

# *Spectrum...a state-wide personality disorder service-Victorian experience*



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Spectrum, State-wide personality disorder service

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- It is a public funded state-wide service for persons suffering from severe personality disorders.
- **The access is limited to patients who are registered with in the Public Mental Health services in Victoria.**
- Nearly all our patients suffer from severe Borderline Personality Disorders

# OBJECTIVES

The primary objective is to provide **support and work with** Victorian Public Mental Health services to treat patients with **severe** personality disorders who are often at risk from **serious self harm** and suicide and who have particularly complex needs.

# METHODS

- Secondary consultations
- Training
- Treatment
- Research
- Advocacy

# HISTORY

- Spectrum was born in late 1998 after a few high profile patients came to the attention of media and the government.
- All Public Mental Health services contributed to the formation of Spectrum.
- Tender was called and one of the Public Mental Health services won the tender.

# THE PROBLEMS BEFORE THE BIRTH OF SPECTRUM

- Self harm required to obtain services
- Significant number of hospitalizations
- Prolonged admissions
- Over-emphasis on *short-term* suicide risk
- Risk assessment based on patients self report of suicidal thoughts
- Minimal support and supervision for staff
- Unmetabolized counter transference
- Limited psychotherapeutic treatment
- Limited case formulations, management plans and crisis plans

# BIRTH OF SPECTRUM

**Spectrum was established in late 1998 with two main aims:**

1. to provide **support** to state mental health services in the **process of change towards new treatment strategies.**
2. to **provide specialised intensive assessment and treatment** services for patients with particularly complex needs.

How do you organise a service to provide a meaningful specialist service for a geographical area similar to the **size of Britain** that is spread across 15 Public Mental Health services?

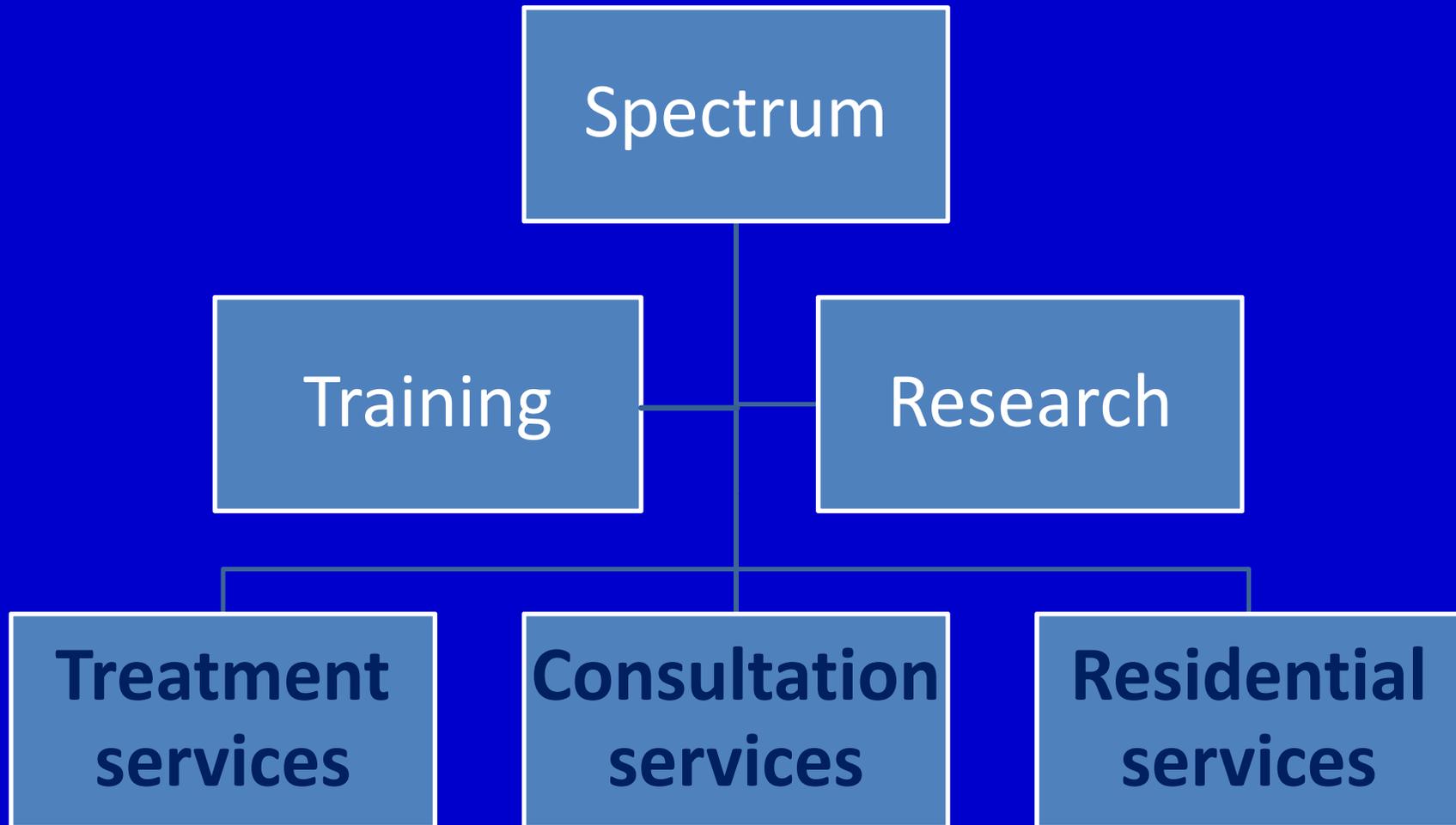
# INITIAL MODEL-RESIDENTIAL TREATMENT

- Initial model was an Hospital inpatient unit with 13 beds.
- Top 10% of resource users
- 1-6 months
- Only patients who can manage to live in a community
- Model- object relations, some process groups, some adapted skills training from DBT
- Remain linked to mental health services
- Also provided secondary consultations and training

# CHANGES

- Spectrum has gone through several changes in the last decade
- Until last year we had an 8 bedded residential facility (24/7 care) and we were able to provide intensive therapy for about 12 patients a year.
- Intensive Outreach Program (IOP)
- We also provided secondary consultations and training

# CURRENT MODEL OF SERVICE DELIVERY



# PRIMARY ACTIVITIES OF SPECTRUM

## Treatment

1. Individual therapy
  - Standard patient
  - Complex patients
2. Group therapy
  - ACT based Therapy
  - Body Mind therapy
  - MBT based therapy
3. Residential Therapy

## Workforce development

- Secondary consultations
- Supervision
- Case conferences
- Shared treatment planning
- Training
- Modelling
- In-services
- Second opinions

# PATIENT PROFILE

**Broadly two types of patient groups:**

## **1. Complex patients:**

Severe personality disorders, multiple co-morbidities, complex treatment issues, several failed treatments, high risk, often coming to the attention of police, ambulance services, media, office of Chief Psychiatrist and the DoH

- We require about 5 years to settle these patients
- About 1/3<sup>rd</sup> of our patients fall in to this category

# PATIENT PROFILE

## 2. Standard patients:

Routine referrals from AMHS- severe BPD patients who are high risk/several failed treatments/multiple co morbidities/ multiple hospitalisations.

- We require about 2 years to treat these patients
- About 2/3<sup>rd</sup> of our patients fall in to this category

# SPECTRUM

Direct Treatment

Secondary Consultation  
≈ 200/year

## Group Therapy

≈ 45 patients/year @ 120 sessions per patient

## Residential Services

≈ 4 Beds – 34 patient separations /year

## Individual Psychotherapy

≈ 60 patients/year  
≈ 30 patients/year

Wise Choices 1  
(ACT)  
2 staff members

Wise Choices 2  
(ACT)  
2 staff members

MBT Groups  
2 staff

Body Mind Therapy  
(Movement Based)  
2 staff members

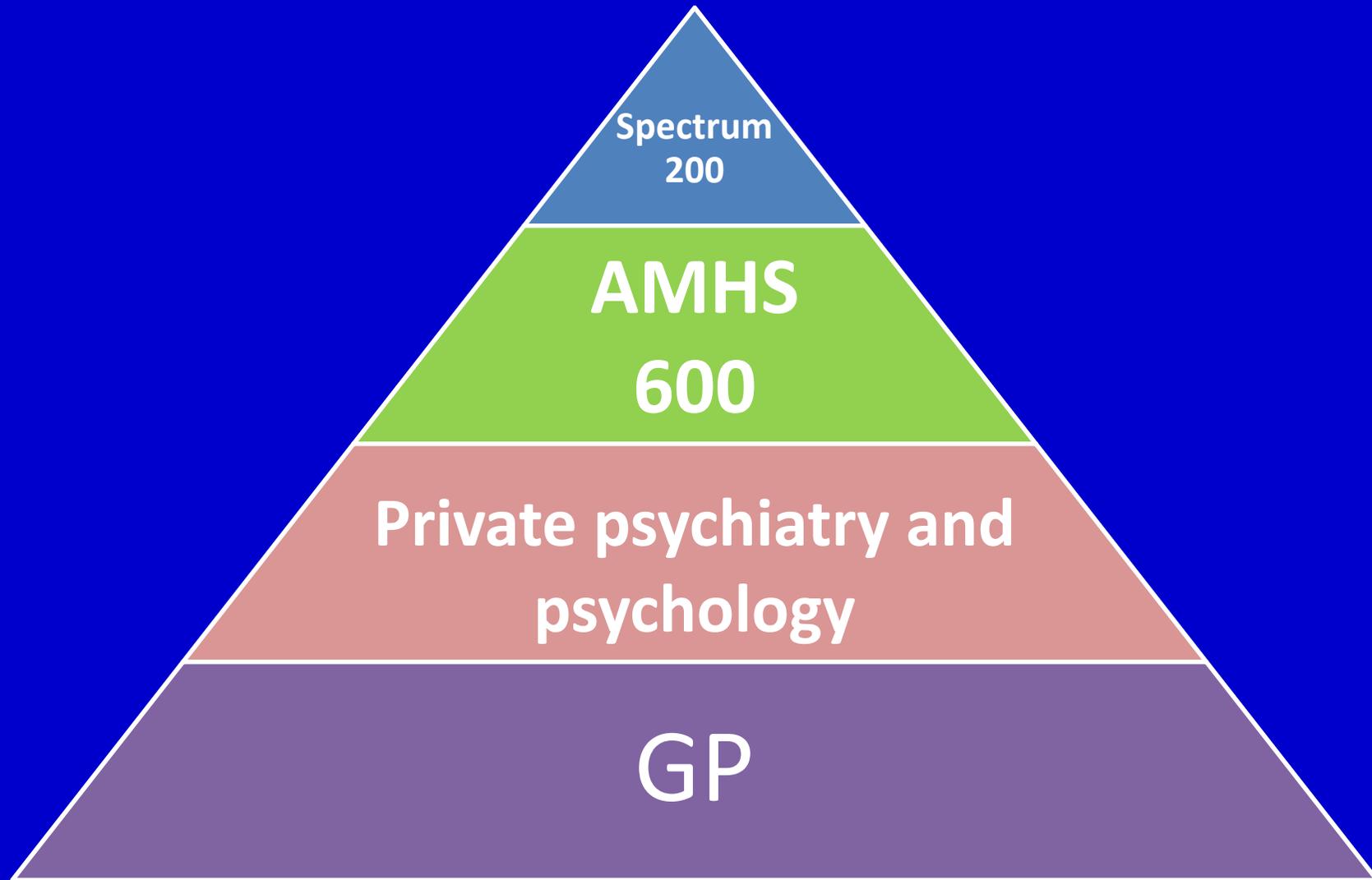
**Total of 8 staff**  
**2 hour sessions**

# VICTORIA



- Population 6 million
- At 1% prevalence rates, there are potentially about **60,000 BPD patients in Victoria.**
- AMHS treat about 600 patients
- We can treat about 200 patients
- Relatively small budget of **\$ 3 million.**

# ACCESS TO SERVICES- 60000 PATIENTS



# SCOPE

- Severe BPD
- Antisocial Personality – forensics, corrections
- Narcissistic personality
- Dependent Personality
- No cluster A
- 15 AMHS

# OUR CAPACITY

- **Intake request**- about 600 per year
- **Opened cases** – about 200- 250 per year
- **Group psychotherapy** – 45 group places per term over 2x Wise Choices, 1 X Body Mind and 1 X MBT groups
- **Individual psychotherapy** for about 50 patients per year
- **Residential services** - about 35 patient separations per year
- After-hours **telephone support** services to about 150 patients per year.
- **Secondary consultations**- 200 per year
- **Training** for 1000 clinicians per year

# Intake requests since 1999

Year	Intake requests (total)	Opened cases	Opened cases %
1999	265	92	35%
2000	394	91	23%
2001	412	127	31%
2002	365	123	34%
2003	308	122	39%
2004	351	106	30%
2005	492	168	34%
2006	609	<b>235</b>	39%
2007	716	<b>232</b>	32%
2008	738	<b>255</b>	34%
2009	674	202	30%
2010 (17/6)	347	<b>116</b>	35%

# Top 11 callers for 2009

Type	Number of calls	% of total calls (674)
<b>AMHS/CAMHS</b>	<b>252</b>	<b>37.4 %</b>
Family	104	15.4%
Self	93	13.8%
Other*	38	5.6%
PDSS	35	5.2%
Support Agency	32	4.7%
Private Psychologist	22	3.3%
Hospital	14	2.1%
Drug and Alcohol	13	1.9%
<b>Forensic</b>	<b>10</b>	<b>1.5%</b>
GP	10	1.5%
<b>Total</b>	<b>623</b>	<b>92.4%</b>

# What have AMHS asked for this year?

2nd consult	training	Outpatient group	Individual work	Case conf	Ax	General consult	Primary consult	Interest Group	Total Number
<b>74</b>	<b>17</b>	<b>8</b>	<b>6</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>121</b>

# OTHER ROLES

- Expert advice to DoH panels- MACNI (Multiple and Complex Needs Interventions) panels
- Supporting and liaising with other Victorian state-wide services
- Family therapy
- Policy advice
- Participation in OCP lead case conferences for complex and challenging patients with system dynamics
- Forensic services, corrections
- Dual disability services

# FORMAL TRAINING

- Free of charge- highly subsidised
- We train all MDT clinicians of AMHS
- We train Psychiatrists
- We train IMG psychiatrists
- Psychiatry Registrars- examination training
- Sabbatical psychiatrist
- Student placements- psychology

# STAFF NUMBERS

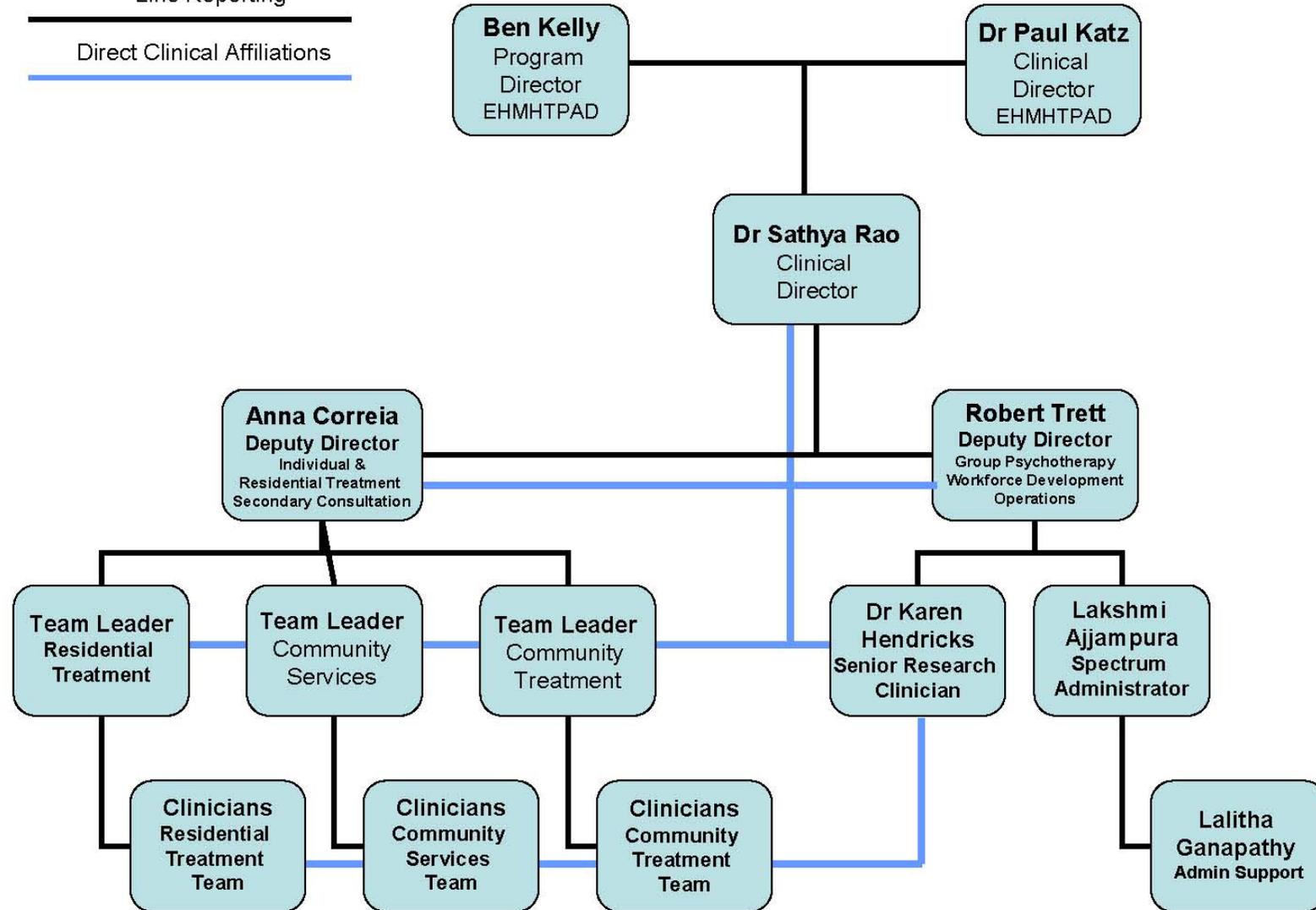
- Total 28 FTE
- Psychologists-14
- Nurses-7+1
- OT-1
- Social workers-3+1
- Psychiatry Advanced Trainees-2
- Psychiatrist and Clinical Director-1
- Senior Nurse and Deputy Director- 1
- Senior Social worker and Deputy Director-1
- Intake/triage-2
- Research -2
- Administration-2+1



# Spectrum Org Chart

Line Reporting

Direct Clinical Affiliations



# OTHERS

- Complaints- very few if any
- No burn out- even though we have several clinicians who have been with us for more than a decade

# Spectrum culture

- Overall agreement on philosophy and approach.
- Ability to hold robust dialogues and discussions
- Sensible case loads. Balanced lives.
- Plenty of time for reflection
- We strive to model what we expect of our patients with respect to IPR, managing our emotions, repairing IP conflict etc
- A very strong patient advocacy
- Clinicians value and take pride in their work

# Spectrum culture

- Happy place to work
- Non-authoritarian, but well lead.
- Egalitarian culture
- Recruitment and retention. Striving to retain staff
- Patients' split emotional responses do not cause the team to split.
- Clinicians are encouraged to think and function independently
- Adopting changes
- Support from senior management and staff.
- Eclectic theoretical approach

# OUR CLINICIANS

- Non judgemental attitude
- Intellectually robust
- Highly self confident
- A high self esteem with respect to their identity as Spectrum clinicians
- **Therapeutic optimism**
- Superior IP skills
- Strong work ethics
- Some what leftist
- Egalitarianism
- Therapeutic intent
- Strong patient advocacy

# Supervision and support for clinicians

- Internal and external supervision
- Seniors supervising juniors
- Reflective space
- Clinical review process
- Meetings with Chief Psychiatrist
- Clinical governance structures of Spectrum

# THEORETICAL MODELS

- Spectrum treatment principles
- DBT principles
- ACT
- MBT
- Psychodynamic principles
- Relationship management
- Object relations
- Systems theory- Family therapy
- Humanistic, existential

# SENIOR ADVISORS

- **Chief Psychiatrist**
- **Senior Clinical Advisor-** Psychiatrist, ex Spectrum staff
- **Senior Research advisor-** Senior psychologist, academic, ex Spectrum staff
- **Eastern Health Senior executive**

# RELATIONSHIP WITH OCP

- Office of Chief Psychiatrist- **key support**
- MoU that guides the relationship
- OCP may order AMHS to seek Spectrum consultation
- OCP may authorise treatment plans of AMHS that are endorsed by Spectrum and **provide appropriate clinical authority**
- Bi monthly meetings with Chief Psychiatrist office to discuss complex and high risk patients
- OCP may hold case conferences

# OTHER KEY RELATIONSHIPS

- AMHS- referral base
- Department of Health- complex care coordination
- Eastern Health – corporate support
- Coronial systems

# What glues Spectrum?

- Strong allegiance to Spectrum values and culture
- Thursday meetings
- Our patients and AMHS who access various components of Spectrum
- Senior staff supervising junior staff
- THE SPECTRUM CULTURE

# Challenging issues

- Tension between **direct treatment** versus **secondary consultation**
- Motivating, inspiring and up skilling AMHS staff to treat BPD patients
- Negotiating with AMHS to keep the patients registered for long enough to offer meaningful treatments (at least two years)
- Improving access to AMHS

# Challenging issues

- On going workforce development in the context of challenging recruitment and retention of staff in AMHS
- Continuing to prevent staff burn out
- What is our model of care? What is Spectrum therapy?
- Utilising the influence and the authority of Office of Chief Psychiatrist with out being perceived as agents of Chief Psychiatrist

# Challenging issues

- Diagnosis/formulation
- **Medical** versus **non medical** models of care
- Organising a robust research program
- Evidence Based practice versus Practice based evidence
- Recruitment and retention in the changing world
- Rules versus values

# Research

- Two books on BPD
- Few chapters in books
- Couple of papers
- Wise choices manual
- Clinical research
- Spectrum evaluation project
- Wise Choices trial
- PhD students

# BORDERLINE PERSONALITY DISORDER

*Towards Effective Treatment*



**BORDERLINE PERSONALITY DISORDER**  
*Towards Effective Treatment*

Josephine Beatson  
Sathya Rao  
Chris Watson

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Sathya Rao  
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This book provides a well-presented synthesis of current best practice in the management of people with borderline personality disorder. Its positive and practical approach will appeal greatly to the postgraduate student and the busy clinician alike.

- Cris Mileshkin  
*Consultant Psychiatrist*  
*(Formerly Clinical Director, St Vincent's Mental Health Service, Melbourne)*

This concise book is to be recommended to basic and advanced psychiatry trainees and psychiatrists. It successfully fulfils its promise of providing a clear, easy to use textbook for a sophisticated clinician in training, working with people with borderline personality disorder.

The chapter answering frequently asked questions from the mental health clinician community is an outstanding quick reference. The book is clearly written, authoritative and detailed, but focused on the essence of what we all need to be able to know and do for this patient group. It unravels the shroud of misunderstanding that exists around this disorder and points the way towards working constructively and effectively with this patient group.

- Richard Newton  
*Chair, Fellowships Attainment Committee, RANZCP*  
*Medical Director, Mental Health, Austin Hospital, Victoria*

Psychiatrists working in the public sector are challenged not only by the treatment of the individual patient with BPD but also by an expectation that they support and guide the work of junior colleagues and staff. This patient group often arouses anxieties, which may be difficult to contain. This text provides a readily revisable and concise overview of the contemporary conceptualisation of BPD and its treatment. At every turn, the evidence is clearly presented while the approaches advocated are grounded by the authors' wealth of clinical experience. As such, it can be drawn upon not only to inform individual treatment, but also to educate, inform and support clinicians engaged in working with these patients on the front line.

Highly recommended.

- Dominika Baetens  
*Director of Postgraduate Medical Education*  
*St Vincent's Mental Health Service, Melbourne*

ISBN 978-0-646-52778-9

# Lessons learnt

- A stand alone service.
- Residential services at the inception of Spectrum
- Workforce development with an eye on core competencies
- Targeting the entire mental health workforce
- Adopting a clear theoretical model/models.
- Consistency with service evaluation tools over a period of time.

# Perception of others

- Spectrum is generally held in high esteem within the Victorian psychiatric community
- Our clinical opinions and advice are respected
- Criticism about difficulty in accessing Spectrum
- Criticism about our response time

# Our dreams

- Primary prevention
- Complex care units- Drug and alcohol+ Spectrum + Mental Health services
- Best practice guidelines for AMHS
- MBT based service models of care in AMHS

# Our dreams

- Expansion of our service- Youth, CAMHS
- Access to PDRSS, GPs, Private psychiatrists/psychologists- the 59, 400 patients....
- Contribute to research- Articulate and document the work we do
- Academic appointments
- Retain our work culture- if possible teach others

**Thank you for your  
attention**

# Key innovations

- Secondary consultation model
- Intensive Outreach Program
- Wise choices group therapy programs

# Limitations

- Limited to AMHS
- Limited to BPD
- No acute services, no involuntary treatment
- Only a secondary consultation service

# Strategic plans

- Review and expansion of budget
- New infrastructure- capital works, IT
- Service development models-AMHS
- Research and publication
- Broad based workforce development

# Dialectics

- Treatment / Supporting treatment
- Diagnosis/Formulation
- Culture – Values/Rules
- Autonomy /Micro Management
- Medical/Non medical
- Us and them (EH, AMHS)
- Subjective versus objective  
(Risk assessment, diagnosis, core competencies)
- Rules versus values
- Evidence Based practice versus Practice based evidence

# Group therapies

1. **Body Mind therapy groups**- 2 hour per week- 10 patients
  2. **MBT groups** - 2 hour per week- 10 patients
  3. **ACT-Wise choices (west)**- 2 hour per week- 8 patients
  4. **ACT-Wise choices (east)**- 2 hour per week- 8 patients
- Capacity- 45 patients per year
  - Staffing –  $2 \times 4 = 8$

# Individual psychotherapy

- Capacity- 50 patients in therapy at any point in time
- Therapeutic orientations- variable (ACT, MBT, DBT, Spectrum, Psychodynamic, Eclectic, etc)

# Residential services

- 4 beds- not an inpatient unit
- Staffing - 4+3
- Through put = 34 patient discharges per year
- Assessment
- Support patients in individual therapy/ group therapy
- Rural and remote areas- provide access

## Secondary consultations

- Case based support, supervision and incidental training to AMHS clinicians- dealing with system dynamics and processing transferences, splitting etc.
- Assist with case formulations, risk assessments, developing treatment plans, formulating treatments, facilitating direct treatments at Spectrum

# Workforce development

- Training
- Supervision
- Secondary consultations
- Modelling
- In-services
- Case conferences
- Second opinions
- Shared treatment planning
- Publication
- Books
- Conference presentations
- Website
- Student placements
- Interest groups
- Reading groups