Canterbury’s new talking therapy approach for service users with Borderline Personality Disorder

The Mentalisation Based Treatment model

“If we can get services to respond [to service users with BPD]... in a more compassionate, psychological and consistent way then it looks like we get better outcomes”.
Robert Green, consultant clinical psychologist, MindSight clinical supervisor, CDHB

AT A GLANCE
What: An innovative and sustainable implementation of a training model for a talking therapy known as Mentalisation-Based Treatment (MBT).
Why: To enable a consistent and sustainable clinical approach for working with and supporting service users with a diagnosis of Borderline Personality Disorder (BPD).
How: Providing a simple and quick to learn therapy training programme alongside an effective implementation strategy that minimises clinician “burn-out”, promotes sustainability and ensures consistency of practice.
Target: Community mental health service clinicians.
Where: Canterbury District Health Board (CDHB) region.

THE PROFILE
In 2009, CDHB mental health services trained a group of clinicians across their community services in MBT. After the three day training programme, clinicians receive ongoing supervision and guidance to support sustainability and consistency of the approach.

Each of the four community mental health teams (named sector bases) has two 0.5 FTE clinicians trained who provide weekly individual and group MBT to service users with a diagnosis of BPD. In order to sustain service longevity, each team has additional clinicians trained in MBT who are ready to replace clinicians who may leave the service.

Clinicians in other services (such as acute inpatient services and psychiatric emergency/crisis teams) where service users with BPD often seek support have been trained in MBT to support an understanding of the approach and to assist in consistency of practice delivery.
In addition, others in the team, including nurses, social workers and occupational therapists, are trained in Therapeutic Case Management so that all clients with BPD are supported from a treatment framework that can provide for their unique needs.

“People with BPD are frequently seen at acute services and crisis services. Traditional approach to threats of self harm has been to try to stop them… with a high cost to them and to the service”

Robert Green, consultant clinical psychologist, MindSight, clinical supervisor, CDHB

THE BEGINNINGS
The changes to the care of service users with BPD had its roots in training in the CDHB over the last ten years. Clinicians and service users had expressed a sense of dissatisfaction with old service delivery models where people with BPD were often seen in crisis, often with thoughts of self-harming. The existing practice models were reactive to service users’ distress and continued to focus on risk minimisation rather than the causes of the individual’s distress. Interventions therefore often consisted of being asked to “take responsibility” for such thoughts, or be admitted to an acute unit because of the perceived risk of self-harm. This led to service-users often being on a rapid cycle of assessment, hospitalisation and discharge. This process was frustrating to clinicians and service users alike.

In response to these frustrations, the CDHB began a series of workshops for clinicians to help them understand the experience of BPD, and better ways of offering care. The workshops appear to have contributed to a better understanding of BPD and care by clinicians.

In recent years, there has been a growing focus on using talking therapies to assist service users with BPD. One therapy, MBT, caught the attention of Dave Carlyle of the Otago Medical School and Robert Green of the CDHB. It appealed to them because of the evidence of usefulness to service users and the sustainability of this model.

In 2006, Anthony Bateman and Peter Fonagy, two United Kingdom based clinicians and leading academics in the field, came to Christchurch as keynote speakers for the Gathering Conference, an annual meeting of New Zealand health professionals providing services for people with BPD. This visit forged an ongoing relationship, and Bateman and Fonagy were subsequently invited to Christchurch, where they provided training for clinicians from the CDHB and elsewhere in the South Island.

“Mentalisation training has a shorter time frame [than other talking therapies] and fitted our clinicians existing skill set”

Robert Green, consultant clinical psychologist, MindSight clinical supervisor, CDHB

THE PROCESS
Training in MBT was first offered in the South Island in 2009, and the service delivery model started in 2010.

A number of vital factors contributed to a successful implementation of the model.
- MBT training was seen as a good fit with the DHBs clinical needs.
- It was affordable as the training takes only three days and a large number of clinicians can attend at once.
Supervision for staff is paramount to ensure consistency, ongoing therapist development, and to maintain momentum and motivations. To this end weekly individual and group supervision, ongoing journal meetings, training groups and fortnightly supervision with Anthony Bateman utilising Skype are employed.

Talking therapies with service users can be demanding and result in clinician “burn-out”. The CDHB addressed this by targeting community clinicians and two 0.5 FTEs based in each of four sector bases. Having other clinical work, the support of a colleague in a similar position and the provision of regular supervision are all measures designed to minimise the risk of clinical “burn-out” and to ensure sustainability and consistency for service users.

The MBT training and practice model recognises that consistency of approach and continuity of a relationship with the same clinician or clinicians is vital for service users with a diagnosis of BPD. The training of extra clinicians has meant that replacements are immediately available in the event of a clinician leaving the sector base, ensuring that service users have uninterrupted therapy.

"The aim is to have ongoing training, to bring in more people in roles of back-up therapists to have ongoing work for clients ensured”
Dave Carlyle, University of Otago.

Finally, the training was also focussed on clinicians from other services, such as crisis and inpatient services, that service users are likely to attend. This has meant that these clinicians are “champions” of the MBT model, can help with delivering an understanding of the model to fellow clinicians and ensure that care delivery remains consistent for service users.

**THE UNIQUE APPROACH**

- Service users have an appointed MBT therapist.
- Service users have weekly face to face and group sessions based on the MBT approach.
- The service delivery model has therapists 0.5 FTE embedded in community sector teams.
- MBT champions are based in other significant services to promote understanding and to ensure consistency of care.
- A sustainability model is built in to the training, with extra clinicians already trained to ensure continuity of care, and a train the trainers model being established.

**THE RESULTS**

Robert Green (CDHB) and Dave Carlyle (Otago Medical School) are researching the effectiveness of MBT. They will compare a range of outcomes for service users who received MBT with a control group who received standard care.

The research study itself will be three years or longer as the participant enrolment is staggered to manage the service and the delivery of treatment to clients. The MBT intervention is 18 months long for each service user.

At this stage Green and Carlyle are only collecting the data for the first intake of participants. They have comparative data on hospital admission rates between the MBT and the control group of other service users who receive standard care. For the first 11 months of the study the MBT group has demonstrated a sustained 57 per cent reduction in admissions, compared to the control group. Although this is only an initial and ‘gross’ measure of impact, the results appear promising.

Anecdotal evidence indicates that service users found the group work challenging, but ultimately helpful.
MORE INFORMATION

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Further references
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