

# **Dialectical Behaviour Therapy in Forensic and Correctional Settings**

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# Disclosure statements

- Shelley McMain is an unpaid member of the Scientific Advisory Board of the Linehan Institute.
- Shelley McMain receives payment for some DBT trainings.

# Presentation plan

- Overview of DBT
- Rationale for adapting dialectical behaviour therapy (DBT) to forensic and correctional settings
- Evidence base of DBT in forensic and correctional settings
- Common elements of DBT programs and examples of specific models
- Implementation challenges and facilitators

# Ashley Smith



First incarcerated at age 15 for assault, trespassing and causing a disturbance.

Diagnosed ADHD, BPD and ASPD

Non-compliant, disruptive, aggressive, impulsive

Chronic self-harming behaviour

“Pushed staff to their limits”

Numerous transfers to correctional facilities

Oct. 19, 2007, age 19, dies by suicide in custody

# Jury recommendations

“This case study can demonstrate how the correctional system and federal/provincial health care can collectively fail to provide an identified mentally ill, high-risk, high-needs inmate with the appropriate care, treatment and support.”

# Background

- Limited treatment options for mentally ill individuals with criminal justice involvement (e.g., NICE, 2014).
- Individuals with personality disorders are vulnerable to inadequate care (McCann et al., 2007).
- Staff burnout is common (Schaufeli & Peeters, 2000).
- 



The word "why" is written in a blue, cursive, handwritten style on a solid orange rectangular background. The letters are connected and fluid, with a prominent 'y' tail.

## **Dialectical behaviour therapy**

- designed for multi-disordered, high-risk individuals and compatible with best-practices
- targets criminogenic risk factors
- responsive to diverse learning styles
- addresses staff burnout

# DBT in a nutshell

- Developed originally for suicidal patients with borderline personality disorder (BPD).
- Integrates a focus on change, acceptance and dialectics.
- Principle-drive approach for severe, multi-diagnostic, difficult-to-treat individuals.
- Recommended for the treatment of BPD by several national practice guidelines (e.g., NICE, 2009; Australian Clinical Practice Guidelines, 2015).



**Marsha Linehan**



# Biosocial theory

**Behavioural dyscontrol**



**Emotional vulnerability or insensitivity**



**Invalidating environment**

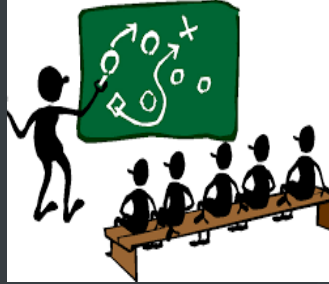
Disturbed caring; emotions are disregarded, minimized, rejected, punished; reinforcement of antisocial behaviour

# DBT modes and functions



1:1 counseling

Enhance  
motivation and  
engagement



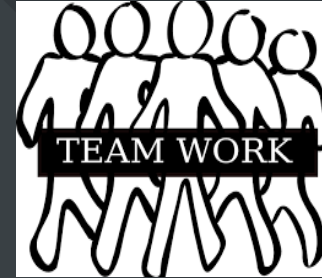
Skills training

Skill acquisition



Milieu coaching

Ensure  
generalization to  
the environment



Consultation team

Motivate and  
engage staff



Environment

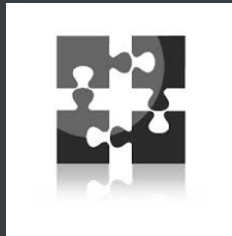
Structure the  
environment

# **Evidence Supporting DBT in Forensic and Correctional Settings**

# Research overview



> 31 studies

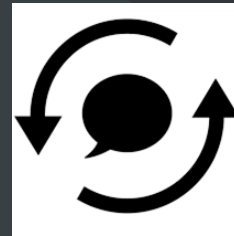


Case studies

Pre post

Quasi-experimental

Small sample



Prisons

Forensic

Residential

Outpatient forensic

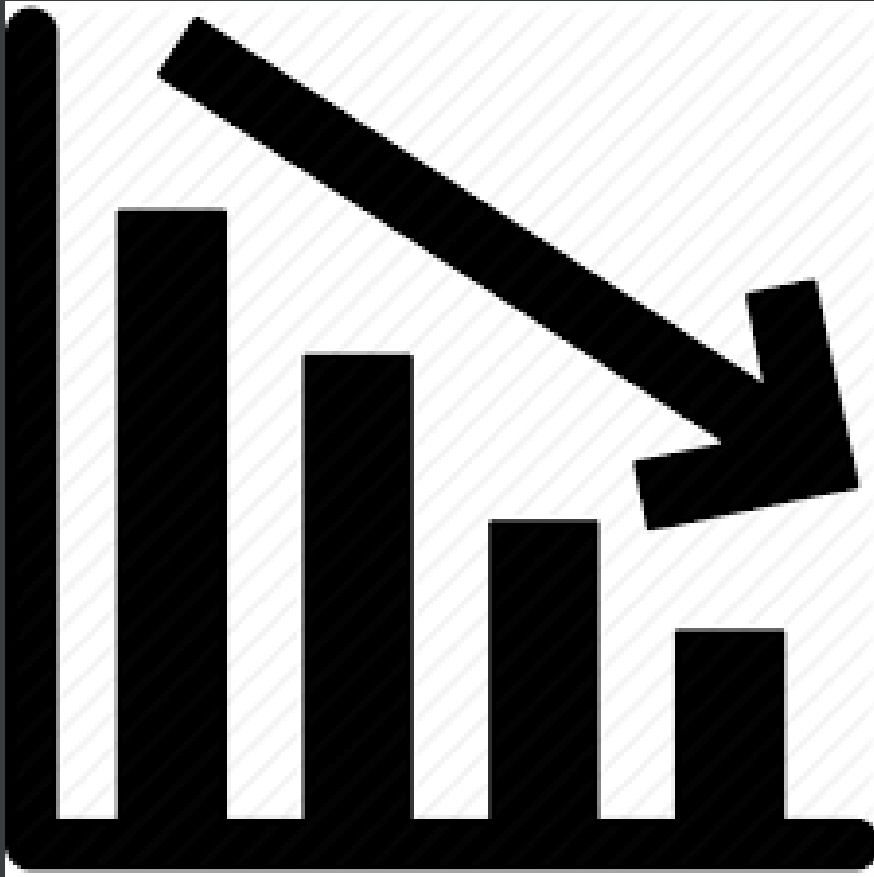


Male and female

Adolescent, adult

BPD; ASPD

Behaviorally dysregulated



## **DBT outcomes**

Physical aggression

Self-harm

Disciplinary tickets

Impulsivity

PTSD symptoms

Depression symptoms

# DBT outcomes

Anger management

Social support seeking

Planful problem solving

Accepting responsibility

Emotional control

Coping skills



# **Special populations**

# Individuals with intellectual disabilities

Pilot program at the National High Secure Learning Disability Service, U.K.:

- DBT > wait list
- reduced symptom distress
- *more likely to move to a less security setting*

## Program features:

- simplification of concepts
- small groups (4-5)
- repetition
- creativity and variety
- handouts using symbols and pictures
- individual support.



# **Specific DBT Program Examples**

# Examples of applications

## Published applications

**Outpatient forensic clinic in The Netherlands** (van den Bosch, Hysaj & Jacobs, 2012)

**The RUSH Program, Australia** (Eccleston & Sorbello, 2002)

**WA State juvenile residential** (Trupin, Stewart, Beach & Boesky, 2002; Drake & Barnoski, 2006; WSIPP, 2002, 2006)

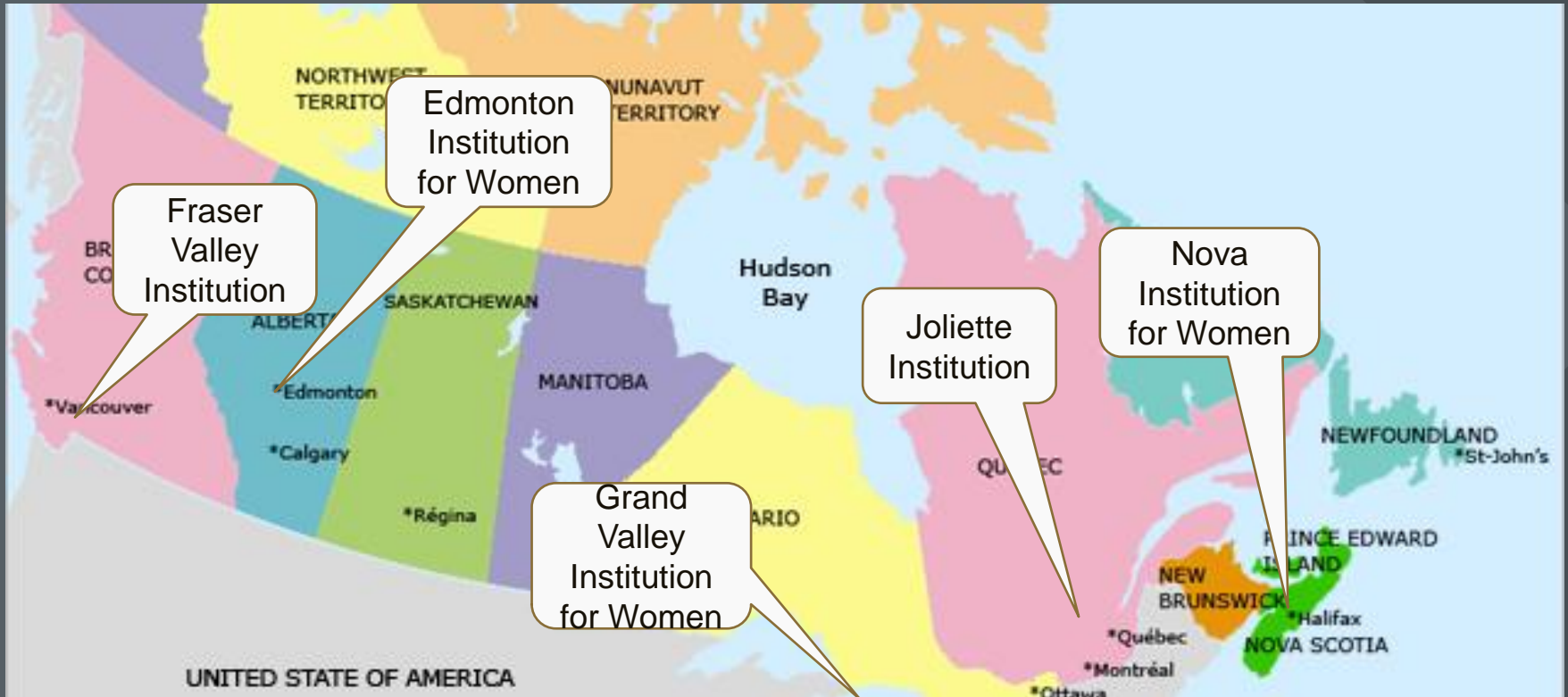
**Colorado inpatient forensic population** (McCann, Ball & Ivanoff, 2000; McCann, Ivanoff, Schmidt & Beach, 2007)

**CT State Prison – youth and adults** (Berzins & Trestman, 2004; Shelton et al 2009, 2011)

**NYC stalking offenders on probation** (Rosenfeld et al., 2007)

**Telephone-linked care system (TLC) for forensic outpatients and probationers**  
(Berman, Farzanfar, Kristiansson, Carlbring & Friedman, 2012)

# Correctional Services Canada (CSC)



# Model of DBT implementation in CSC

1. General population
2. Maximum security female offenders
3. Offenders in the community
4. **Specialist units for mentally ill offenders**

*Individual counseling*

*Group skills training*

*Consult Team*

*Psychoeducational groups*

*Activities centered around treatment*

# CSC DBT Training Program

## Basic courses

- 2-day introductory course (all)
- 2-day skills training (treatment staff)
- 2-day individual therapy (psychologists)
- 1-day consult team (treatment team)
- webinars (English/French)

## Consultation

- monthly site consultation
- complex case rounds - monthly
- monthly consultation (national)

## DBT trainer training

- train the trainer 2-day workshop

# Focus of staff training and intervention

Motivational  
strategies

Structural  
strategies

Coping skills

Problem  
assessment

Compassion-  
based  
approach

# Is DBT too complex to master?

State Department of Mental Health DBT training initiative was evaluated.

Sample: 109 clinicians with diverse backgrounds and roles

Predictors of knowledge:

- reading
- consultation
- study group

*but not prior education.*

# DBT outcomes - Corrections Canada

## Positive outcomes:

- better institutional functioning
- interpersonal functioning
- emotion regulation, coping skills and self control
- improved mental health symptoms
- effective coping post-discharge

Blanchette, 2010





# Implementation challenges

## General

Tension between security and treatment teams.

Staff frequently have low level of formal training in mental health.

High staff turnover.

Operational challenges.

Adapting to a new way of delivering treatment.



# More challenges

## DBT specific

Adapting DBT with low fidelity.

Staff perceived too few suitable clients.

Difficulty find time to meet for consultation.

Lack of individual therapists.

Training before staff are committed.





# Successful facilitation

Buy-in at senior level

Identify champions

Adequate program size

Expert consultation

Cultivate relationships

Train teams



# Take-away

**Evidence to support the application of DBT in forensic and correctional settings.**

**Treatment helps to reduce behavioural dyscontrol and increase effective coping.**

**Successful implementation of DBT requires full support of administration and clear goals.**

# Contact information

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