



BPD^{CO}

Borderline Personality Disorder Collaborative

GPM Complex: implementation of a systems approach to the treatment of BPD

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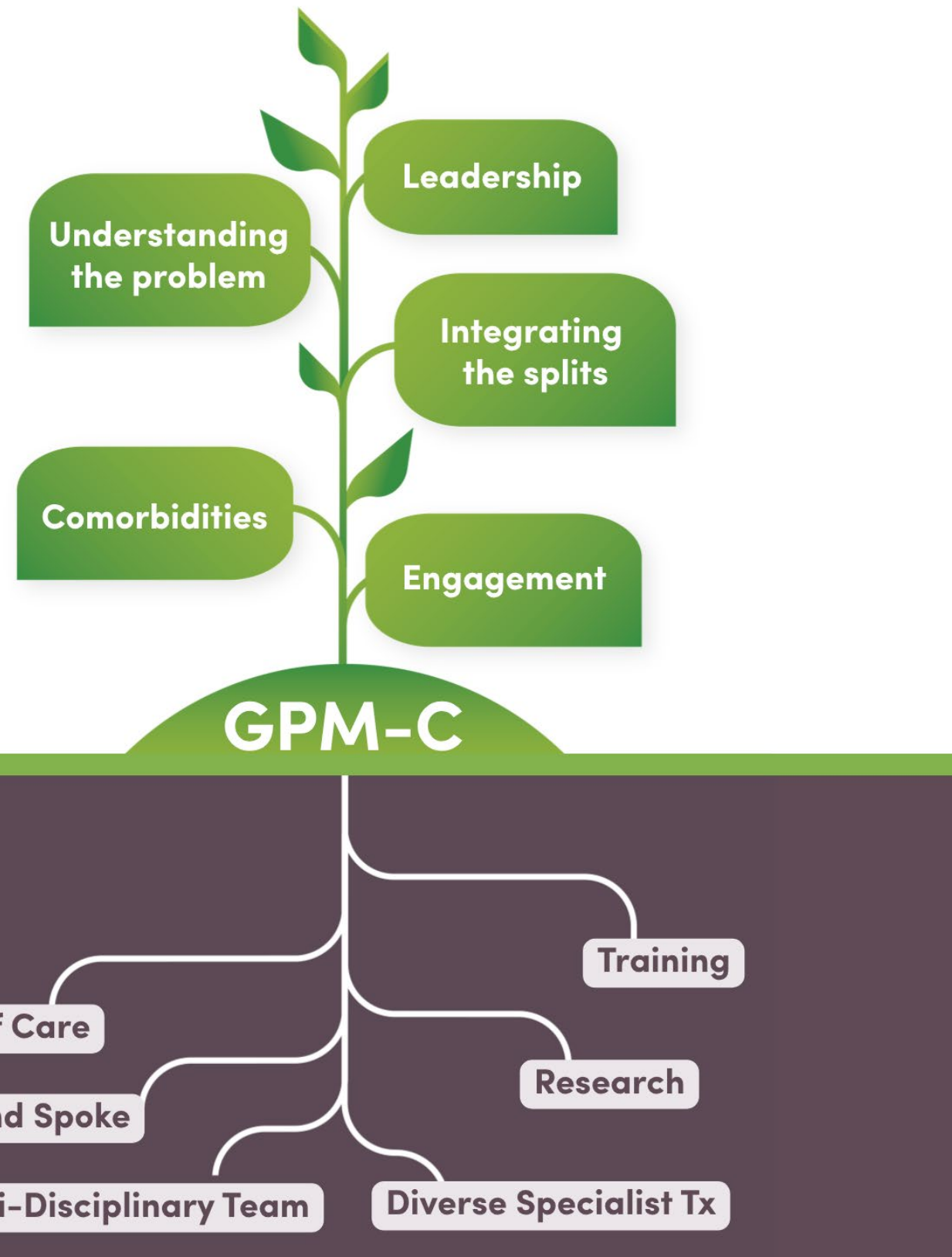


Population: 2m
Area 983, 482km²

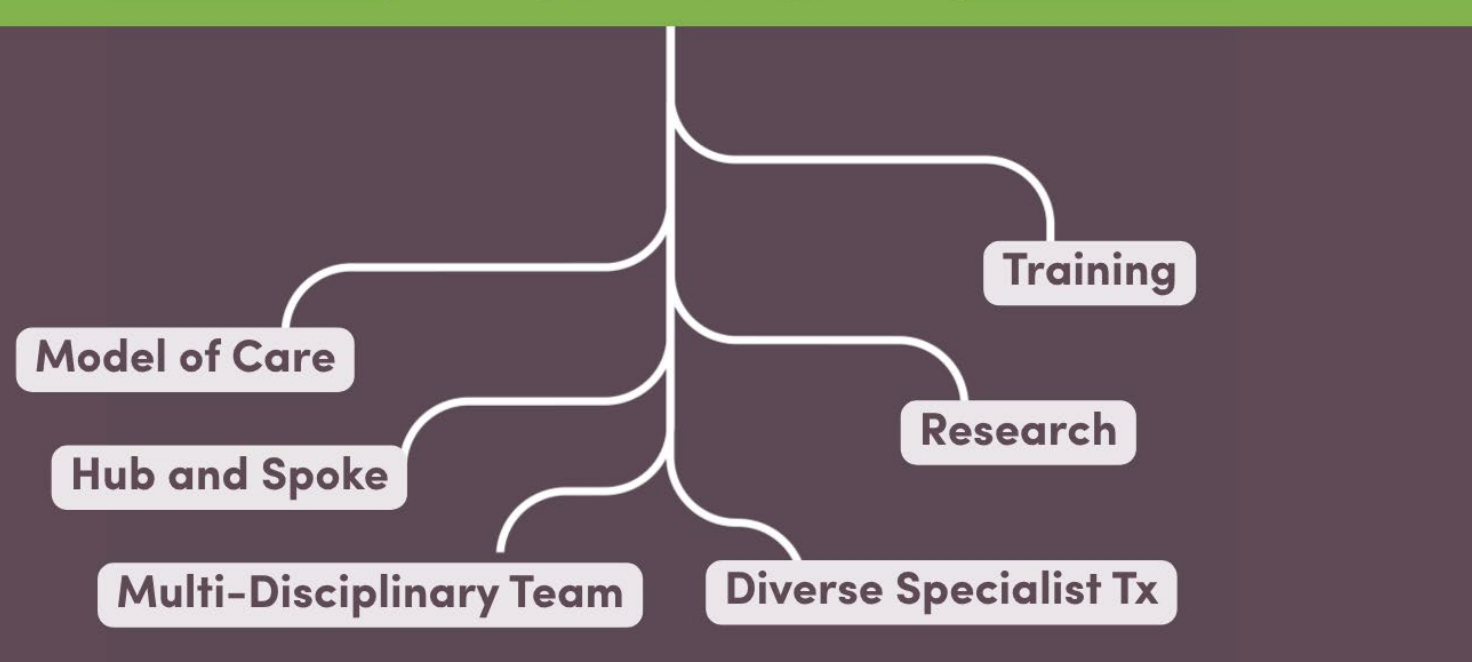
BPD pop est:
17,700 – 70,800

BPD Co: 12.5
Clinical FTE

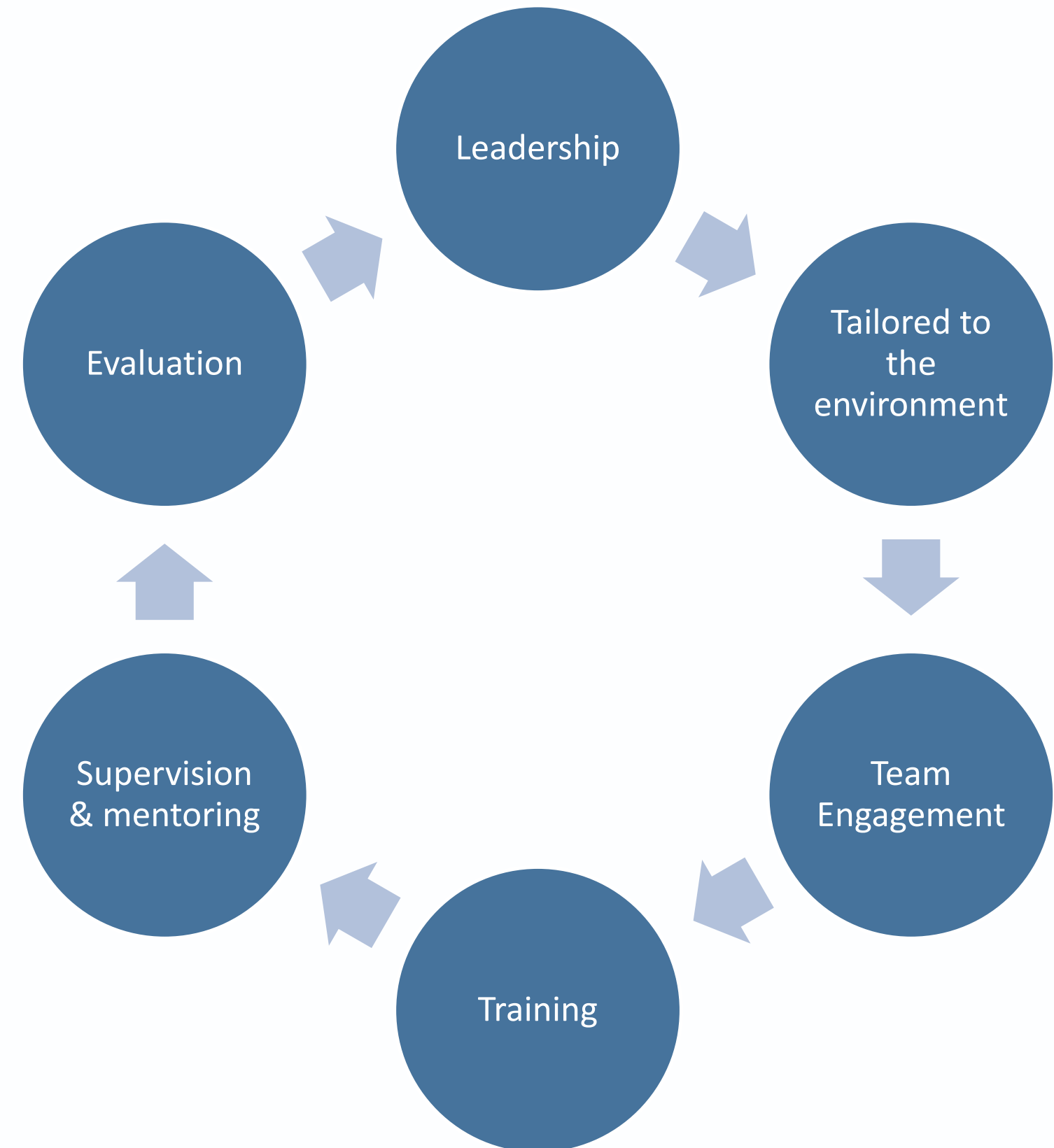
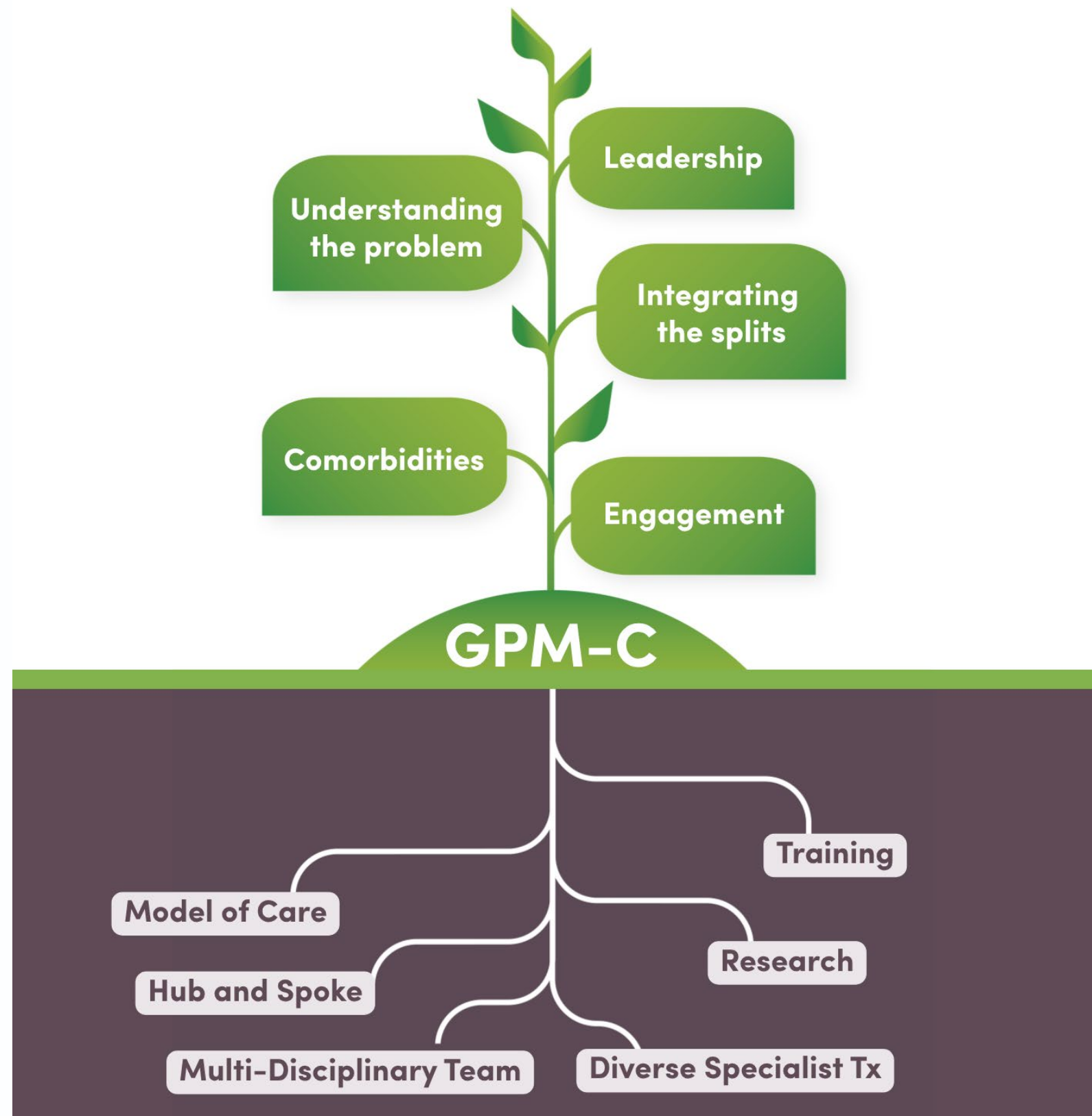
Stepped Care Model



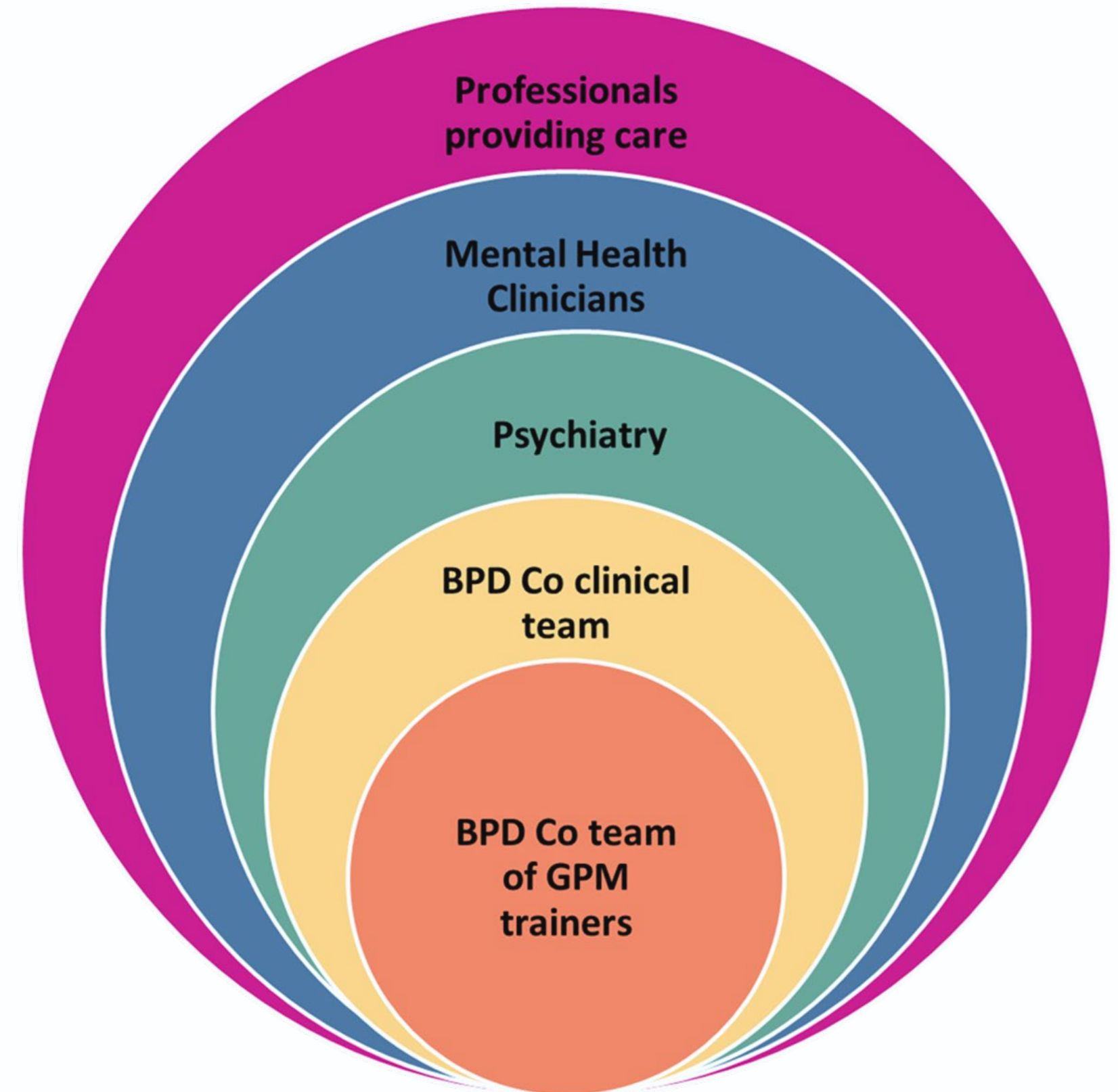
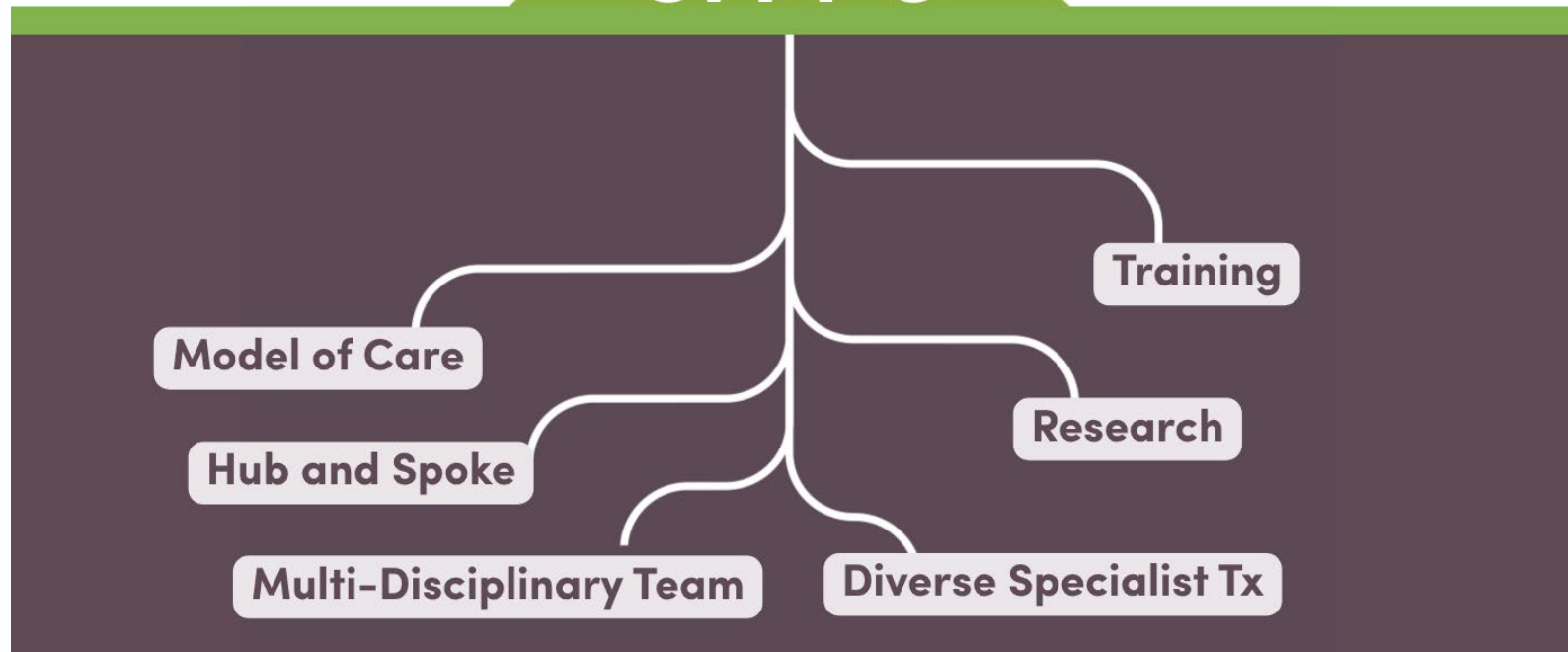
Hub and Spoke



Implementation Process



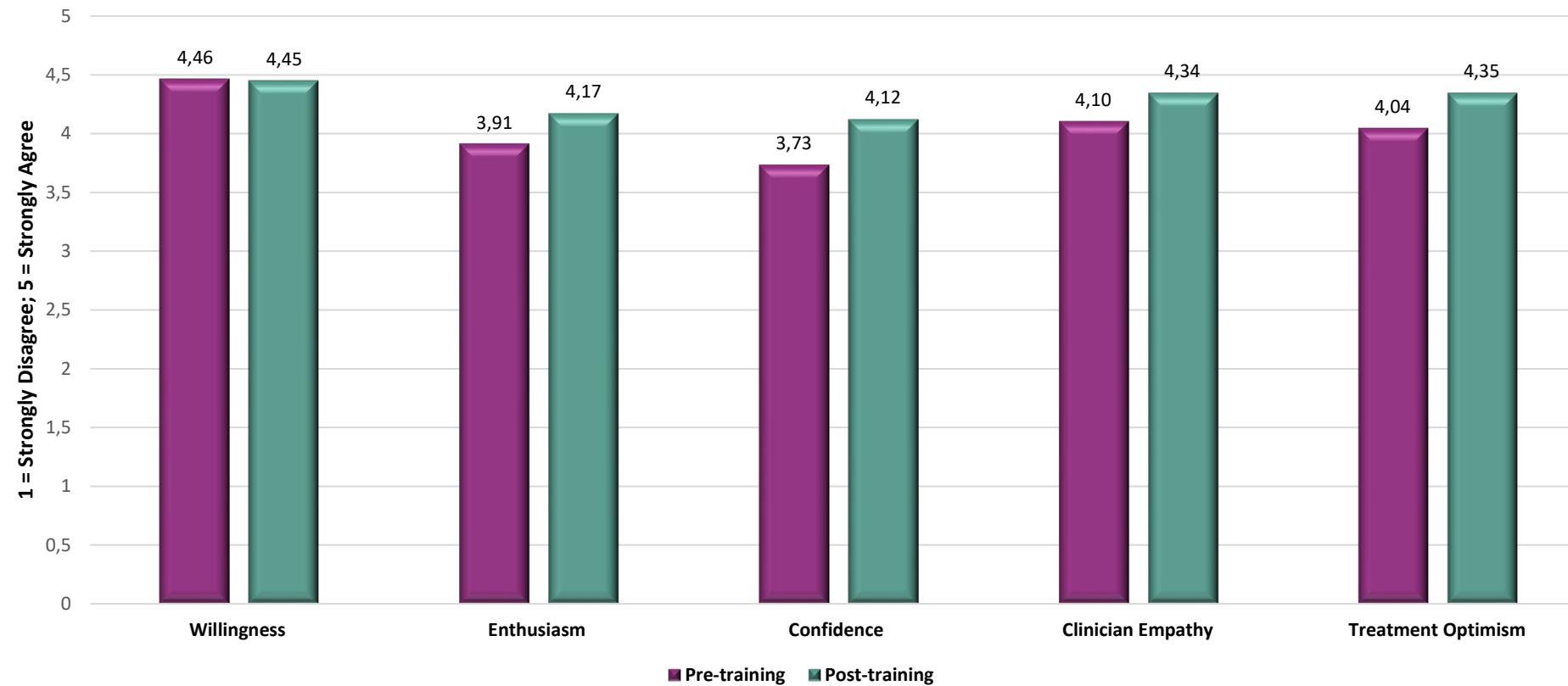
GPM training



GPM Training Evaluation

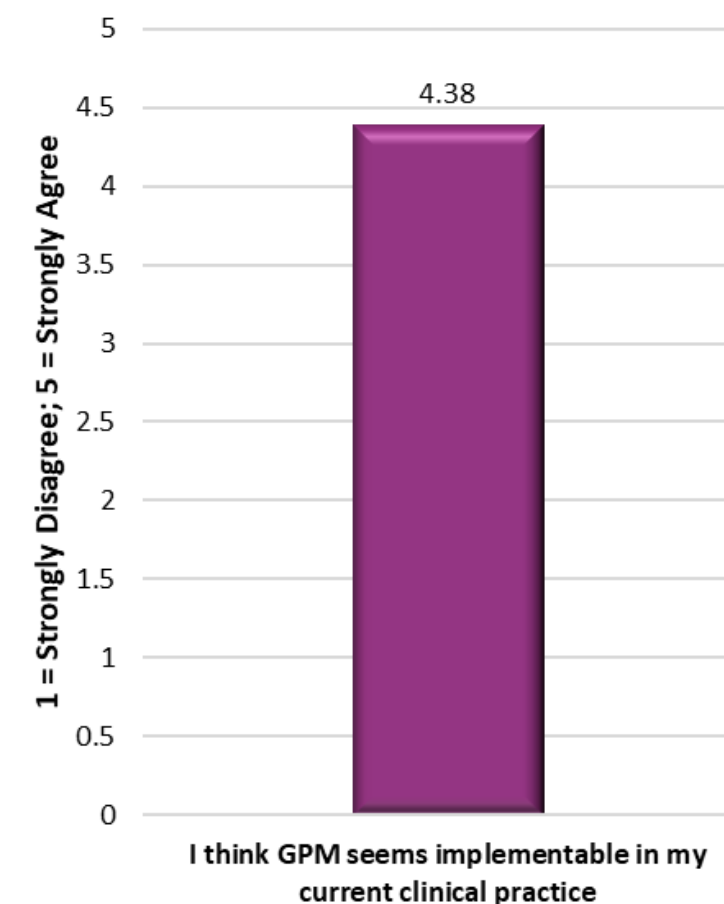


Clinician Attitudes (n = 324)
Nov 2021 - Mar 2026



GPM and GPM-A training 2021 -2026: 461 participants
GPM Complex training 2024: 74 participants

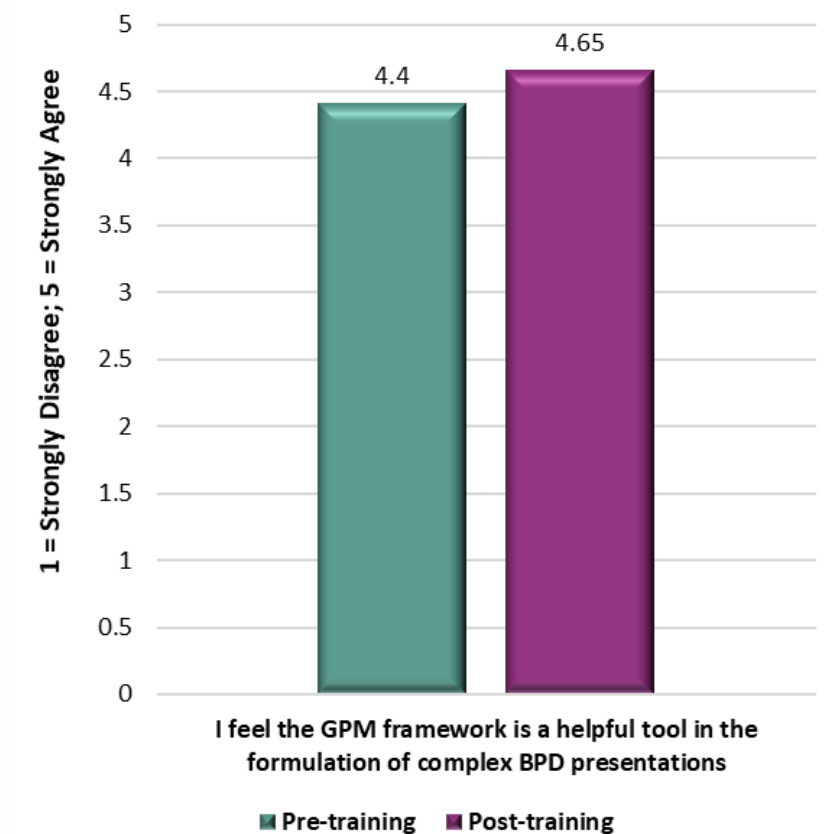
Feasibility Perception (n = 327)
Nov 2021 - Mar 2026



Training-Specific Items (n = 325)
Nov 2021 - Mar 2026



GPM Complex (n = 48)
Mar 2024

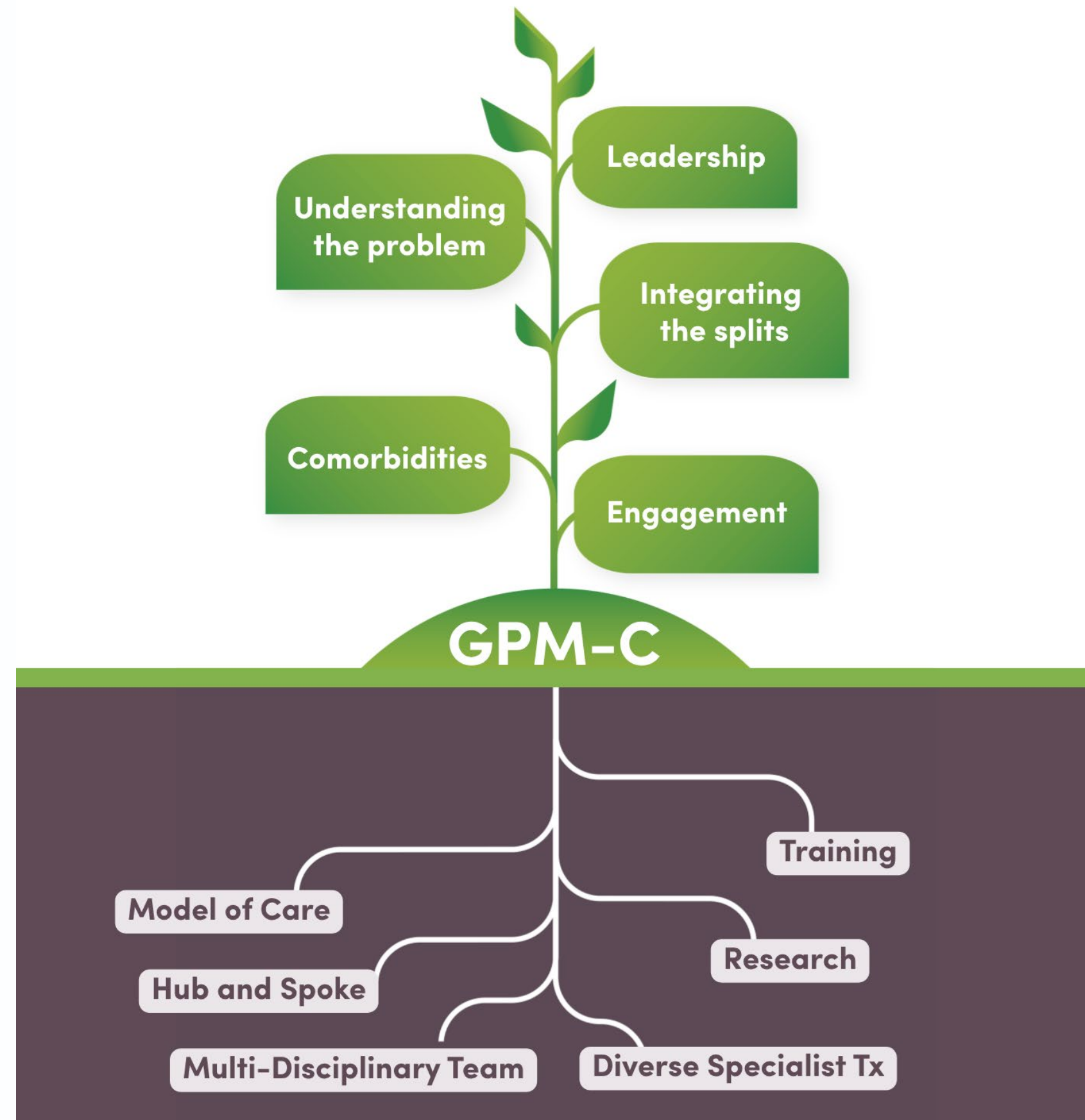


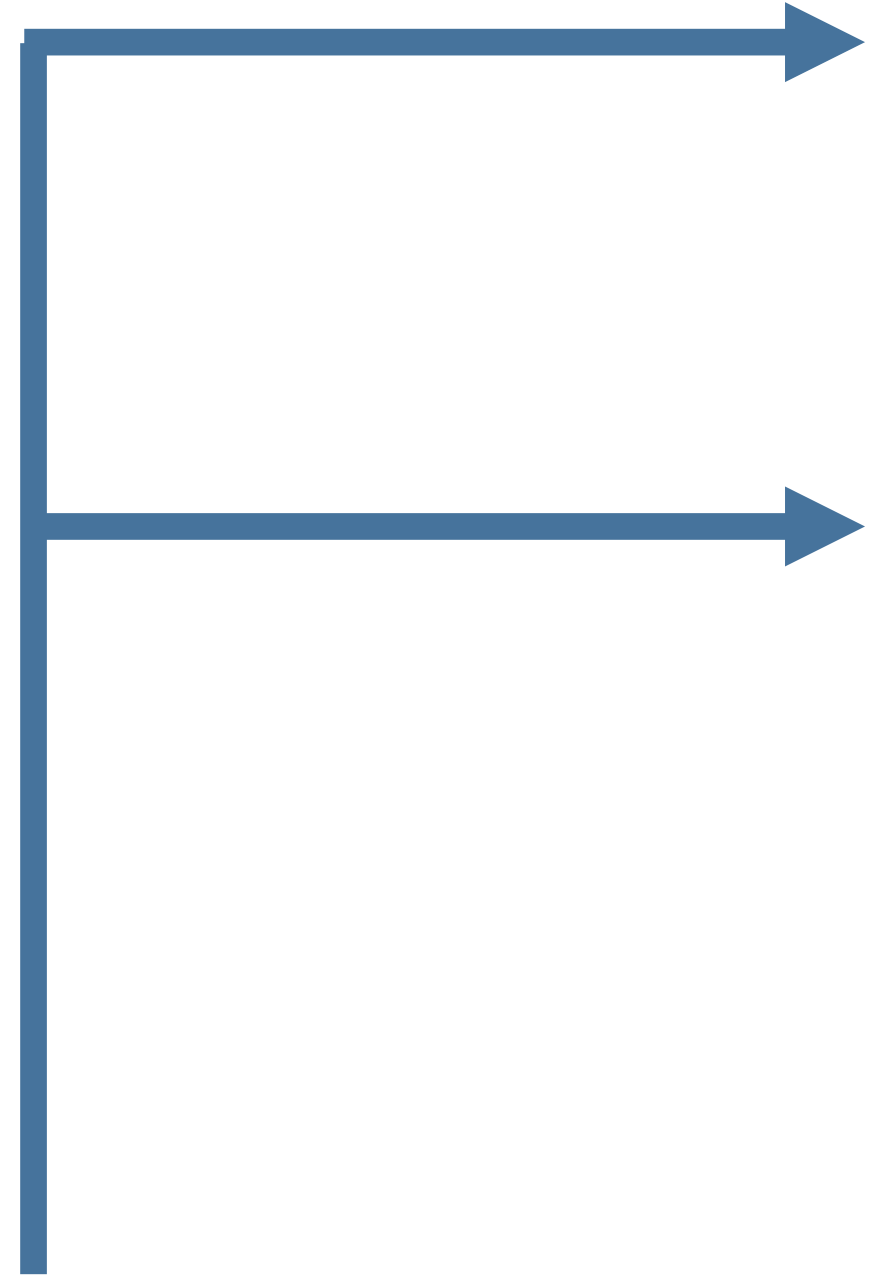
Complexity



- 3 or more comorbid psychiatric diagnoses
- Frequent acute service utilisation
- Presenting with high risk
- Requiring support from multiple systems (Mental Health, Acute hospital/ED, First Responders, NDIS)

GPM – COMPLEX CARE PRINCIPLES





Connected
Controlling-caregiving
Safety-seeking

Threatened
Controlling-punitive
Stress- Fight or flight

Alone
Unanchored from reality

Despair
Worthless, hopeless
Suicidal, lost

Real or perceived threat
to self or relationship with
other

Withdrawal of others

Unilateral intervention by
others to rescue, confront,
or contain (interventions,
hospitalizations, police)

***GPM's Interpersonal
Hypersensitivity
(IHS) Model***

GPM: Therapeutic approach

- **Education is essential** – especially for the social safety network
- **Non-specific factors are central** – reliability, listening, concern
- **Relational issues are central** – attachment, trust
- **Situational changes can be essential** – advise, assist
- **Pragmatism** – every patient is different; forego theory if it isn't working; if not now, wait



Case Study



Background

Name: Lenora

Details: 16 yo female

Background: Complex developmental trauma, disrupted attachment. Removed from parents as a child, placed in care with grandparents, then returned to live with mother age 14yo. Removed from mother's care by Child Protection Services, placed in residential care with multiple placement changes and breakdowns.

Maladaptive care seeking behaviour, frequent presentations to Hospital following self harm and presenting with physical issues to elicit admission, some complaints fictitious.

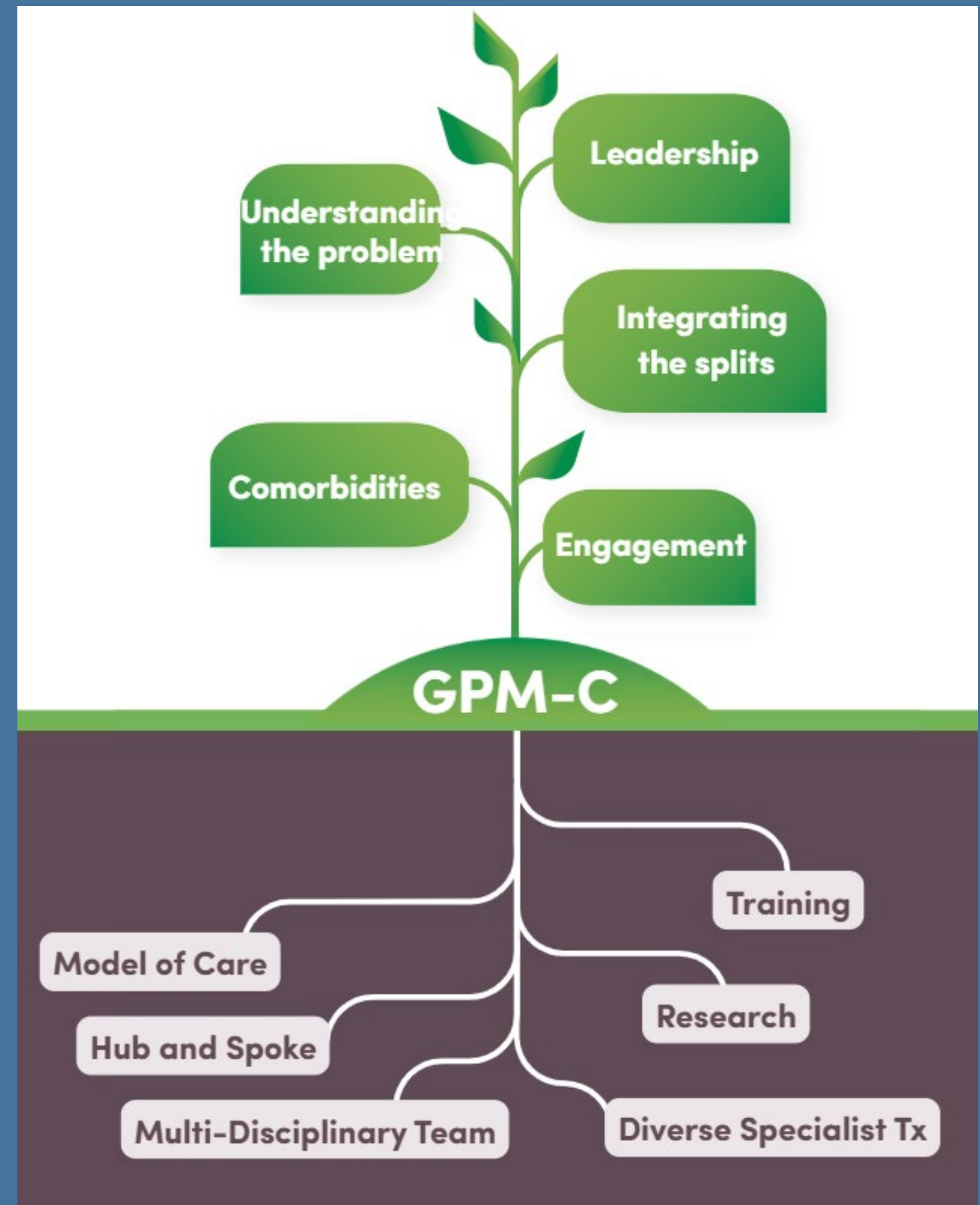
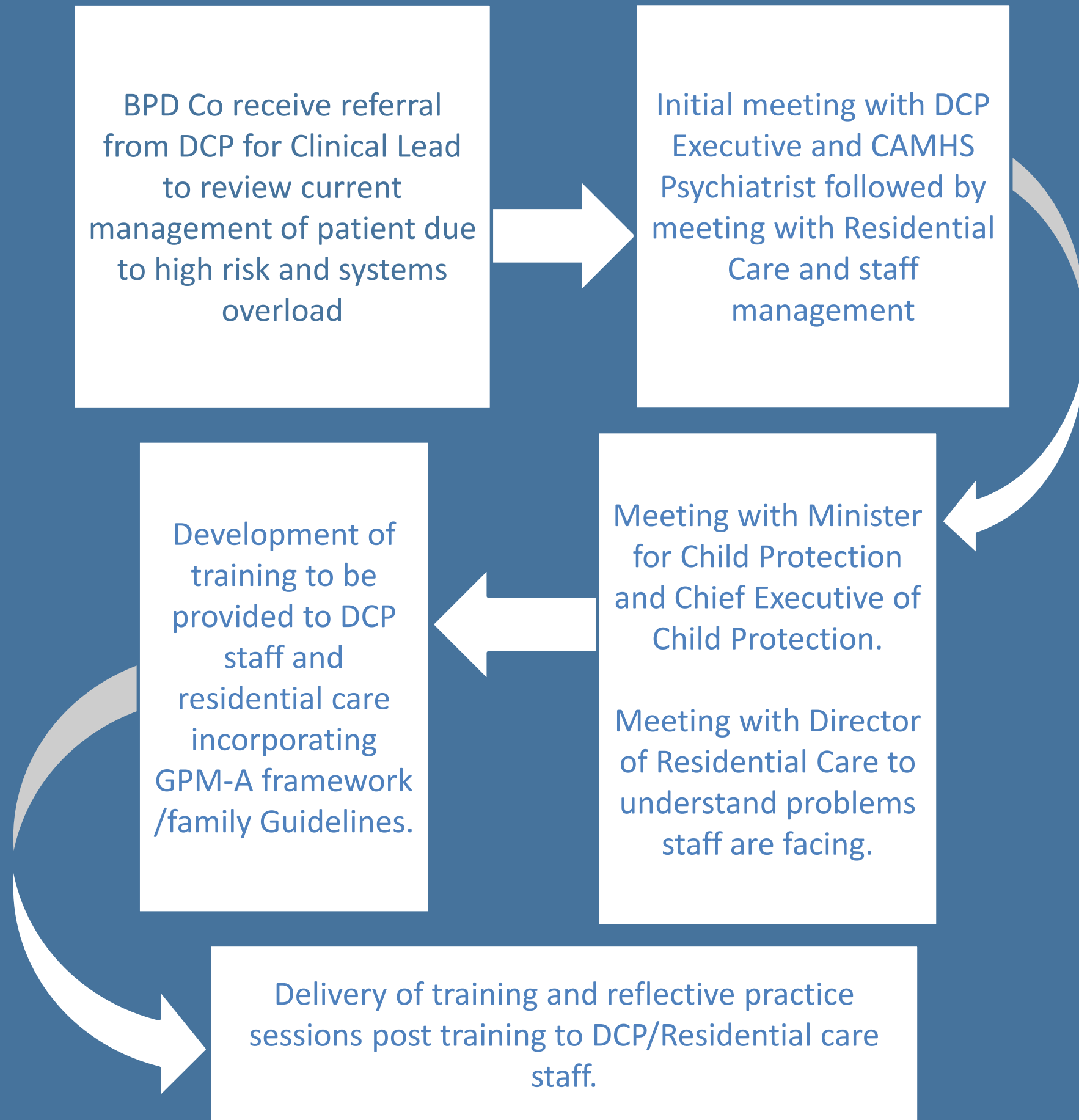


Symptoms: emotional dysregulation, auditory/visual hallucinations, suicidal/homicidal ideation, severe self-harm ingestion of glass, razor blades, self starvation.

Diagnosis : BPD, C-PTSD, FND, ADHD, ID.

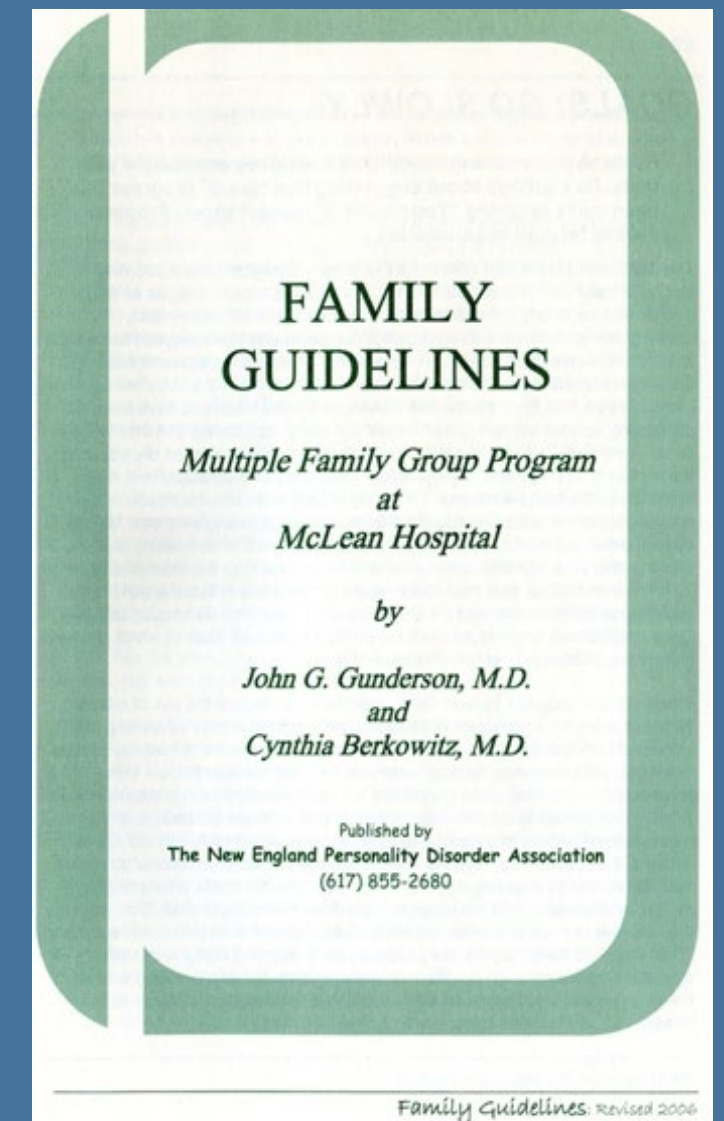
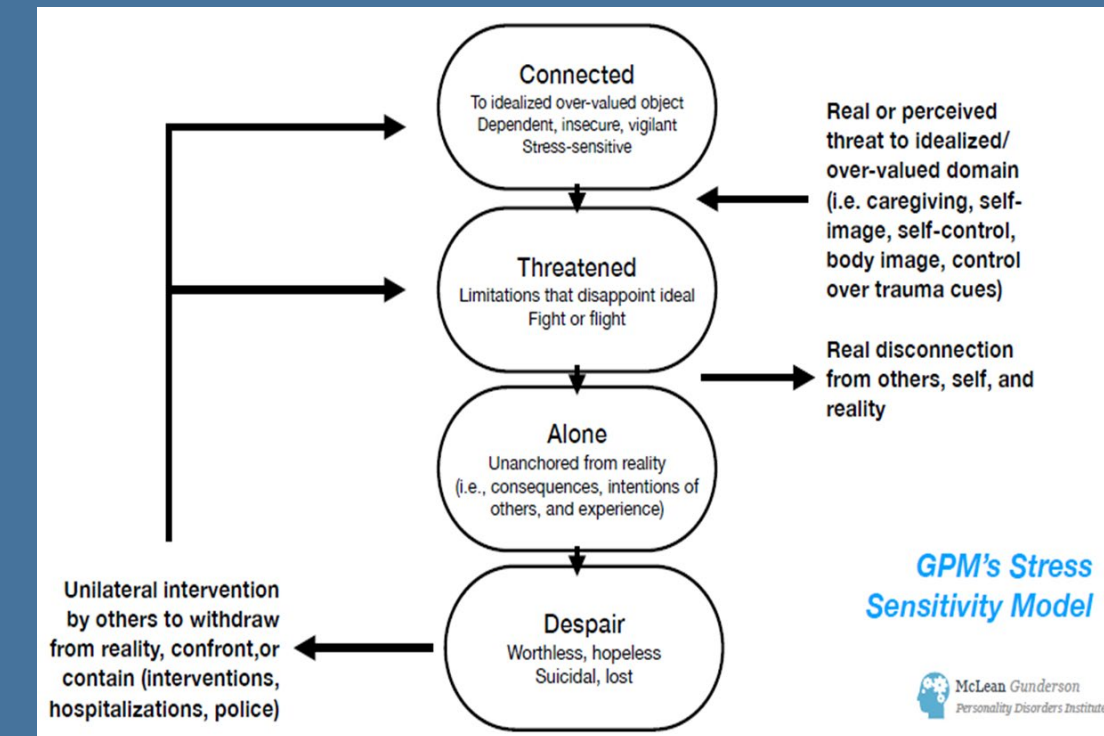
Services involved: Department of Child Protection, Residential Care, CAMHS Guardianship team, Children's Hospital ED, Adolescent inpatient ward, RAH surgical team, RAH consultation/liaison team, SAAS, SAPOL, Education, NDIS





Training the residential care team

- Introducing the ICM as a framework to help increase understanding
- Exploring how to lean in, to be active and not reactive, to get them more organised, responsive, predictable, consistent and reliable
- Using the principles in the family guidelines to:
 - Providing care not treatment
 - Keeping things cool and calm
 - Change is difficult and fraught with fears – go slowly with setting goals
 - Being realistic about expectations
 - Not getting defensive in the face of accusations and criticisms
 - Listening to negative feelings
 - Paying attention to self destructive acts
 - Acting in concert with one another



Feedback from staff after training and reflective practice sessions introducing GPM framework;

They acknowledge they were not responding to Lenora but to the system needs/demands. That the high number of staff/services involved was more about how many people it takes for staff to feel safe.

They tell you they have reduced the care team and have noticed there is less interpersonal noise in the house.

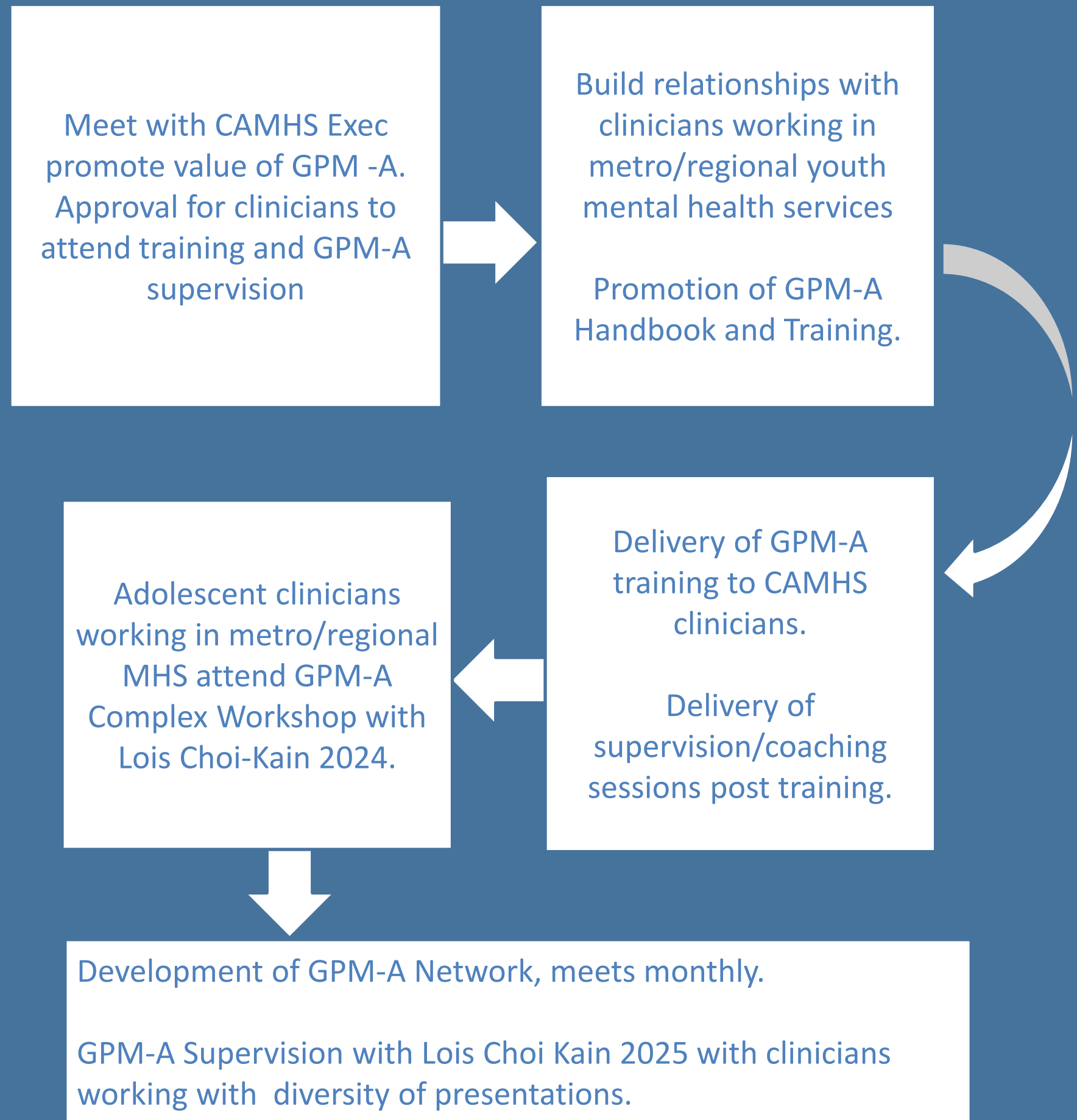
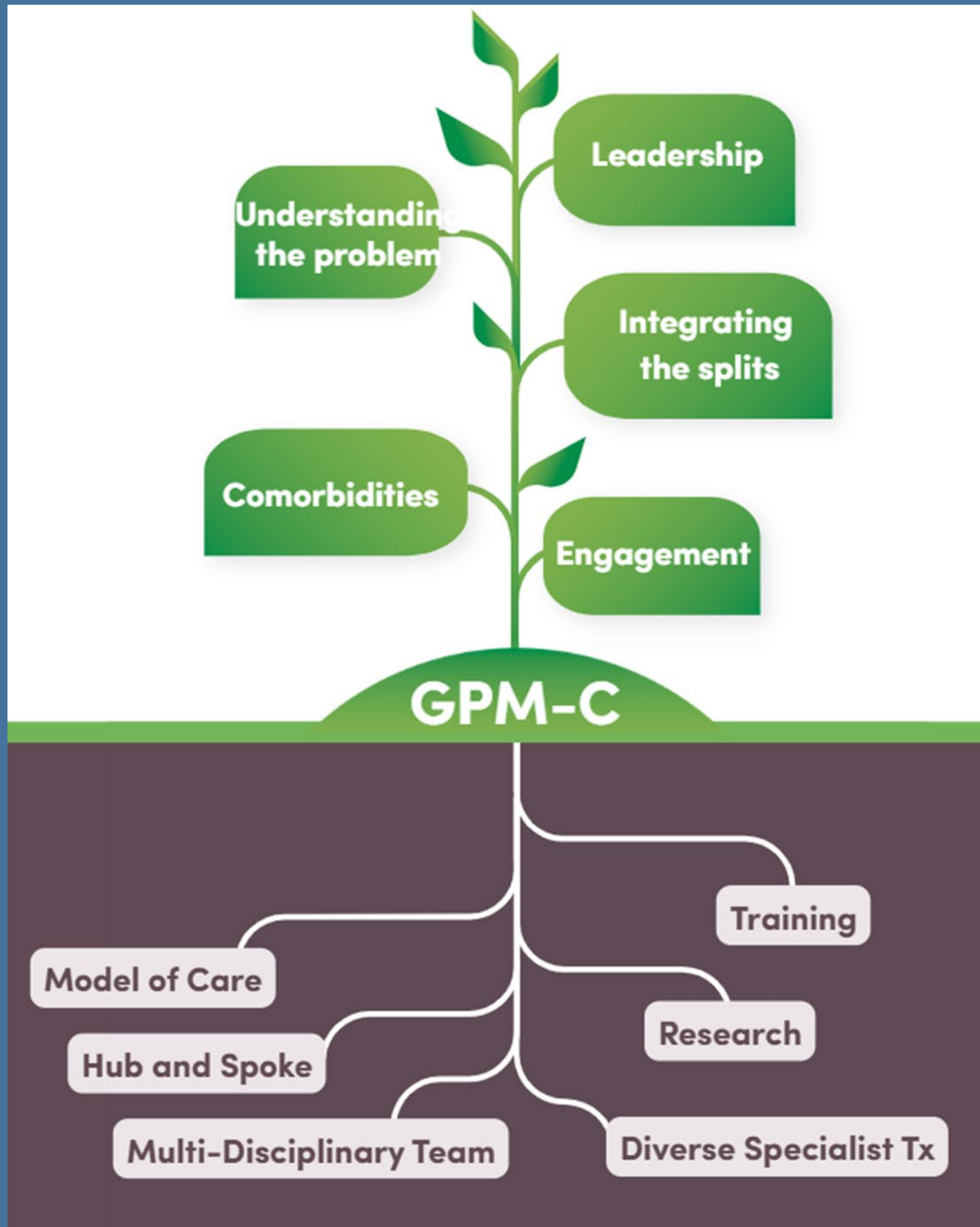
They are focusing on spending time with Lenora, instead of filling in forms about her, taking the time to lean in and have noticed their tolerance for risk has increased. That there is a focus on consistent behaviour from staff.

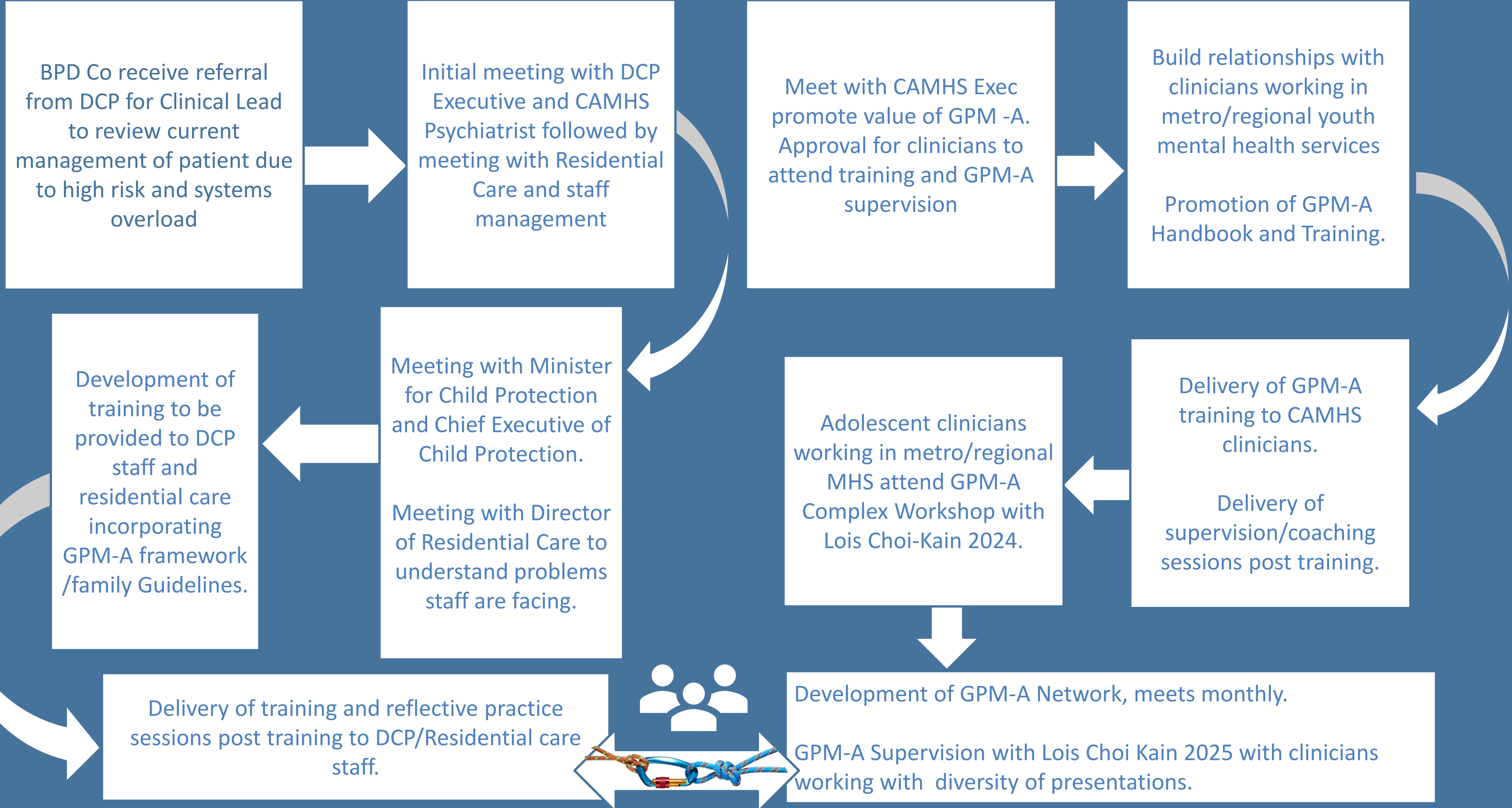


You meet with the CAMHS clinician to provide GPM-A coaching until they can attend training and supervision:

- They let you know the GPM-A approach is helping them manage their own anxiety from the daily emails coming in from multiple services, which cause them to step out of their lane.
- They are focusing on their job of maintaining a therapeutic alliance with Lenora and instilling hope and encouraging agency



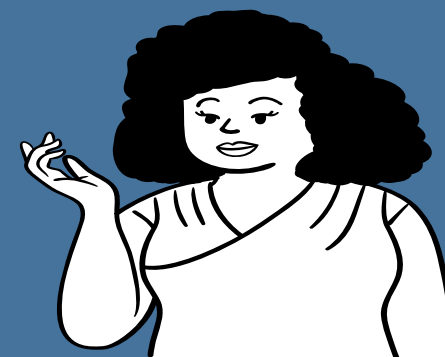
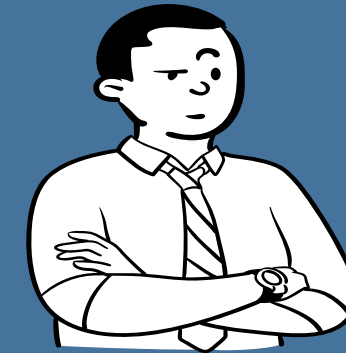




Reflective practice session to the residential care team and supervision to CAMHS clinicians.

Feedback from staff attending the reflective practice highlights how they feel:

- They have been on a BPD learning journey together
- They are being more of a detective about what is going on for the young person
- They have a greater understanding of connection rather than attention
- Senior staff have been modelling leaning in to new staff
- They are staying in their lane
- Getting back to basics and keeping it simple
- Communication is improving, providing consistent messaging as a team and initiating restorative conversations when things have cooled down
- Less punitive in approach
- Learning how to hold risk that it is all helping with the next young person they will be working with



GPM framework for BPD Co Team



Organising framework

- Shared language
- Scaffolding and integration of diverse specialist therapies
- Clarity of roles and responsibilities
- Realistic expectations
- Helps manage countertransference
- Maintaining limits





THANK YOU



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END of presentation