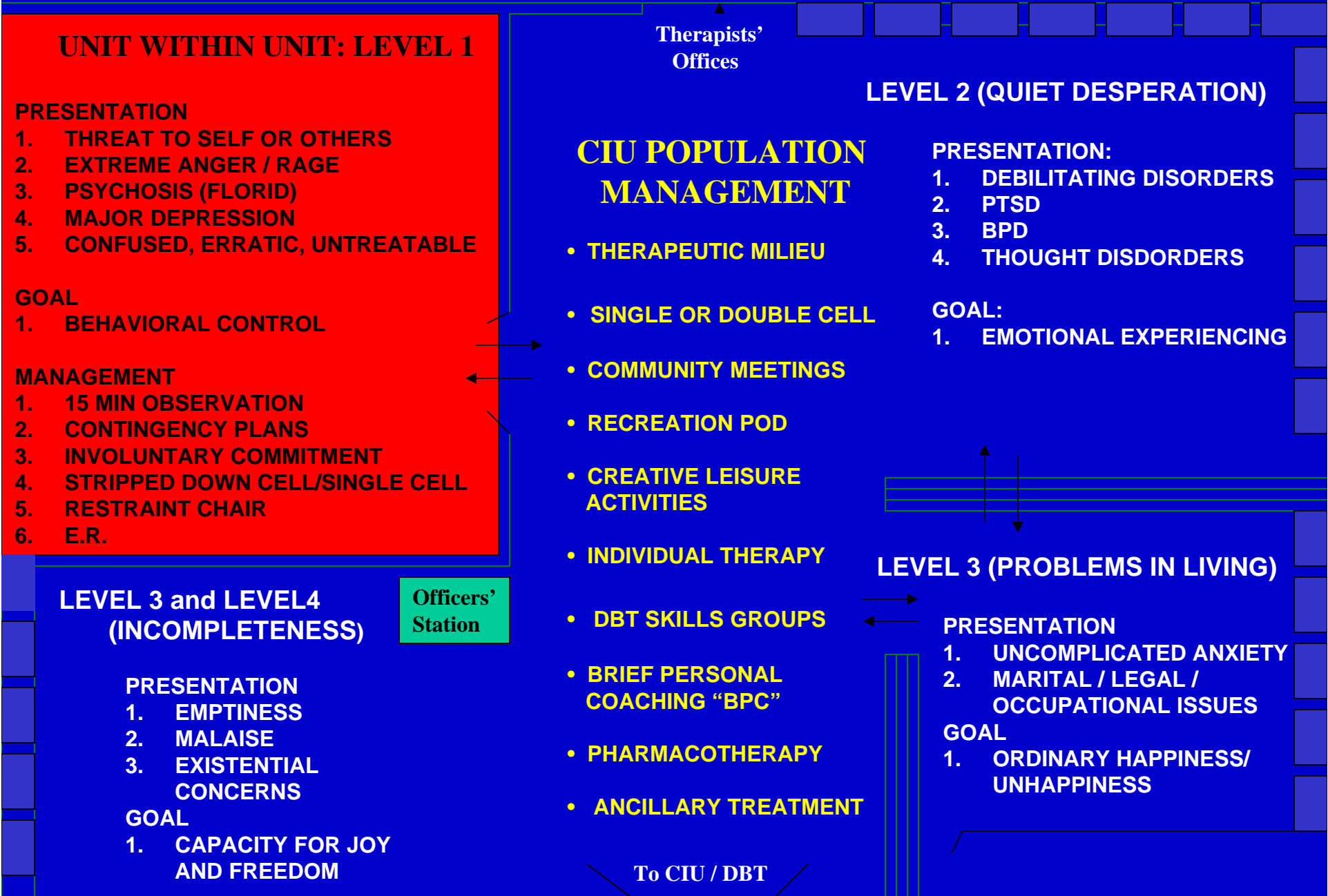
LEVEL 2 (QUIET DESPERATION)

- PRESENTATION:**
1. DEBILITATING DISORDERS
 2. PTSD
 3. BPD
 4. THOUGHT DISORDERS
- GOAL:**
1. EMOTIONAL EXPERIENCING

LEVEL 3 (PROBLEMS IN LIVING)

- PRESENTATION**
1. UNCOMPLICATED ANXIETY
 2. MARITAL / LEGAL / OCCUPATIONAL ISSUES
- GOAL**
1. ORDINARY HAPPINESS/ UNHAPPINESS

To CIU / DBT



X. AGREEMENTS

- **Therapists formulate individualized agreements for Individual Therapy with clients.**
- **There are also explicit agreements for both clients and team.**

XI. ASSUMPTIONS

- **Therapists subscribe to biosocial theory of personality function and accept and understanding assumptions about clients and therapy in standard DBT.**
- **Therapists are cognizant of jail-imposed communication boundaries but create atmosphere that promotes trust and change without compromising security or violating policy. For example, irreverent communication must be used with caution since irreverence by inmates is not tolerated.**

XII. PROGRAM ELEMENTS IN PROGRESS AND/OR AREAS NEEDING ASSISTANCE / IMPROVEMENT

1. KNOWLEDGE AND APPLICATION OF BASIC INGREDIENTS

COGNITIVE-BEHAVIORAL & MINDFULNESS PRINCIPLES

- Therapists understand cognitive behavioral principles but need to better communicate (1) disorders “at-a-glance” for all staff (2) goals of treatment by levels of disorder, in a manner that clearly articulates and reinforces use of DBT language with all unit staff.
- Therapists accept DBT assumptions about patients and therapy but must be posted in unit

DIALECTICAL PHILOSOPHY

- Because there is no dedicated” DBT team of Officers”, it is difficult to achieve consistent practice of balancing acceptance and change at every level of the program.

BIOSOCIAL THEORY

- Biosocial theory of personality function is fully accepted by Therapists as evidenced through their interventions with clients; however, this concept is not regularly communicated or articulated effectively to officers when discussing clients.

2. IN PATIENT (JAIL) GROUP SKILLS TRAINING

- **Length of groups has been modified to accommodate offenders with short sentences or those who remain on pre-trial status up to the time of their court hearing and/or release. All groups can be completed in a period of 14 weeks.**
- **All DBT participants start with Mindfulness and are required to attend twice a week for two weeks. It is highly encouraged that they continue to attend this group beyond the required time. This is the only group that has no size limit.**
- **From Mindfulness, clients are randomly assigned to Emotional Regulation, Distress Tolerance and Interpersonal Effectiveness. Each of these groups are offered twice weekly and clients are expected to attend 4 weeks of each group.**

3. GENERALIZATION OF SKILLS: COACHING

- **Generalization of Skills: Phone consultation is not part of our program. Instead, inmates obtain “Brief Personal Coaching”(BPC). This falls primarily on CIU Officers since they are on duty 24/7. CIU is a “direct supervision unit” and this facilitates client access to Officer at anytime.**
- **Psychiatric nurses and Therapists also coach clients during work hours, 7 days/week.**

4. THERAPIST CONSULTATION MEETINGS AND OTHER SUPPORT

- **Consultation meetings are scheduled once/wk**
- **Direct support from DBT Director: (1) advocated for Intensive training (2) paid leave for professional improvement; (3) identifying DBT sites to visit (VA, CT); (4) access local and out of state trainers (D.C., NY); (5) encourage training to maintain Therapists level of motivation, enhance their personal and professional capabilities, and validate their efforts and accomplishments with DBT at MCCF .**
- **Indirect support by DBT Director by: (1) networking and outreach (DOCR, County, State, and National levels; (2) cultivating professional relationships to benchmark MCCF's DBT trends against external standards; (3) providing monthly data to DOCR Department Director (4) disseminating DBT information (from journals,conference, etc.) to staff**
- **Direct support from CIU Supervisory Therapist who, under supervision of DBT director: (1) oversees nuts and bolts of DBT (2) first line supervision to Therapists ; and (3) develops and conducts short training to present at Consultation meetings.**

5. STRUCTURING THE ENVIRONMENT:

- **Chief, MHS:**
 - spearheads DBT, directs every aspect of the program and is responsible for the overall direction of the mental health programs for inmates in detention.
 - enlist s support and responds to concerns within DOCR
 - keeps DOCR Leadership apprised of DBT trends in CIU and of DBT initiatives at the national level.
- **CIU is conducive to DBT Skills groups, coaching and overall treatment / programming.**

Ancillary Treatment:

- **Uncontrolled: Pharmacotherapy, ER hospitalizations, Hospitalization in State Hospitals (driven by Court orders or involuntary commitment by Psychiatrist and second physician)**
- **Controlled: Creative Leisure, Guided Relaxation, Music Appreciation Group and other therapeutic activities or services outside of the DBT Program Unit (Jail Addictions, AA, or NA groups or activities such as Library time, or Religious services respectively).**

DBT Program Modifications

- Program is in-patient and $\frac{1}{2}$ duration of out-patient program
- Participants start of with Mindfulness
- Participant is assigned to one skills set but starts with Mindfulness
- One Skills set is completed in 8 wks, Mindfulness in 2 wks. but it is on-going with open participation to all
- Visuals, Spanish, English cards used, games, etc. to teach skills
- Mindfulness practice during e/DBT group and Pod mtgs (M-T-Th)
- 3 Skills Groups are offered weekly for 2 hrs twice/wk for e/grp
 - Tuesday - 1 hr review homework/diary cards
1 hr new material/didactic/discussion
 - Thursday -1.5 hr review and practice of skills learned in grp.

XIII. FUTURE GOALS/PLANS

- **Address and tackle all areas identified in section XII : “Elements in Progress and/or Needing Assistance/Improvement”**
- **Reinforce and Adhere to DBT Consultation group**
- **Gradually implement recommendations obtained at Intensive training (Officers’ Team)**
- **Present information regularly regarding status of DBT to all DOCR/HHS staff.**
- **Conduct yearly 40 hr. MH /DBT training for CIU Officers with emphasis on all aspects of DBT**
- **Display visible DBT posters and “props” such as “skills cards” for clients.**
- **Design “pins” to foster sense of “ownership” of program for Officers and staff accepting all tenants of DBT**
- **In addition to unit and patient evaluation data, collect data to measure client and staff perceptions of DBT program**
- **Research /Publish/ Invite constructive criticism/ open to changes**
- **Maintain DBT fidelity and consult with Dr. Linehan’s community and other professionals**

Does DBT work in Jails?

**MCCF DBT Program modifications
and trends...**

DBT Program Modifications

Participants:

- are male offenders, ages 16-50+, housed in the Crisis Intervention Unit (CIU) where the DBT program takes place.
- may have Axis I or Axis II disorders (including BPD and APD) and/or any Co-morbidity, including substance abuse disorders.
- with cognitive impairment are not excluded from DBT participation unless they are disruptive to group

Telephone Consultation and Skills coaching: Officers' roles

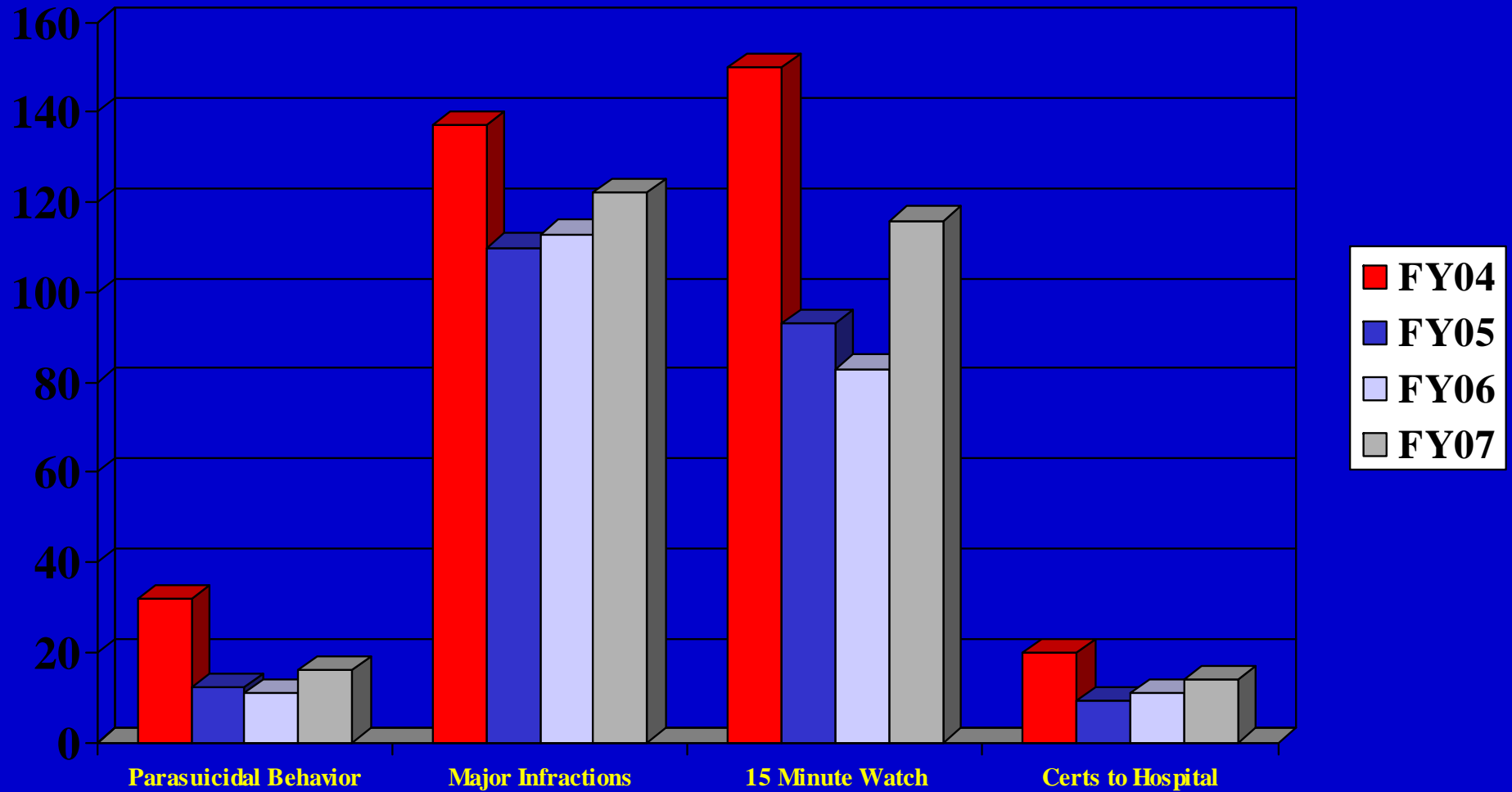
PRE/POST DBT TRENDS

MCCF / Crisis Intervention Unit

ELEMENTS	FY04	FY05	FY06	FY07
Parasuicidal Behavior	32	12	11	16
Major Infractions	137	110	113	122
15 Minute Watch	150	93	83	116
Certs To Hospital	20	9	11	14

PRE/POST DBT TRENDS

MCCE / Crisis Intervention Unit



Challenges experienced with DBT Program

- fidelity to DBT Model
- staff intensive
- turn over of mental health staff and officers impacts groups, therapy, consultation teams
- Dx - inmate's level of functioning
- requires basic level of intelligence
- short term incarceration
- sabotage (external parties)
- objective individualized pre/post DBT testing
- difficult to remove supervisor's hat role in consultation mtgs.
- training new staff and officers
- incentives for participants
- autonomy for management
- continuity of care once released
- All or Nothing management approach
- not enough time to evaluate
- program sabotage by untrained staff

CULTURE SHIFT

DOCR MILIEU

- DOCR initially encouraged with DBT trends/outcomes at MCCF
- DBT referred to as MCCF's "cutting edge" MH program
- Recognized by DOCR as "official" direction for detention MH Services
- "DBT Group" announcements regularly made through Jail's PA system-
- Visitors to Jail noted Officers volunteering to report that "DBT works"
- Movement of general population inmates to CIU for DBT groups increasing (from 12 to 20/day) and CIU Officers accept additional supervision responsibility

Culture Shift (Cont.)

COMMUNITY MILIEU

- Colleagues in community refer to and cite merits of Jail's DBT program
- Community providers report inmates' request for similar Jail DBT Program
- Co.HHS requested DBT training
- Judges have requested information about DBT because inmates have brought it up when planning release recommendations
- Community providers requesting presentations/training on DBT
- DHMH Clinical Director openly attributing decrease of involuntary commitments by Montgomery County to Jail's DBT Program
- Have been asked to present on DBT program at various conferences conferences (NAMI, MASMHPD, NCCHC)

Criteria for DBT Program Exclusion

- Female of any age
- Not housed in CIU, except individuals who return to CIU for Skill Groups
- Clients not willing to participate in DBT
- Clients with cognitive impairment who are disruptive &/or not able to understand
- Clients who return to group from general population and miss more than 2 sessions
- Not willing to meet all requirements such as group skills, individual therapy, chain analysis, etc

Culture Shift (Cont.)

INMATE MILIEU

- Inmates who participate report benefiting from DBT
- When HHS' Chief Psychiatrist came to visit CIU, inmates spontaneously volunteered compelling testimony about their experience with DBT as compared to past treatment.
- HHS Transition Team Psychiatrist, reports that ex-incarcerated clients have praised the merits of DBT and have requested DBT in the community.
- It is cumbersome to bring inmates back to CIU for groups but they are requesting to return for DBT groups they did not finish.
- Inmates are "talking" about DBT to family members and in turn family members have reported inmates have praised "DBT" and therefore are wondering who offers DBT in the community.

THANK YOU

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BORDERLINE PERSONALITY DISORDER

Re-Organized

1. Emotion Dysregulation:

- affective liability
- problems with anger

2. Interpersonal Dysregulation

- chaotic relationships
- fears of abandonment

3. Self Dysregulation

- identity disturbance/difficulties
- sense of self/sense of emptiness

4. Behavioral Dysregulation

- parasuicidal behavior
- impulsive behavior

5. Cognitive Dysregulation

- dissociative responses
- paranoid ideation