PROJECT AIR

A PERSONALITY DISORDERS STRATEGY

Overview of the Project Air Strategy for Personality Disorders and challenges to implementing BPD treatment principles within the NSW public and private mental health systems

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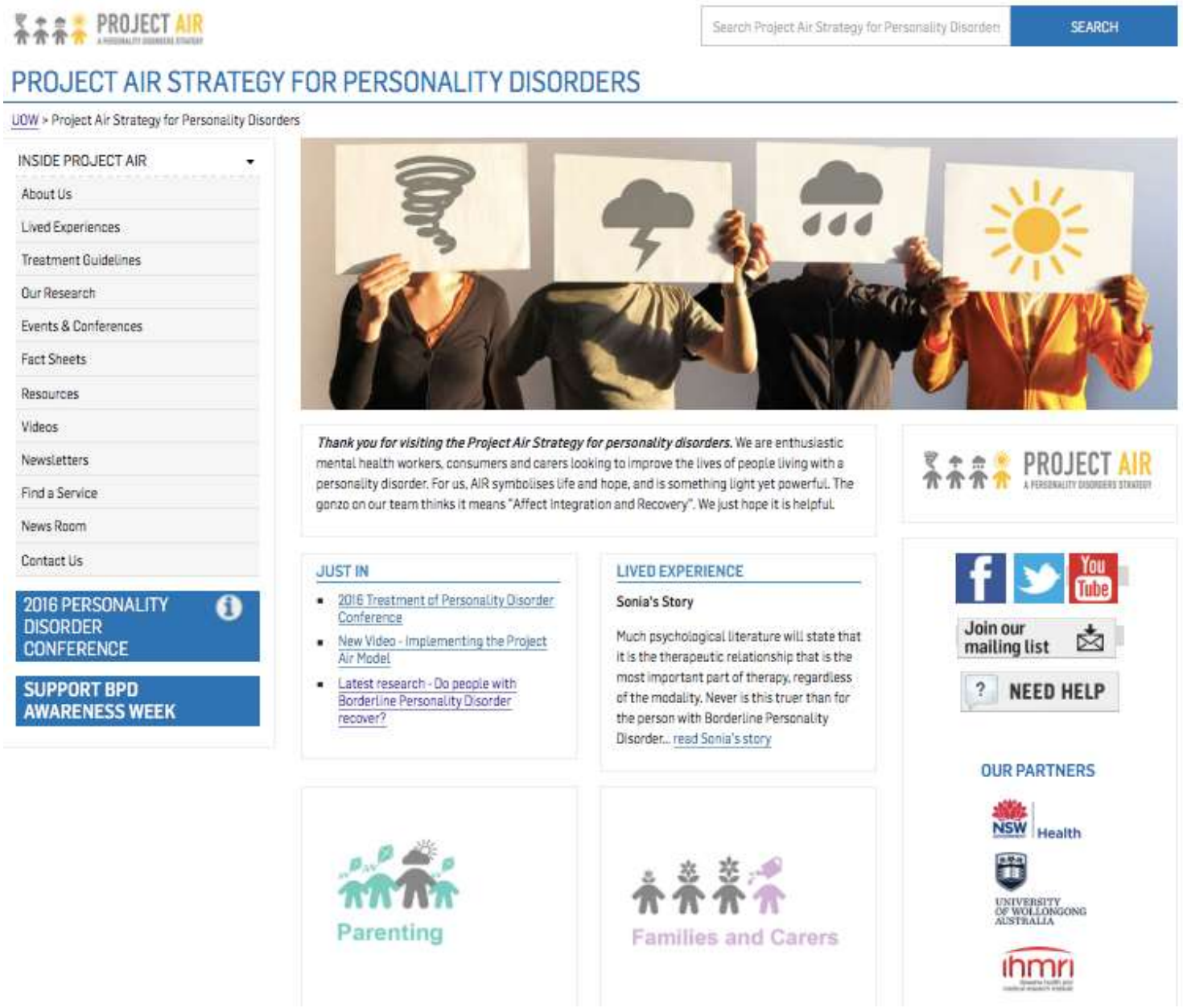
NSW GOVERNMENT Health

ihmri illawarra health and medical research institute

http://www.projectairstrategy.org



Project Air Strategy for Personality Disorders

1. **Improve** the capacity of mainstream mental health services to manage and treat personality disorders
2. **Expand** specialist treatment options including improved referral pathways between generic and specialist treatment
3. **Deliver** well constructed and supported education
4. **Evaluate** expert intervention models to provide guidance for future service development

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REDESIGNING SERVICES

ENGAGING & INSPIRING SERVICE LEADERS

PROVIDING MANAGERS WITH SYSTEMS TO BUILD CHANGE

UPGRADING MENTAL HEALTH STAFF SKILLS

WHOLE OF SERVICE TRAINING

SPECIALIST SKILLS TRAINING

EVALUATING OUTCOMES

MORE CONFIDENT & SKILLED STAFF

BETTER PATIENT OUTCOMES

ENHANCING QUALITY OF CLINICAL SERVICES

EARLY INTERVENTION & PSYCHOLOGICAL TREATMENT

COMPLEX CARE REVIEWS

IMPROVING AWARENESS INFORMATION

WEBSITE, FACT SHEETS, & GUILDELINES

PUBLIC EVENTS & CONFERENCES

CONNECTING WITH FAMILIES, CARERS & CONSUMERS

GROUP SUPPORT MEETINGS

EDUCATION SESSIONS

EXPERT ADVISORY COMMITTEE

The Strategy is accountable to the Mental Health and Drug and Alcohol Program Councils of NSW Ministry of Health.

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Eileen McDonald, Carer Representative and Advocate

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Kylie Pillon, Consumer advisor, NSW Consumer Advisory Group

Karina Whitehurst, Consumer Advisor, SES LHD

Sonia Neale, Consumer advocate

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Peter Heggie, Carer Advisor, ARAFMI

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Consultant Trainers: Professor Andrew Chanen, Dr Louise McCutcheon, Professor Brin Grenyer, Simon Milton, Dr Andrew McKenzie, Dr Annemarie Bickerton, Toni Garrety, Janice Nair, Alison Soutter

Effective strategies with personality disorders:

Understanding what works

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1991-1992

Cognitive-Behavioral Treatment of Chronically Parasuicidal Borderline Patients

Marsha M. Linehan, PhD; Hubert E. Armstrong, PhD; Alejandra Suarez, PhD; Douglas Allmon, PhD; Heidi L. Heard

• **A randomized clinical trial was conducted to evaluate the effectiveness of a cognitive-behavioral therapy, ie, dialectical behavior therapy, for the treatment of chronically parasuicidal women who met criteria for borderline personality disorder. The treatment lasted 1 year, with assessment every 4 months. The control condition was "treatment as usual" in the community. At most assessment points and during the entire year, the subjects who received dialectical behavior therapy had fewer incidences of parasuicide and less medically severe parasuicides, were more likely to stay in individual therapy, and had fewer inpatient psychiatric days. There were no between-group differences on measures of depression, hopelessness, suicide ideation, or reasons for living although scores on all four measures decreased throughout the year.**

(*Arch Gen Psychiatry*. 1991;48:1060-1064)

tients with BPD.[8] Although a number of brief studies have suggested that psychosocial interventions might effectively reduce parasuicidal behavior,[9] none have focused specifically on parasuicidal patients who meet criteria for BPD. O
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An Outcome Study of Psychotherapy for Patients With Borderline Personality Disorder

Janine Stevenson, M.B., B.S., F.R.A.N.Z.C.P., and Russell Meares, M.D., F.R.A.N.Z.C.P., F.R.C.Psych.

Objective: This study evaluated the effectiveness of well-defined outpatient psychotherapy for patients with borderline personality disorder. Method: Thirty patients with borderline personality disorder diagnosed according to the DSM-III *criteria were given twice weekly outpatient psychotherapy for 12 months by trainee therapists who were closely supervised. The treatment approach was based on a psychology of self (this term being used in its broad sense), and strong efforts were made to ensure that all therapists adhered to the treatment model. Outcome measures included frequency of use of drugs (both prescribed and illegal), number of visits to medical professionals, number of episodes of violence and self-harm, time away from work, number of hospital admissions, time spent as an inpatient, score on a self-report index of symptoms, and number of* DSM-III *criteria (weighted for frequency, severity, and duration) fulfilled. Results: The subjects showed statistically significant improvement from the initial assessment to the end of the year of follow-up on every measure. Moreover, 30% of the subjects no longer fulfilled the* DSM-III *criteria for borderline personality disorder. This improvement had persisted 1 year after the cessation of therapy. Conclusions: The results suggest that a specific form of psychotherapy is of benefit for patients with borderline personality disorder.*

(Am J Psychiatry 1992; 149:358–362)

2003

NHS

National Institute for Mental Health in England

Personality disorder: No longer a diagnosis of exclusion

Policy implementation guidance for the development of services for people with personality disorder

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2005

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25 years of research progress
1991 - 2016

Seminar

Borderline personality disorder

Falk Leichsenring, Eric Leibing, Johannes Kruse, Antonia S New, Frank Leweke

Lancet 2011; 377: 74–84

Department of Psychosomatics and Psychotherapy, University of Giessen, Germany (Prof F Leichsenring DSc, Prof J Kruse MD, Prof F Leweke MD); Department of Psychosomatic Medicine and Psychotherapy, University of Goettingen, Germany (Prof E Leibing DSc); Mental Illness Research, Education and

Recent research findings have contributed to an improved understanding and treatment of borderline personality disorder. This disorder is characterised by severe functional impairments, a high risk of suicide, a negative effect on the course of depressive disorders, extensive use of treatment, and high costs to society. The course of this disorder is less stable than expected for personality disorders. The causes are not yet clear, but genetic factors and adverse life events seem to interact to lead to the disorder. Neurobiological research suggests that abnormalities in the frontolimbic networks are associated with many of the symptoms. Data for the effectiveness of pharmacotherapy vary and evidence is not yet robust. Specific forms of psychotherapy seem to be beneficial for at least some of the problems frequently reported in patients with borderline personality disorder. At present, there is no evidence to suggest that one specific form of psychotherapy is more effective than another. Further research is needed on the diagnosis, neurobiology, and treatment of borderline personality disorder.

www.thelancet.com Vol 377 January 1, 2011

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What 25+ RCTs tell us …

DBT Dialectical Behaviour Therapy

CBT plus treatment as usual

SFT Schema-Focused Therapy

TFP Transference-Focused Psychotherapy

MBT Mentalisation Based Therapy

TEC Therapy by experts in the community

GPM General Psychiatric Management

CAT Cognitive Analytic Therapy for Youth

- **All treatment types work**

BUT:

- **No treatment types are superior**
- **RCTs are all specialist interventions**
- **No whole of service approaches**
- **Many studies now being done on short term therapy**

Guideline-based treatment

AJP in Advance. Published September 15, 2009 (doi: 10.1176/appi.ajp.2009.09010039)

Article

A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder

Shelley F. McMain, Ph.D.
Paul S. Links, M.D.
William H. Gnam, M.D.
Tim Guimond, M.D.
Robert J. Cardish, M.D.
Lorne Korman, Ph.D.
David L. Streiner, Ph.D.

Objective: The authors sought to evaluate the clinical efficacy of dialectical behavior therapy compared with general psychiatric management, including a combination of psychodynamically informed therapy and symptom-targeted medication management derived from specific recommendations in APA guidelines for borderline personality disorder.

Method: This was a single-blind trial in which 180 patients diagnosed with borderline personality disorder who had at least two suicidal or nonsuicidal self-injurious episodes in the past 5 years were randomly assigned to receive 1 year of dialectical behavior therapy or general psychiatric management. The primary outcome measures, assessed at baseline and every 4 months over the treatment period, were frequency and severity of suicidal and nonsuicidal self-harm episodes.

Results: Both groups showed improvement on the majority of clinical outcome measures after 1 year of treatment, including significant reductions in the frequency and severity of suicidal and nonsuicidal self-injurious episodes and significant improvements in most secondary clinical outcomes. Both groups had a reduction in general health care utilization, including emergency visits and psychiatric hospital days, as well as significant improvements in borderline personality disorder symptoms, symptom distress, depression, anger, and interpersonal functioning. No significant differences across any outcomes were found between groups.

Conclusions: These results suggest that individuals with borderline personality disorder benefited equally from dialectical behavior therapy and a well-specified treatment delivered by psychiatrists with expertise in the treatment of borderline personality disorder.

1. Once a week individual meetings
2. Focus on person's priorities (not specifically targeting self-harm and suicidal thinking)
3. Psychoeducation about problems
4. Here and now focus
5. Emotion focus
6. Relationship focus
7. Hospitalisation if helpful

Research not done by Linehan or Gunderson, but both support its validity and findings.

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Five common characteristics of evidence-based treatments for borderline personality disorder

1. Structured (manual directed) approaches to prototypic borderline personality disorder problems
2. Patients are encouraged to assume control of themselves (i.e. sense of agency)
3. Treatment providers help connections of feelings to events and actions
4. Treatment providers are active, responsive, and validating
5. Treatment providers discuss cases, including personal reactions, with others

Bateman, Gunderson, Mulder
(Lancet 2015)

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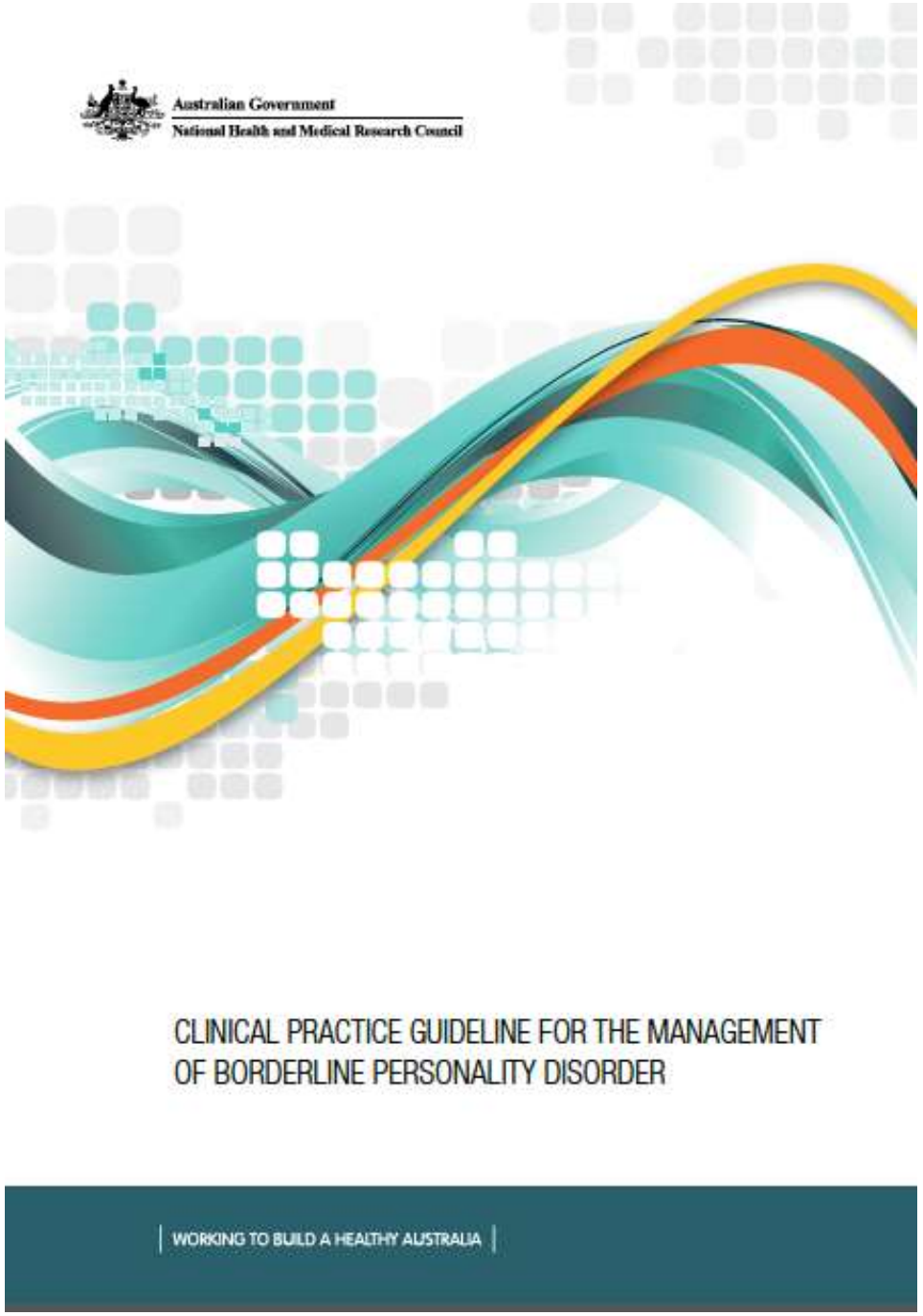
NHMRC Clinical Practice Guideline 2012



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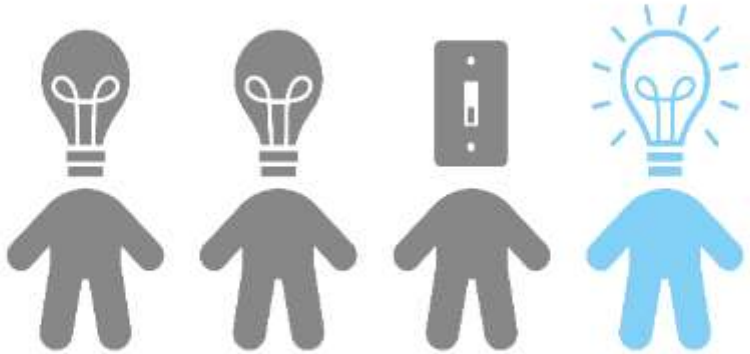
8 Key Recommendations

1. BPD is legitimate diagnosis for healthcare services
2. Structured psychological therapies should be provided
3. Medicines should not be used as primary therapy
4. Treatment should occur mostly in the community
5. Adolescents should get structured psychological therapies
6. Consumers should be offered a choice of psychological therapies
7. Families and carers should be offered support
8. Young people with emerging symptoms should be assessed for possible BPD

Early Intervention in Schools…

SCHOOLS, TEACHERS & STUDENTS



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Supporting carers, family, partners

Journal of Personality Disorders, 28, 2014, 136

SUPPORTING A PERSON WITH PERSONALITY DISORDER: A STUDY OF CARER BURDEN AND WELL-BEING

Rachel C. Bailey, BA (Hons), and Brin F. S. Grenyer, PhD

Personality disorders are characterized by impaired interpersonal functioning. There are few studies and little data available using validated questionnaires on the impact of caring for a person with personality disorder. The 287 carers included in this study were administered the McLean Screening Instrument for Borderline Personality Disorder–Carer Version, Burden Assessment Scale, Grief Scale, Difficulties in Emotion Regulation Scale, Mental Health Inventory–5, and a qualitative question. Scores were compared to those of published comparison groups. Burden and grief were significantly higher than that reported by carers of persons with other serious mental illnesses. Carers endorsed symptoms consistent with mood, anxiety, and posttraumatic stress disorders. A qualitative concept map highlighted the impact of caregiving on the interpersonal environment. Carers of persons with personality disorder report grieving their change in life and impairment in well-being. Carers are burdened, and appear more so than carers of persons with other serious mental illnesses. The results highlight the need for interventions to support carers.

2016 www.projectairstrategy.org

McCarthy *et al. Borderline Personality Disorder and Emotion Dysregulation* (2016) 3:10
DOI 10.1186/s40479-016-0044-2

Borderline Personality Disorder and Emotion Dysregulation

RESEARCH ARTICLE Open Access

A new intervention for people with borderline personality disorder who are also parents: a pilot study of clinician acceptability

Kye L. McCarthy, Kate L. Lewis, Marianne E. Bourke and Brin F. S. Grenyer*

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PLOS ONE

RESEARCH ARTICLE

Recovery from Borderline Personality Disorder: A Systematic Review of the Perspectives of Consumers, Clinicians, Family and Carers

Fiona Y. Y. Ng, Marianne E. Bourke, Brin F. S. Grenyer*

School of Psychology, Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong, New South Wales, Australia

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OPEN ACCESS

Citation: Ng FYY, Bourke ME, Grenyer BFS (2016) Recovery from Borderline Personality Disorder: A Systematic Review of the Perspectives of Consumers, Clinicians, Family and Carers. PLoS ONE 11(8): e0160515. doi:10.1371/journal.pone.0160515

Abstract

Purpose

Longitudinal studies support that symptomatic remission from Borderline Personality Disorder (BPD) is common, but recovery from the disorder probably involves a broader set of changes in psychosocial function over and above symptom relief. A systematic review of literature on both symptomatic and personal recovery from BPD was conducted including the views of consumers, clinicians, family and carers.

What do people with BPD want?

- There are four main areas:

1. Symptomatic improvement – reduction in emotional dysregulation, impulsivity, anxiety and suicidal ideas
2. Greater wellbeing - paid work, reductions in medications, better health
3. Improved relationships – especially with close family and partners, greater trust and more secure attachments
4. Improved self-identity – self-confidence, self-acceptance, sense of direction in life

Implementing Project Air in the NSW public and private mental health systems

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The Need …

Soc Psychiatry Psychiatr Epidemiol (2000) 35: 531–538

ORIGINAL PAPER

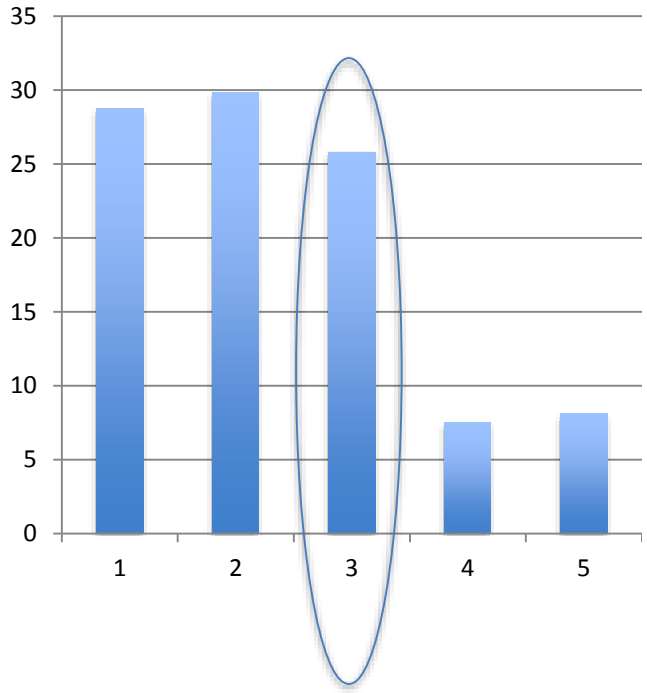
H. J. Jackson · P. M. Burgess

Personality disorders in the community: a report from the Australian National Survey of Mental Health and Wellbeing

- **6.5% of the population**: 1.5 million Australians have a diagnosable personality disorder
- 1.1% of the population have schizophrenia (i.e. 285,000 people in Australia)

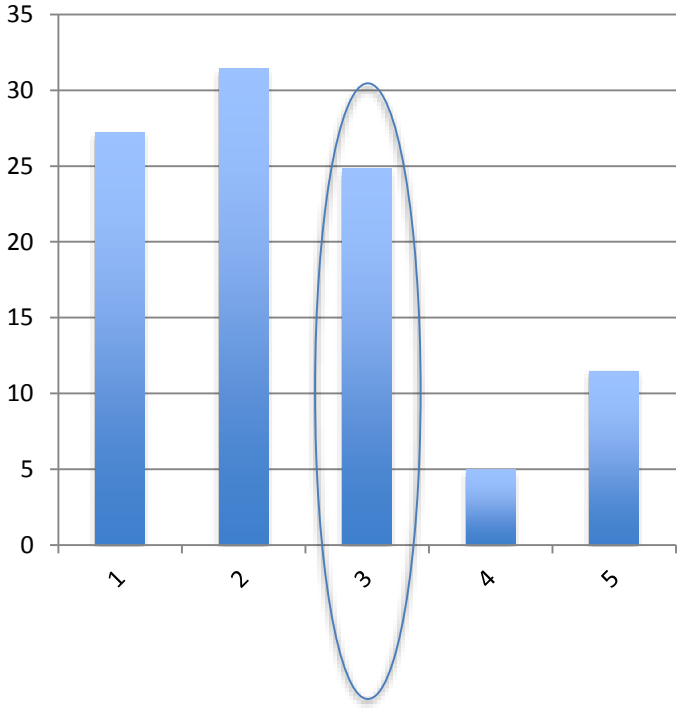
Who presents to Emergency and Hospital with mental health problems?

Emergency



Source: all mental health ED presentations Nov 2008 - Nov 2012 Illawarra Shoalhaven LHD (N=1988)
Personality disorders and related conditions = **26% of presentations**

Inpatient admission



Source: all mental health inpatient presentations Nov 2008 - Nov 2012 Illawarra Shoalhaven LHD (N=6338)
Personality disorders and related conditions = **25% of presentations**

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Australasian Psychiatry • Vol 15, No 1 • February 2007

SELF-HARM

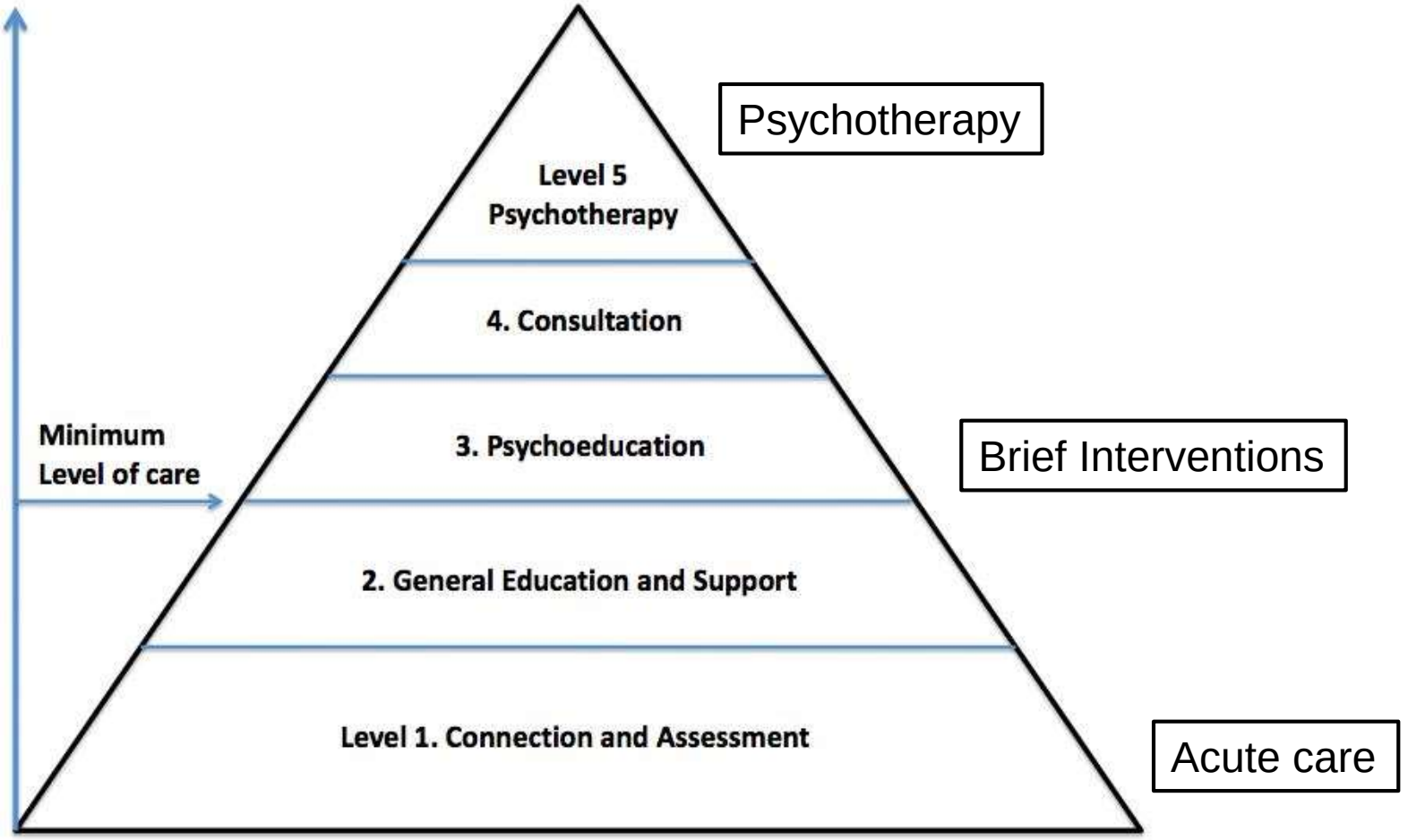
The Green Card Clinic: overview of a brief patient-centred intervention following deliberate self-harm

Kay Wilhelm, Adam Finch, Beth Kotze, Karen Arnold, Geoff McDonald, Peter Sternhell and Beaver Hudson

Objectives: *The aim of this study was to present an overview of the Green Card Clinic, a novel brief intervention service for patients presenting to the emergency department following deliberate self-harm (DSH) or with suicidal ideation, to examine its effectiveness in terms of service utilization, and patient and clinician feedback, and to explore the correlates of repeated DSH.*

Method: *The aims and structure of the Green Card Clinic are described. We highlight our patient-centred approach involving self-identification of difficulties from a list of problem areas, coupled with tailored intervention strategies. Relevant data are presented and characteristics of repeat DSH patients are compared to the first-episode group.*

Stepped care for personality disorders



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gold card clinic

Do you experience any of these?

- Impulsive and self-destructive behavior?
- Changing emotions and strong, overwhelming feelings?
- Problems with identity and sense of self?
- Thoughts of suicide and self-harm?
- Challenging personality features?

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What is the Gold Card Clinic?

The Gold Card Clinic is a brief intervention service that offers people in crisis a set of specific individual appointments. During these sessions, an experienced clinician will talk with you and provide support, help you navigate your way through the crisis, and link you into further services as needed.

Who can attend?

The Gold Card Clinic provides help for young people and adults. You or your local health professional can call your closest service and discuss a referral to the clinic. The clinic works in specific ways so it is important to ensure it will suit your needs.

What will I do in the Gold Card Clinic sessions?

An experienced clinician will work with you to:

- Provide support and encouragement
- Explore factors that led to your current situation
- Develop a plan to assist in the prevention of future crises & problems
- Gain clarity on your goals and help you maintain focus
- Provide you with additional information and resources to aid your recovery
- Link you into other services where desired

Who can refer to the Gold Card Clinic?

The Gold Card Clinic accepts referrals from emergency departments and hospitals, other services such as Headspace, School Counsellors and General Practitioners whose clients present in crisis, including with recent self-harm or thoughts of suicide. Where appropriate, clinicians may refer to the Gold Card Clinic rather than sending clients to hospital. Often it is more helpful to refer clients in crisis for community treatment rather than hospital services. Some Gold Card Clinic services may require an assessment prior to booking in an appointment, call the nearest service for information on how to refer.

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Our training outcomes

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Number of trainings delivered and total number of attendance overall and by year

	Number of trainings delivered	Number of attendances
2011	49	879
2012	18	813
2013	22	615
2014	8	72
2015	24	686
2016	14	935
Total	**133**	**4000**

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Reported professions of staff attending Project Air training

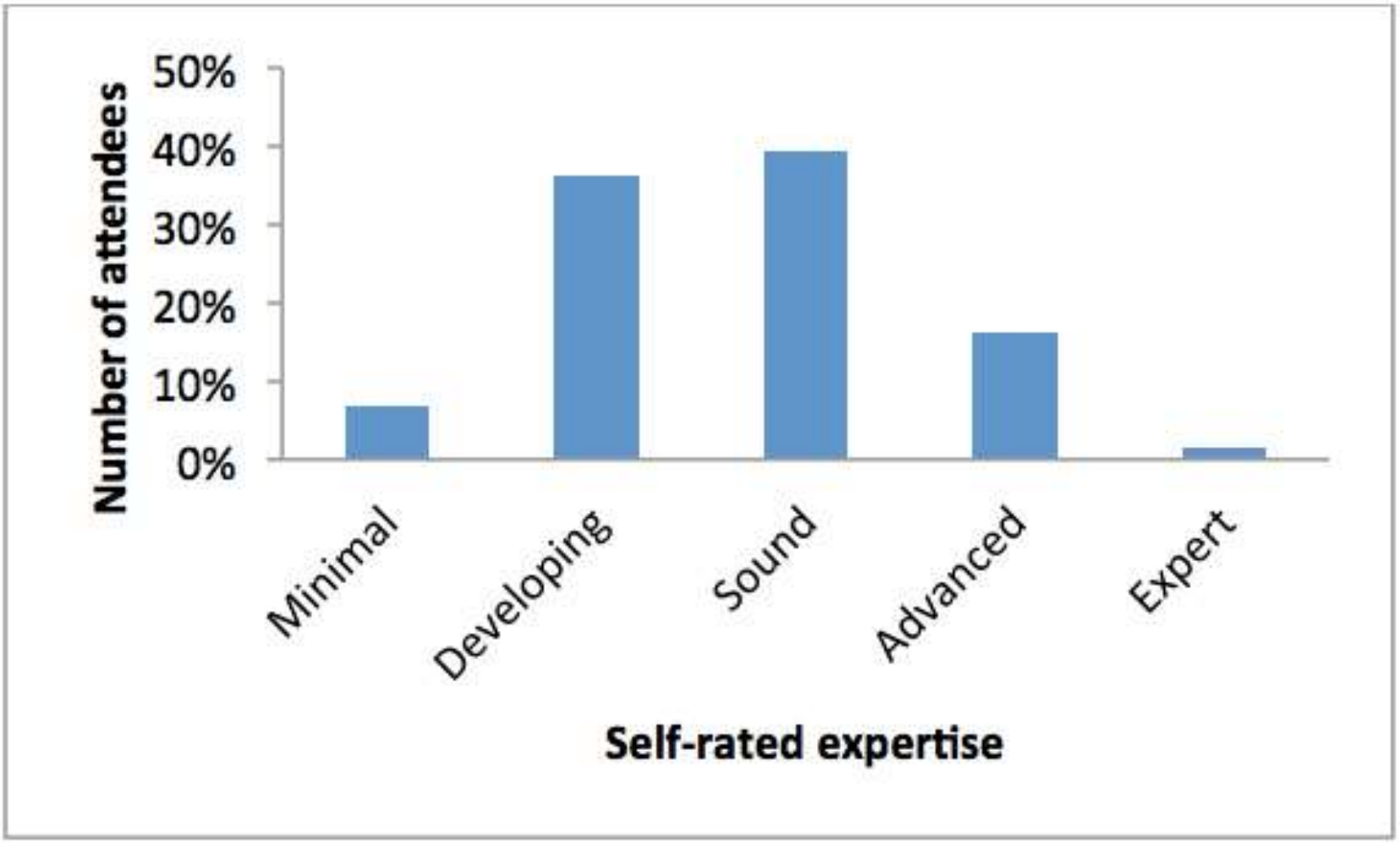
Staff professions	%
Nurse	31%
Psychologist	24%
Allied Health	17%
Social Worker	6%
Support Worker	5%
Medico**	4%
Leadership	4%
Psychiatrist	1%
Other***	4%
Not stated	5%
Total	**100%**

*Allied includes speech therapist, occupational therapist, dietician

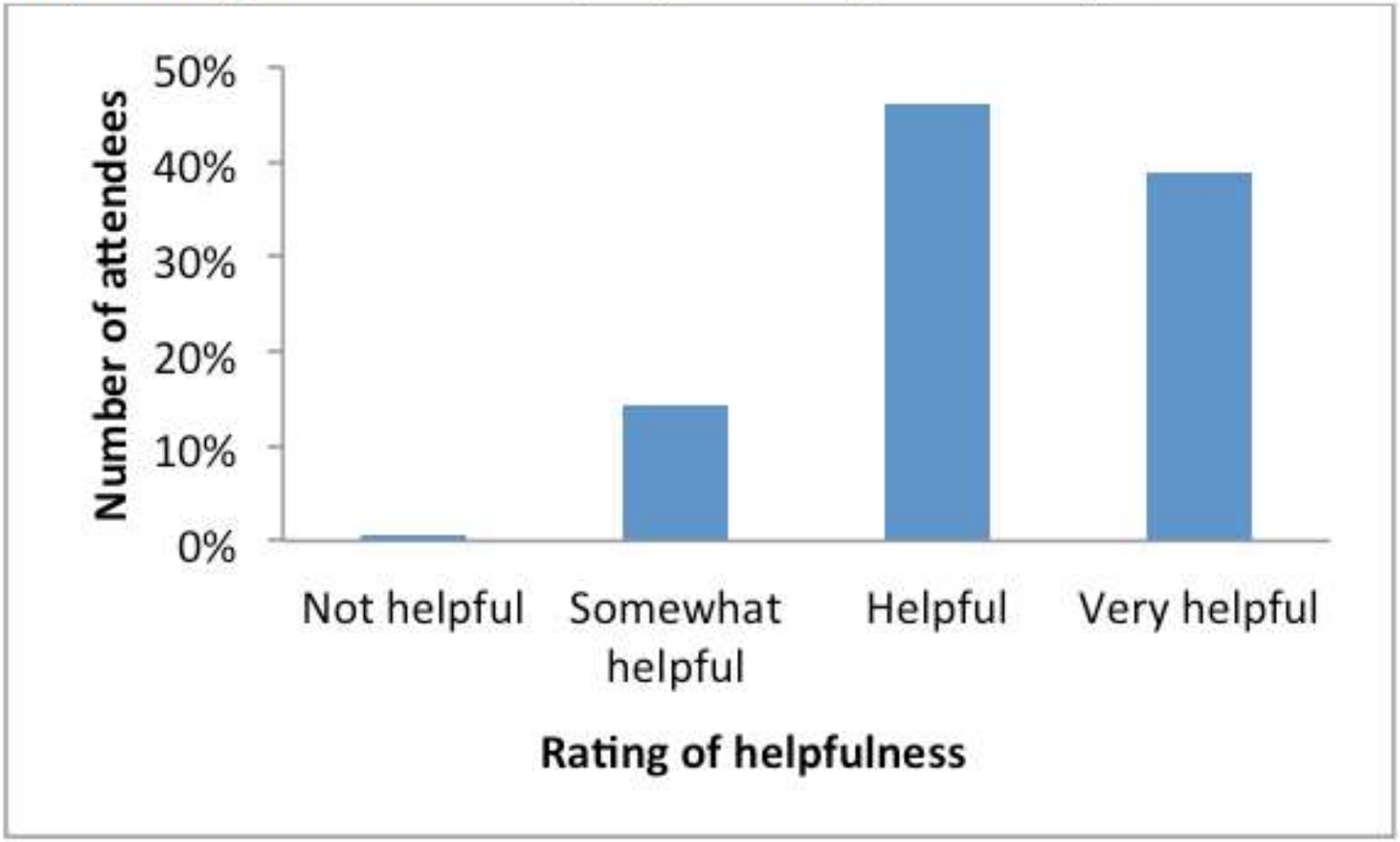
**Medico represents physicians and medical registrars

***Other includes health educator, corrections, administration, counsellor

Self-reported expertise of attendees



85% reported the training was either helpful or very helpful for improving outcomes for people with personality disorders.



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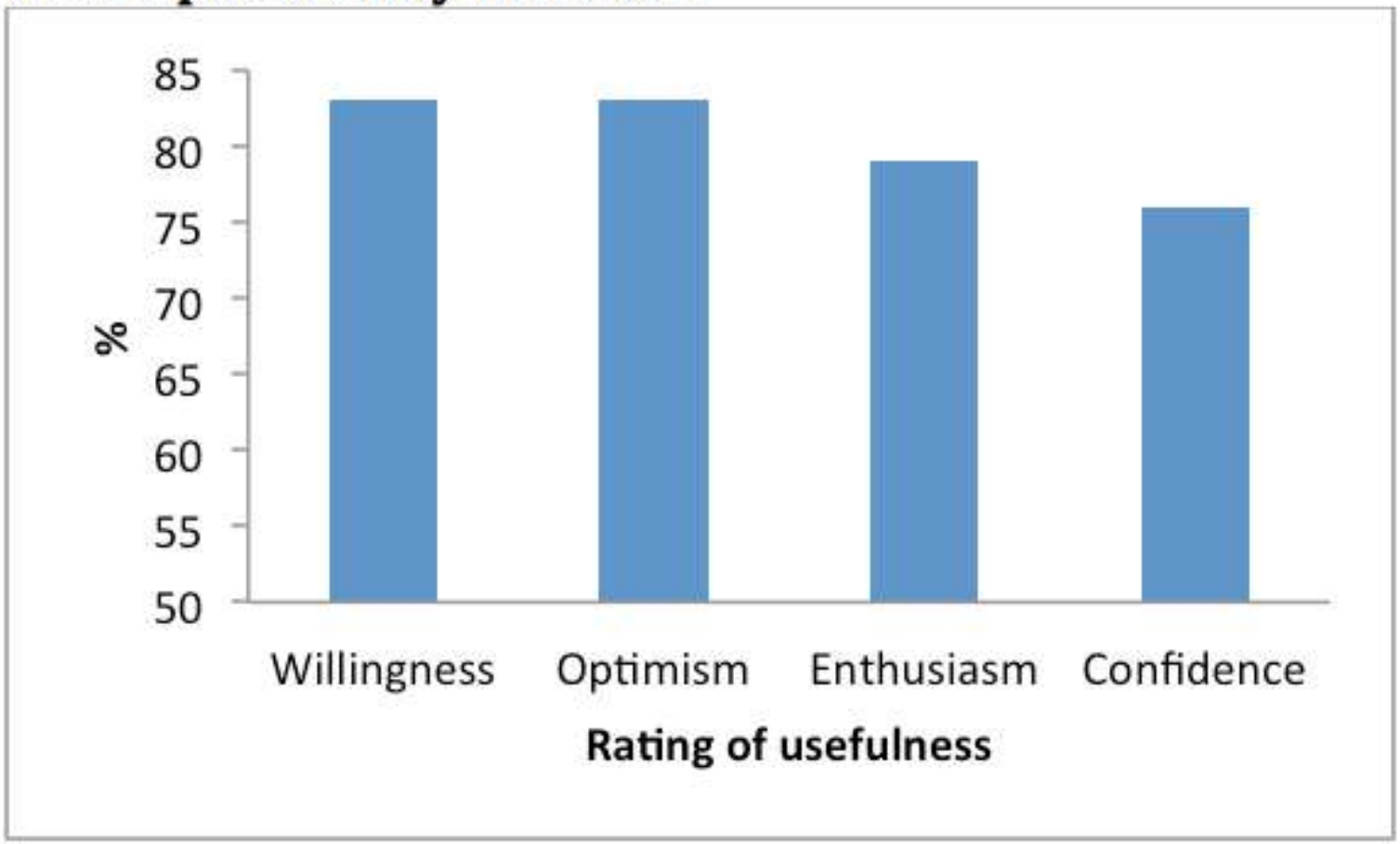
Proportion of people who found the training helpful/very helpful for improving their capacity to work with people who have a personality disorder?



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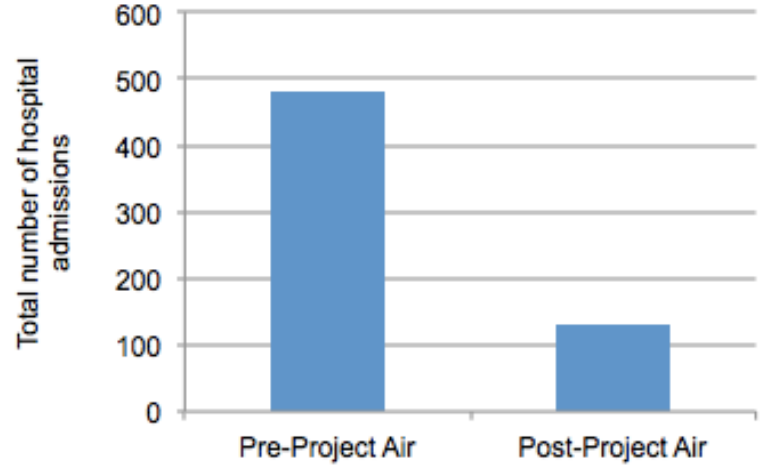
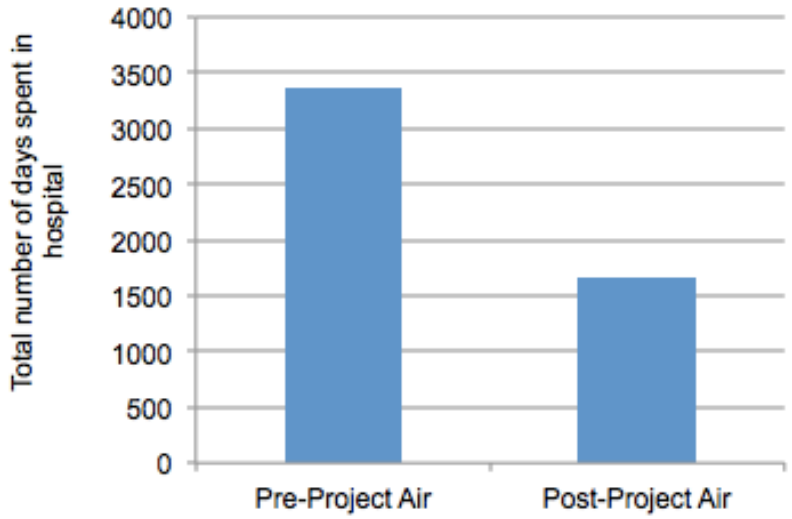
Our patient outcomes





Before Project Air, 361 clients studied in the Illawarra Shoalhaven LHD had on average 1.33 admissions to hospital and spent on average 9.3 days in hospital over 18 months (Oct 2009 – March 2011). Post Project Air (April 2011 – Sept 2012) this average dropped to .36 admissions and 4.64 days over 18 months $t(360) = 13.87$, $p = .000$; [$t(360) = 4.74$, $p = .000$ respectively].

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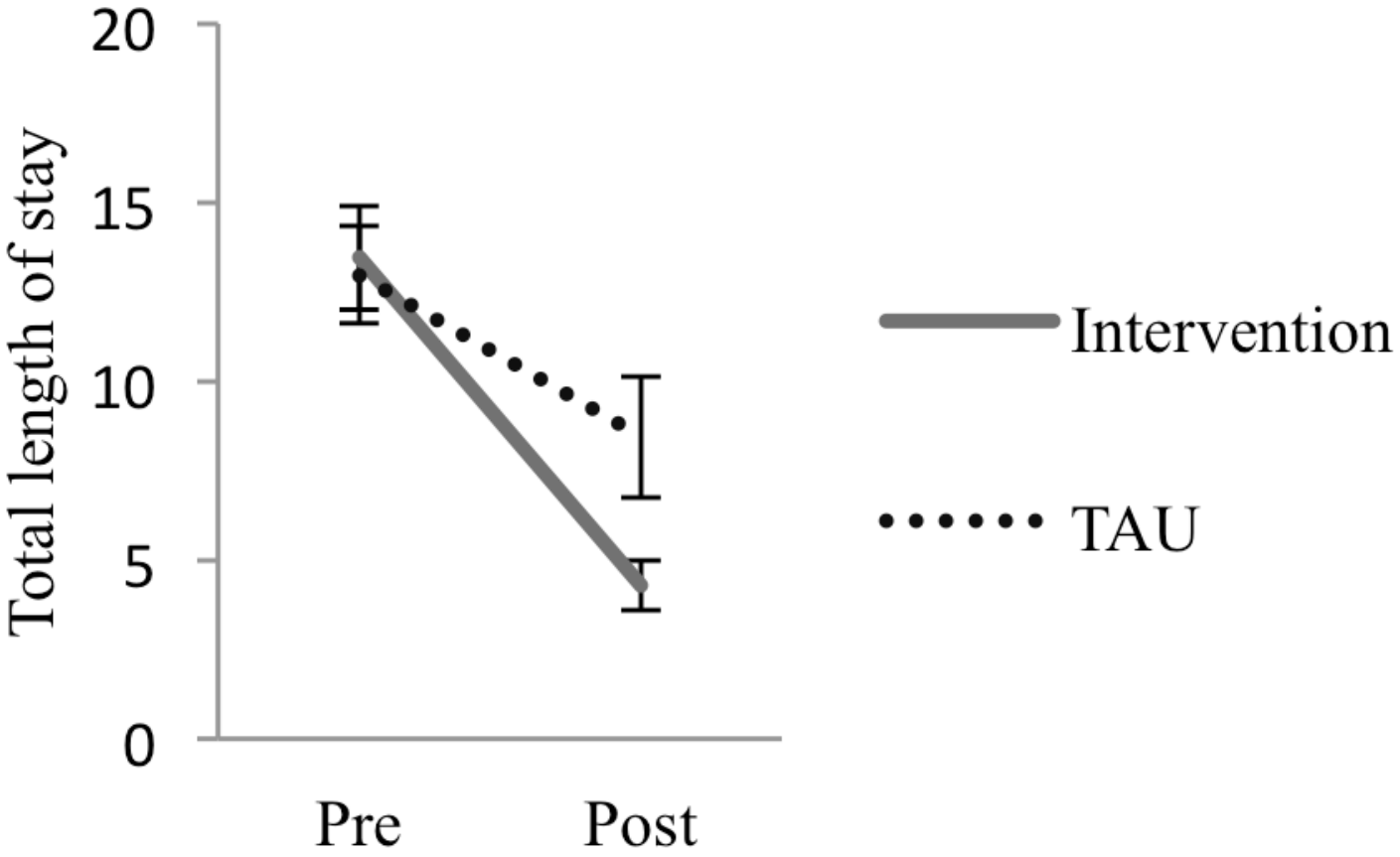

Length of stay decreased from 14 days to 4 days

RCT – Intervention vs Treatment as usual

Difference in the number of days (per patient) spent in the inpatient unit in the 18 months prior to Project Air and in the 18 months of Project Air involvement for the intervention (n = 335) and TAU sites (n = 307).

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Participants

- N= 160 clients diagnosed with BPD
- 71% female.
- Average age 36 (15-72; SD 14)
- 72% not in a relationship: single (50.63%), separated (6.88%), divorced (6.25%) and widowed (1.25%).
- 28% in a relationship: married (18.13%), in a relationship (1.88%) and de facto (1.25%).

Participants

- Diagnosed BPD with 76% currently meeting threshold for BPD (score of 7 or more on MSI; Zanarini et al., 2003)
- Average number of MSI-BPD symptoms = 7.8 (SD = 2.2)
- 83% likely diagnosis of clinical depression (scores over 16 on the MHI-5; Berwick et al., 1991)
- 62% report significant dissociation (according to MSI)
- Self-harming and suicidal behaviours. In the 2 weeks prior:
  - 65% self-harmed and/or attempted suicide, average of 3 times (SD=3.94)
  - 46% 'I have had suicidal thoughts but would not carry them out'
  - 26% 'I would like to kill myself'
  - 11% 'I would kill myself if I had the chance'

After 12 months

BPD

- Significantly fewer BPD symptoms [$t(159)=11.496$, $p=.000$]
  - Baseline (M=7.8, SD=2.2), Follow up (M= 5.4, SD=2.6)
- Proportion meeting criteria reduced significantly [$\chi^2=8.123$, p=.004]
  - Baseline 75.6%, Follow up 40.9%

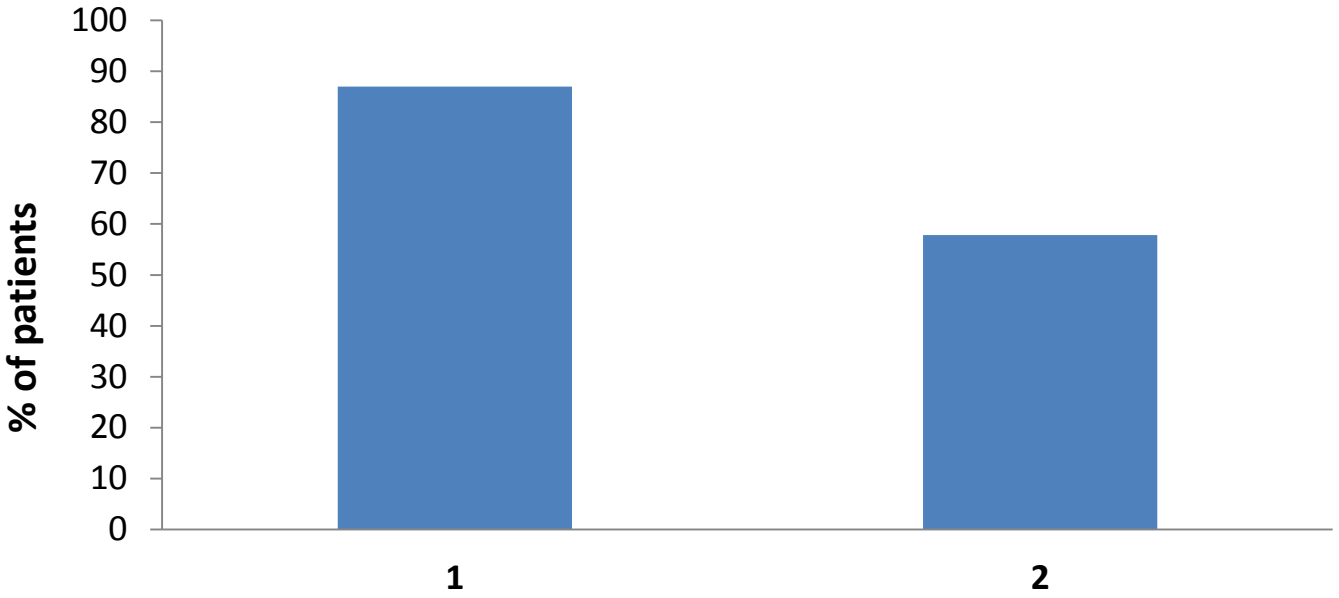
Depression

- 30% fewer meeting criteria for depression [$\chi^2= 5.911$, p=.000]
  - Baseline 82.9%, Follow up = 52.5%

Quality of life

- Significantly higher ratings on the WHO-QOL [$t(159)=11.496$, $p=.000$]
  - Baseline (M=39.6, SD=23.1), Follow up (M= 58.1, SD=26.3)

Clinical Depression Reduced



t(43) = 4.34, p =.000

Most clients at intake had at significant symptoms of depression (measured by the clinical cut-off on the mental health inventory SF-36), which had significantly reduced after 12 months.

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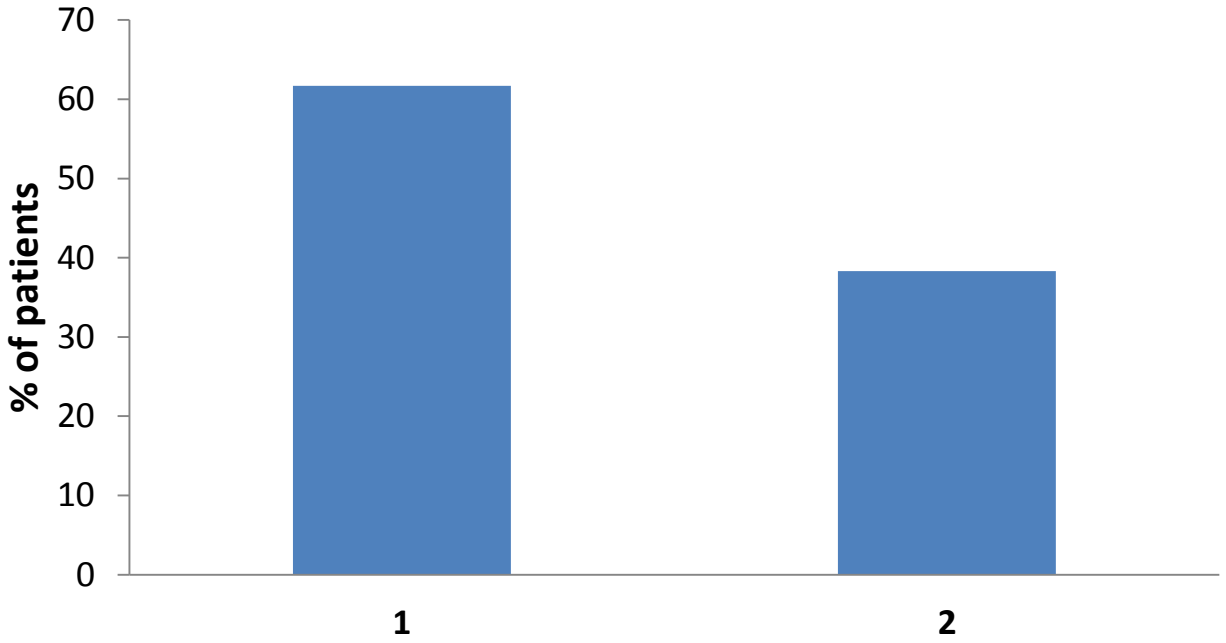
DSH or suicide attempt

(past 2 weeks)



McNemar test, p = .000

Most clients at intake had engaged in deliberate self-harm, but by 12 months this had significantly reduced.

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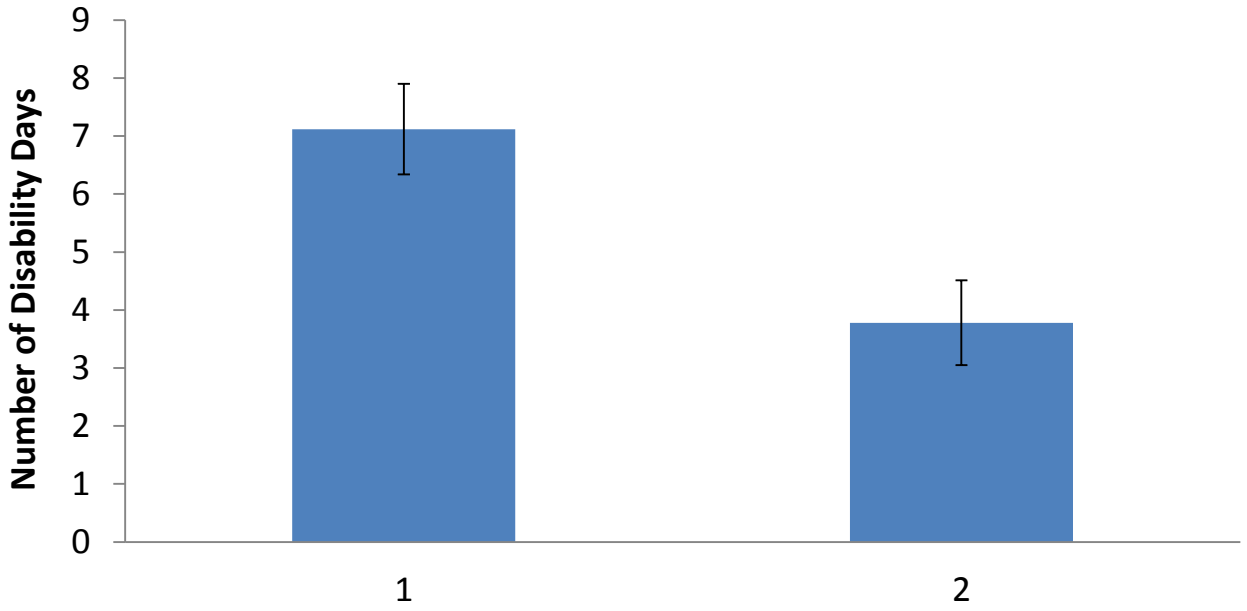
Disability days

(past 2 weeks)



t(40) = 2.867, p = *.007*

The number of days that clients were totally unable to carry out their usual activities due to their health conditions decreased significantly, as measured by the WHO-DAS.

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Results – effect of treatment intensity

- Intensity (duration) of treatment – brief, moderate, longer-term – did not change improvement in disability
- $F(3, 152) = 2.391$, $p = .071$

- Similarly, retainment in treatment at follow-up did not predict disability improvement
- $F(1, 154) = .188$, $p = .666$, 95% CI [-.314, .201]

Did BPD-Interpersonal predict reduction in disability days?

Multiple Regression Coefficients for Interpersonal Dysfunction Model.

Variable	B	β	*p*	CI
Unstable Relationships	.063	.063	.518	[-.129, .255]
Anger	.046	.045	.671	[-.166, .257]
Paranoia	.100	.100	.296	[-.088, .289]
Abandonment	.034	.034	.716	[-.149, .217]
Dissociation	-.007	-.007	.934	[-.184, .169]

Note. CI = 95% confidence interval

$F(5, 148) = .979$, $p = .432$.

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Did BPD-self predict reduction in disability days?

Multiple Regression Coefficients for Self-Dysfunction Model.

Variable	B	β	*p*	CI
Affective Instability	-.307	-.304	.002*	[-.503, -.111]
Self-harm/Suicidality	.548	.259	.002*	[.199, .897]
Identity Disturbance	-.113	-.112	.247	[-.305, .079]
Impulsivity	.284	.280	.003*	[.101, .468]
Chronic Emptiness	.158	.156	.134	[-.049, .365]

Note. CI = 95% confidence interval, * = significant at p < .05

$F(5, 148) = 5.027$, $p = .000$, $R^2 = .145$, Adjusted $R^2 = .116$

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Discussion

- Over 12 months of psychosocial treatment, capacity to study and work significantly improved
- The improvement was not due to intensity of therapy or retainment in therapy
- BPD-Interpersonal did not predict change in disability
- BPD-Self predicted change in disability, particularly
  - Low - Affective stability
  - High - self-harm and suicidality
  - High - impulsivity
- Suggests these three make it particularly hard to study or work

Our service learning – implementing Project Air in Health, Drug and Alcohol and NGO services

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Demographic and Clinical Variables of Participants (N=20)

Variable	N	%
Profession		
Psychologist	6	30
Nurse	5	25
Clinical Psychologist	4	20
Psychiatrist	1	5
Occupational Therapist	2	10
Social Worker	2	10
Current Role		
Clinician	12	60
Manager – Team Leader	5	25
Manager - Service	3	15
Attended training		
Yes	20	100
No	0	0

Implementation experiences

Statements from Participants on their Perception of Implementation Success

ating	Site	N	Evidence
oderate	1, 4	13	"The mental health service doesn't – hasn't really change its policy around, seeing personality disorders as a seriou mental illness." [12_M] "I don't believe the [intervention] is working. I don't think we are capturing enough people". [12_M]
ood	2, 3, 5	8	"…there [are] clear strategies and people are seeing that they are having a really good impact." [14_C] "…we're running five appointments a week… putting them through this different pathway, actually, frees up th access". [16_M] "So it's increasingly becoming embedded in the culture, think." [21_C]

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Key implementation factors

(1) Clear and accountable leadership commitment at the level of director and senior clinical staff.

(2) Establishing and supporting clinical governance outlining clinical pathways to specific treatment clinics and clinician support structure.

(3) Ensuring sufficient penetration of training to all staff, including ongoing training opportunities.

(4) Training managers and senior clinical staff or clinical champions on how change occurs and factors associated with success or barriers.

(5) Development of prospective plans for evaluating and disseminating outcomes of implementation.

Conclusion

(1) We now have the evidence for what works with BPD

(2) Whole of service training is effective

(3) Staff want more training, resources and models of care

(4) People with the disorder benefit from stepped care that is targeted to their needs

(5) Further focus on self-harm as a specific factor that makes return to study and work difficult

(6) Families, carers and parents benefit from support

(7) Management and clinical leadership on the ground needs to be included as an implementation outcome

(8) We still have a lot to do!

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Project Air Conference: 4-5th November 2016

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