The effect of Dialectical Behaviour Therapy on patients diagnosed with Borderline Personality Disorder in a rural setting of NSW, Australia

Executive Summary

> *"DBT has helped me in every aspect of my life – I now work two days per week (after not working at all for 12 years). I have a new best friend and go out socially. My relationships with my children have improved and I don't get stressed by them so much and tolerate them. I have the skills to observe myself, especially in relation to my health and have had the confidence to seek better medical attention. I am calmer, healthier, and happy and have confidence in myself. I am able to cope with situations that before would have upset me. I am able to see more of the picture of life. I have also lost weight and have a better self-image. DBT has greatly helped me in all aspects and I continue to work on it every day."*
>
> Participant – completed stage one of DBT - 2009

Issue

Clients diagnosed with Borderline Personality Disorder (BPD) are known to utilize mental health services at a greater rate than people with other mental illnesses (Krawitz, 1999) (except schizophrenia). The suicide rate for this diagnosis group is high at 10% (Swartz, 1990) and up to 45% if there is co-morbidity with mood disorders and substance abuse. These clients are difficult to engage and to treat because of the complexity of the problems they experience. Conventional approaches to treatment often, unintentionally, reinforce poor coping behaviours (Gunderson, 1987).

The needs of people with BPD are inadequately met by mental health services and a clear direction on more effective ways of treatment would be useful (Krawitz, 1999). In 2008, this diagnosis was brought to the attention of the Australian Senate Standing Committee on Community Affairs for the first time. The report highlights that the needs of this group of consumers does not get a mention in mental health policy or the National Mental Health Strategy (Senate Community Affairs Committee Secretariat, 2008).

Stigmatisation of BPD has lead to discrimination (Krawitz, 1999) and sufferers are blamed for their illness and regarded as attention seekers (Senate Community Affairs Committee Secretariat, 2008), and have been overlooked in past mental health services and reforms. This has lead to marginalisation of people with BPD within existing service systems.

Clinician values and feelings have been identified as critical determinants for effective treatment and Krawitz (1999) proposes that funding for training is likely to be cost effective and give better results for the clients. Health systems need to provide peer advice and support, allowing clinicians to take professionally indicated risks (Krawitz, 1999). People with BPD have a good prognosis (Krawitz, 1999) and can get better when provided with appropriate, effective treatment.

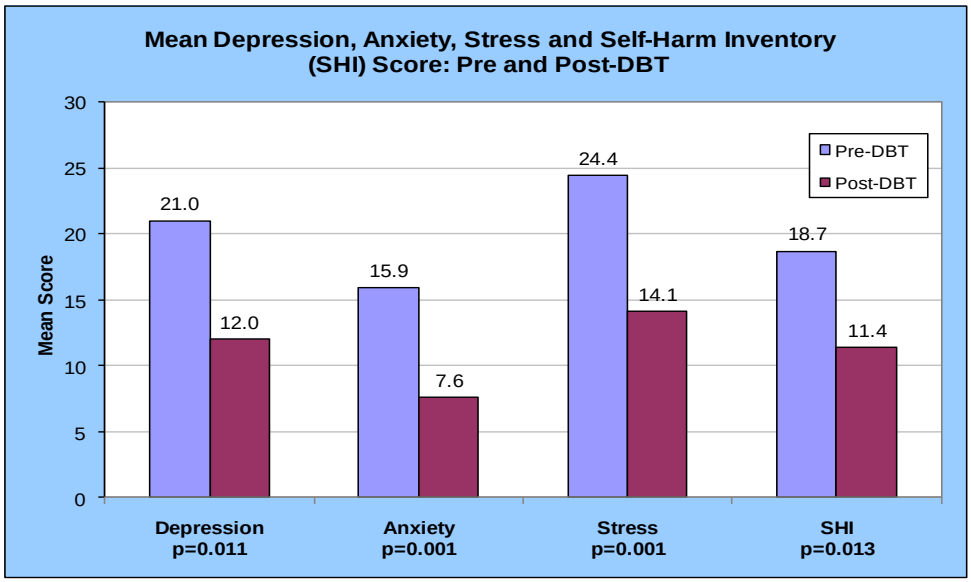
This is a retrospective study evaluating a relatively recent therapy known as Dialectical Behaviour Therapy (DBT) which has now been used to treat people with BPD in a rural location for six years. The literature demonstrates DBT

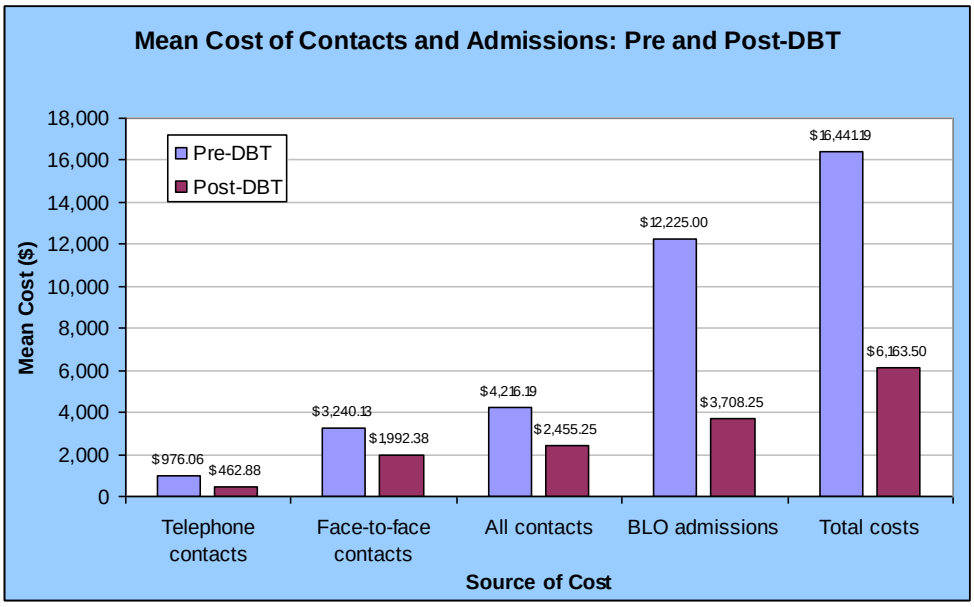
reduces: hospital admissions and occasions of service in community; occasions of self-harm and suicidal behaviours (leading to improved quality of life), and ultimately, a cost saving to the service.

Results of Study

The results show DBT is effective and can be utilised in an everyday clinical setting of a rural public mental health service. This study has replicated results described in the literature (Brassington, 2006; Prendergast, 2007; Linehan, 2006; Verheul, 2003).

People with BPD do respond well to evidence based treatment as shown with the significant reductions in self-harm *(p=0.013)* – from 18.7 to 11.4; depression (*p=0.011)* - from severe to mild (21 - 12); anxiety (*p=0.001)* - from severe to mild (15.9 - 7.6); and stress *(p=0.001)* - from moderate to normal (24.4 - 14.1). See figure below.





Also, as shown in the figure above, there has been a significant reduction in contact with community and inpatient services post-DBT. This is evidenced by the reduction in length of stay (LOS) days at Bloomfield in the 12 months post DBT dropping to 1.14 days compared to 22.56 days in the 12 months pre DBT

(p=0.011). Also, statistically significant reductions can be seen in total community contacts going from 39 pre treatment to 15.5 post treatment (*p=<0.001*).

Implications of Results

1. DBT is effective and can be utilised in an everyday clinical setting of a rural public mental health service.

2. Clinicians have a way to engage and to treat this difficult client group, with clinically significant results and with good support (consult group).

3. The reduction in the Bloomfield LOS days represents a cost saving for the service of $8,517 per person for the 12 months post DBT compared to the 12 months pre DBT. The total cost saving per person, including admissions and community contacts is $10,277.

4. Early intervention (especially youth programs) would enhance greater savings for the health services as clients get well earlier with many years of treatment no longer required.

5. The program is set out in a manual; therefore staff from different professional backgrounds can be easily trained as clinicians to be involved in the local program.

6. Regular staff education about BPD, available treatments and effectiveness would most likely lead to better services for this client group and less difficulty (burnout) for staff when working with them.

Questions that still need to be asked

1. What do Managers and Administrators understand about BPD, its available treatments and cost saving to the service?

2. What are attitudes of staff towards this client group and their understanding of available treatments for BPD?

3. Why is it taking so long to roll out this program when the evidence indicates significant reduction in client disability and their contacts with the service?

4. Should BPD treatments be taught to mental health nurses and allied health professionals at university?

More About the Study

Aim: To determine whether or not the results of this study replicate the results stated in the research literature (occasions of self harm/suicidal behaviours; reduce admissions to hospital; reduce occasions of service in the community) and to see if DBT can be utilised in a rural based public mental health clinical setting.

Method: This is a retrospective study looking at the demographics; a file audit (12 months pre and 12 months post DBT program); two measures - Depression Anxiety Stress Scale (DASS) and a Self Harm Inventory (SHI), both completed at baseline and three monthly whilst on program.

Inclusion criteria: People who have participated in the DBT program and have been diagnosed by a psychiatrist as having BPD; consented to participate in the research project N=19 (in this analysis N=16); and had completed Stage 1 of DBT compared with those that had not completed Stage 1.