Improving the response of public mental health services to patients with Borderline Personality Disorder: the Journey continues

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Complex terrain

- Unwarranted pessimism
- Diversity of views and tensions
  - Theoretical models
  - Treatment programs
    - Time-frame
    - Focus of care: crisis response, symptom reduction, therapy
    - Access to specialist expertise and programs for individuals vs caring for a population
  - Core business
    - Denial of service, stigma, a diagnosis that excludes
    - Inadvertent reinforcement of behaviour: response in crisis
    - Resource intensive
• Severe mental health problem
• Prevalence: 2% general population
• Course: onset adolescence; persistence and intensification into early adulthood; improvement and stabilization in 30s and 40s
• Behaviors persistent and disabling; varies in severity (mild, moderate, severe)
• Completed suicide 8-10%
• Self mutilation and emergency presentations common
• Major social, interpersonal and vocational disruption
• High rates serious co-morbidity: mood disorders, eating disorders, substance abuse...
The challenges

- Reducing stigma: when diagnosis doesn’t help
  - No real agreed alternative, understood commonly
- Dimensional diagnosis with strong overlap with other diagnoses and high rates co-morbidity
- Scope as symptoms and behaviours
  - Challenging and difficult behaviours
  - Distress and dysphoria
  - Self-harm and impulsiveness
- Core business
  - Common language and framework for interaction and management
  - Across disciplines
- Time-frame
  - Substantial progress possible over time (Stone 1990)
- Best practice approach
- Diffusion of expertise
Issues in treatment

- Identified key clinician and consistent system approach: reassurance of care
- Comprehensive clinical care planning
  - Balance in crisis response and longer-term treatment
- Essential role of supervision
- Eclecticism
  - Psychological treatments:
    - Dialectical Behaviour Therapy*
    - Schema Focused Therapy
    - Mentalisation Based Therapy
    - Transference Focused Therapy
    - Self Psychology and the Conversational Model*
      * strongest evidence base
  - Pharmacological treatments:
    - Specifically indicated: antidepressants
    - Adjunctive: “Off label” use antidepressants (SSRIs), anticonvulsants (carbamazepine, valproate) for irritability, anger, impulsivity, aggression
- Integrated care planning: hospitalizations and crises, rehabilitation
- Self help
Best practice approach

• Common elements of therapeutic approaches:
  - prioritisation of focus
  - explicit and clear contracts, limit setting
  - interpersonal relationship based
  - high levels of clinician engagement and emphasis on the clinician’s capacity for self-reflection and capacity to work with error
  - proactive, predictive, not reactive
Values and culture in MHS: Structure and process

- Assertively addressing stigma
  - Language
- Advocacy
- Innovation
- Service system:
  - Policies, procedures
  - Clinical plan
  - Capacity for crisis intervention and ongoing outpatient work
  - Defined pathways to care
  - Key clinician
  - Supervision
  - Senior clinician and management support
  - Individual and system accountability for risk assessment and management
  - Internal capacity to resolve clinical difference of opinion
Innovation and common problems

• Practical application in front-line settings with heterogeneous populations
• Interface within MHS and between MHS and other service partners/components
• Clear Governance
• Supported by formal structure and processes
• Attention to clinical and systemic interventions
• Capacity building: training and resources
• Not re-inventing the wheel: poetry in motion!
Some examples of innovation

- Green Card Clinic St Vincent’s Hospital
- The Sutherland Distress Management Program for persons with Borderline Personality Disorder
- Modifying DBT to an acute adolescent inpatient setting in Sydney West
The Green Card Clinic

- Developed in C-L Psychiatry Department of SVH in collaboration with C-L POWH.
- Acknowledgements:
  - Professor Kay Wilhelm, A/Prof Kotze
  - Drs Vivienne Schnieden, Andrew Finch, Karen Arnold, Geoff McDonald, Peter Sternhell
  - Beaver Hudson
Brief description

• Setting: busy Emergency Departments
• Target group: high-risk immediate period post-suicide attempt
• Structure, process and method:
  – Assessment through usual processes (engagement from outset); outpatient appointment; follow-up non-attendees
  – Meaningful collaborative discourse about problems, priorities and tailored interventions and priming for further work
  – Collaborative clinical audit MH-ED potential self-harm and care planning for frequent presenters
Care planning for frequent presenters: components

- Brief narrative statement about the person, their circumstances, their predicament and customary style/circumstances of interaction with services
- Diagnosis: =/- narrative explanation of difficulties
- Usual presentation, typical presenting complaints and symptoms
- List of involved clinicians and carers, roles and contact details
- Current medications and drugs
- Management plan: crisis and ongoing
  - Coping strategies and what usually works (and what isn’t helpful!)
  - Crisis interventions and what the patient can expect (reassurance of care)
  - When to admit, what to expect
- ED specific items
- Where possible sign-off by patient and copy to patient and in file
- Language of approximation and validation
Brief description

  - Mood Mapping; Ways of punctuating the day using mindfulness; problem solving; Journal writing
Evaluation

- Evaluated over 7 years (456 pts)
- Interventions:
  - Range of possibilities; 3 sessions
  - Tailored to multitude of prioritised presenting needs: highly flexible
    - addressing current stressors vs lifestyle change
- Sustainable at SVH
The Distress Management Program

- Developed in Sutherland Community MH
  - pilot: 2006-2007
- Expanded across Central Network
- Sustainability plan
- Acknowledgments:
  - Tania Alexander, Monica Andrews, Stephanie Allen, Wayne Borg, Doukessa Lerias, Emma Slawitchka, Wendy Smith, Victoria McGowan, Anita Nikolovska
  - The Executive team Central Network MHS
Brief description

- Setting: medium-term (18-24 months) community MH
- Target group: women
- Structure, process and method:
  - Deliberate Self Harm Steering Committee
  - Adaptation of DBT
    - Skills training groups
    - Weekly individual therapy
  - Target group identified, referral pathways explicit, client and carer information packages
  - Capacity building:
    - Training and education
    - The oyster effect:
      - Resource function; consultation across the service; training
Evaluation

• Baseline: disproportionate use of acute MH resources

• Outcome measures:
  – Thoughts and Feelings Questionnaire; Depression, Anxiety and Stress Scale; Problem Behaviour Inventory; Kessler 10 Self Report; HONOS

• Improved in individual reports of self-management and psychological well-being
  – Reduction in negative thinking; reduction in intensity of problem behaviours; reduction in living difficulties

• 33% reduction in presentations to Emergency Dept

• 75% reduction in inpatient MH bed days
Modifying DBT to an acute inpatient setting

- Developed in the Acute Adolescent Unit, Redbank House, Sydney West
- Acknowledgements:
Brief description: a whole of unit approach

- Setting: acute adolescent inpatient unit (secure declared; 12-18 yrs) with a Department of Education school
- Target group: adolescents with a range of psychiatric diagnoses including Cluster B
- Structure, process, and method:
  - 5 week group program
  - Whole of unit approach: Multidisciplinary clinical and education team: common language and framework in the unit and in the classroom
  - Adaptation of DBT to the developmental stage and acute inpatient setting:
    - More practical and experiential, less didactic
    - Mindfulness and distress tolerance skills
    - Included diary cards and behaviour chain analyses
Some details..............

- **Simplification and modification:**
  - For mindfulness instead of using the observe, describe and participate, they use **traffic lights** to prompt “Stop! I just notice... Get ready: I just the facts... and Go! Then Do!”

- **Lots of attention to what grabs adolescents:**
  - Mindfulness: holding ice mindfully whilst being distracted by daggy 70s music
  - Identify distress, label emotions, determine when one is distressed; early warning signs of distress, starting to become distressed and being distressed - acting out emotions in mime
  - Distress tolerance – each adolescent develops a Distress Tolerance Tool Kit: Playing the Cards you’ve been dealt; five senses and soothing (including mindful chocolate eating for taste; distraction)
  - Skills focus on what works for them in various situations like being in school. Home, when out and alone eg at 3am
  - Balloon exercise
  - Diary room: ongoing recording
Evaluation

- Significantly fewer episodes of aggression
- Lower levels of cutting and scratching
- Significantly fewer episodes seclusion
- Reduced use PRN/IM medication
Conclusion: System focused therapeutically centered

- Core business
- Practical solutions to common problems
- Clear governance
- Organizational framework
- Clinical expertise
- Training and development