Project Air Strategy for Personality Disorders

Final report on the treatment of personality disorders research project (2010-2013)

To: NSW Health

From: The Illawarra Health and Medical Research Institute

2015
Report to NSW Health
Treatment of Personality Disorders Research Project

Expert Advisory Committee
Final Project Report, 2013

Citation:

This report summarises activities undertaken by the Treatment of Personality Disorders Research Project (Project Air Strategy) from 20th October 2010 (Consultancy Agreement signed 20th October 2010) to the 20th August 2013 and comprises the final project report released for publication in 2015.

For correspondence: Brin Grenyer grenyer@uow.edu.au
For copies: www.projectairstrategy.org
ISBN: 978-1-74128-245-0
Executive Summary

The Project Air Strategy for Personality Disorders is a collaboration between the Illawarra Health and Medical Research Institute, Local Health Districts and Community (families, carers and consumers) to contribute to improved wellbeing of people with personality disorders and their families.

The Project Air Strategy was initially funded by NSW Health as a three-year pilot implementation project. It was awarded through a competitive tender to the Illawarra Health and Medical Research Institute in partnership with the South Eastern Sydney and Illawarra Shoalhaven Local Health Districts and Justice Health. The project commenced in November 2010 and this pilot concluded December 2013.

The project sought to improve the capacity of mainstream mental health services to manage and treat personality disorder and to expand specialist treatment options, including improved referral pathways between generic and specialist treatment. The project delivered education and supervision programs in addition to the provision of expert interventions. It also evaluated specialist intervention models to provide guidance for future service development in NSW.

The Project Air Strategy for Personality Disorders developed an innovative model based on 6 key strategies. This is the first project in the world to have developed a whole of service approach to the treatment of personality disorder. The 6 key components of the model developed by the Project Air Strategy team are: Strategy A. Redesigning services; Strategy B. Upgrading mental health staff skills; Strategy C. Evaluating outcomes; Strategy D. Connecting with families, carers and consumers; Strategy E. Improving awareness and information; Strategy F. Enhancing quality of clinical services. The 6 strategies and the 12 specific components are shown in the following figure and described in more detail in this report.

There have been a number of key outcomes from the pilot project, specifically:

- Personality disorder presentations in Emergency Departments have significantly reduced
- Personality disorder admissions and length of stays in hospitals have significantly reduced
- Family and carers have reported increased confidence, enthusiasm, and willingness to remain carers
- NSW Health staff have reported increased clinical skills, confidence and changed attitudes in treating personality disorders
The project has a number of key achievements, including:

- Publication of treatment guidelines
- Development and evaluation of clinical manuals and resources
- Establishment of an effective communication and public education strategy comprising:
  - A website hosting consumer, carer and health professional resources
  - Annual conferences for health professionals
  - Public education workshops, groups and events for families, carers, consumers and health professionals
- Development and evaluation of a comprehensive education program for health professionals

**Development and implementation of service delivery model**

The project has implemented an integrative collaborative model delivered through a pyramid of personality disorders care. The project has implemented a relationship model, firstly addressing negative attitudes, stigma and therapeutic nihilism, then introducing a set of effective evidence based interventions that have established therapeutic effectiveness. Services have been introduced to models of care that expand the skill set of staff, and provide greater options for a more inclusive personality disorder-friendly service approach from brief to extended interventions. The model expands the Collaborative Recovery Model developed at Wollongong into personality disorders, aimed at developing a partnership between the consumer and clinician to promote a healthy sense of self, effective interpersonal relationships, and independence from the health service.

All mental health staff have been trained in Levels 1-2 in order to develop specific personality disorders-focused skills. These include engagement, assessment of urgent needs, establishment of systems of safety, orientation to services, education and support, and the development of a care plan. The collaborative care plan assists in the coordination and integration of services including GP, public and private psychiatry, community, emergency and crisis services, NGO, Lifeline, housing and other relevant services based on a collaborative assessment of needs. Levels 3-5 involve more intensive application of evidence-based interventions for personality disorders treatment. Specific training and resources have

---

been developed that are appropriate for clinicians from a range of disciplines and skill sets, to apply to a diverse multicultural group of clients ranging from 12-85 years. Clinician and patient resources have been also developed for public dissemination on the website.

Interventions developed have mirrored the pyramid of care:

- A Brief Intervention Manual has been developed, based on the St Vincent’s model, for brief interventions of high prevalence presentations.
- An Extended Interventions approach has been developed based on Gunderson’s General Psychiatric Management approach, which is a guidelines based approach to structuring individual sessions with clients over an extended treatment duration. Where DBT programs exist these have been strengthened through the guidelines, clinical resources, training and supervision.
- A Family, Partner and Carer approach has been developed, again reflecting the pyramid of care model - from a single hour intervention, all day workshop, to an extended 8-hour group intervention.

Development and implementation of an innovative model of staff support/supervision

The innovative model of staff support/supervision has involved the relationship model, through the activation of the pyramid of care - developing skill sets appropriate for staff with different levels of expertise and exposure to personality disorders. A range of options for intervention has been developed, from the first steps of care and safety planning, through to complex interventions targeting improved relationship functioning. Complex care reviews have been implemented and evaluated with very high ratings of satisfaction and improvements in knowledge and skills.

Development and implementation of an education package for mental health clinicians that can be utilised throughout NSW

Five levels of training have been developed, from a core 2-hour introductory seminar, through to whole day workshops targeting core assessment and intervention skills for personality disorder treatment. Variations have been developed for specific service settings, including justice health, child and adolescent and drug and alcohol services. Project Air has developed a partnership with the Institute of Psychiatry. Specifically, Project Air has contributed training materials for the 5 day CAAT-MH Community assessment and acute treatment in mental health course (Paul O’Halloran). Other collaborative training opportunities are being negotiated.

Clinical guidelines for the treatment of personality disorder for consideration by the Clinical Advisory Council for state-wide use

Treatment guidelines were completed in 2011 to assist health services to provide effective treatment for people with personality disorders. The guidelines were based on a systematic review of existing guidelines, current research findings, and consultation with the expert project consultants group. The guidelines have also been influential and cited by the NHMRC Borderline Personality Disorder clinical guidelines. The guidelines are organised according to a typical sequence of a whole of service experience: from a presentation in crisis to a hospital emergency department, through to long-term treatments. Along the way, it presents guidelines for good practice in assessment, brief interventions, care planning, involving family members and carers, and ongoing community treatment.
Our Mission Statement:
“Project Air is a Personality Disorders Strategy that aims to enhance treatment options for people with Personality Disorder and their families and carers. The Project Air Strategy endorses an integrative collaborative relational approach and thereby promotes a personality disorders-friendly health service.”

Contents

Executive Summary 1
Background 5
Implementation and Evaluation 6
Strategy A. Redesigning services 8
Strategy B. Upgrading mental health staff skills 10
Strategy C. Evaluating outcomes 18
Strategy D. Connecting with families, carers and consumers 24
Strategy E. Improving awareness and information 27
Strategy F. Enhancing quality of clinical services 32
Conclusion 33
Appendix 1: Sample project poster 34
Appendix 2: Sample Gold Card Clinic poster 35
Appendix 3: Example Gold Card Clinic Business Rule 36
Appendix 4: Key personnel 39
Background

NSW Health funded the Project Air Strategy for Personality Disorders initially as a three-year pilot implementation project. It was awarded through a competitive tender to the Illawarra Health and Medical Research Institute in partnership with the South Eastern Sydney and Illawarra Shoalhaven Local Health Districts (LHDs) and Justice Health. This report is of the three year pilot project as developed by the Project Air Strategy.

The impetus for this NSW Health supported project was the recognition that in the health system, people with personality disorders present in significant numbers to Emergency Departments as well as to Mental Health and Drug and Alcohol services. Generally, health services provide crisis management that may include short-term admission for safety and de-escalation of distress. Longer-term service involvement has traditionally been regarded as counterproductive due to mental health clinicians’ concerns about reinforcing helplessness and escalating help-seeking behaviour through actions, e.g. increased self-harm. This has, in some cases, resulted in a stigmatised response from mental health services and unconscious negative responses (countertransference) from health professionals. Approximately 1 in every 10 persons suffers from a personality disorder (median prevalence rate is 10.56%; mean prevalence rate is 11.39%).

According to an Australian study, 6.5% of the Australian population has a personality disorder. Further, an estimated 40-50% of psychiatric patients have a personality disorder. An estimated 22% of psychiatric outpatients have the diagnosis of Borderline Personality Disorder (BPD). While 31.4% of patients with an Axis I Disorder were found to also be diagnosed with a DSM-IV personality disorder. The prevalence of personality disorders is the same in both men and women.

People with a personality disorder are at increased risk of suicide and self-harm. They frequently have contact with, and pose difficult management issues for, a number of agencies including Health, Police, Corrections and Housing. This client group have not always had consistent or helpful responses from the health service and other agencies; hence there have been difficulties in providing the best treatment responses and clients accepting these when offered. These health service inconsistencies have in some cases lead to greater escalation in help seeking and a greater ambivalence towards help provided.

People in correctional settings have higher rates of personality disorder than people in the general community; with 43.1% of adult prisoners in NSW reception centres meeting criteria for a personality disorder (compared with 9.2% of the community sample). The presence of personality disorder symptoms in adolescents has also been linked to violent offending and rate of recidivism during adolescence and early adulthood. Due to the well-established relationship between personality disorder and violent offending, a diagnosed personality disorder is considered a risk factor in a number of tools used to assess risk of violence (e.g. HCR-20). Offending is often related to symptoms of personality disorder, such as impulsivity, emotion dysregulation, and associated substance abuse. Notably, risk of re-offending among those with a mental illness, including a personality disorder, is increased significantly when a comorbid substance abuse disorder is present. By treating personality disorders in the broader community, we will likely reduce criminal offending associated with the disorder in two ways: (1) by lowering the incidence of substance abuse among people with personality disorder, and (2) by helping people with personality disorder re-integrate into society from prison and abstain from criminal offending.

People with personality disorders that seek treatment (e.g. present to Emergency Departments, require outpatient and inpatient care) pose a high economic burden on society; a burden substantially higher than that found for other mental illnesses such as depression and generalised anxiety. A study conducted in

---

the Netherlands \((N = 1740)\) found that the direct medical costs per patient with a personality disorder were AUD$10,760 \((€7,398)\) per year.\(^{11}\) While the indirect cost per patient with a personality disorder and a paying job was an additional AUD$10,309 \((€7,088)\) per year. The total days lost because of absence from work or inefficiency at work was found to be 47.6 per patient per year. BPD was associated with increased direct and indirect costs.

According to the Australian National Survey of Mental Health and Well-Being, 4.8% of the Australian full-time workforce has a personality disorder, with a personality disorder being predictive of work impairment.\(^{12}\) A current mental illness was associated with an average of one lost day from work, and three days of reduced performance in the month prior to the survey. Lost work productivity due to mental disorders, such as personality disorders and substance-related disorders, contributes a loss of AUD$2.7 billion each year.

The high societal costs of personality disorders suggest the importance of prioritising the development and implementation of effective personality disorder treatments. Research has established a significant cost benefit of implementing appropriate psychosocial treatments for people with BPD.\(^{13}\) One year of psychotherapy was associated with an average decrease in inpatient costs of AUD$21,431 per patient with BPD. Findings suggest a suitable psychotherapy treatment course for BPD will save the State at least AUD$8,000 per patient a year following therapy.

There is growing recognition that mental health services have a significant role with this population group and that services need new systems and supports to improve access, responses, and outcomes. Similarly, enabling mental health and drug and alcohol workers to better respond to people with personality disorders will enhance their work satisfaction, improve their management of clinical risk and deliver greater therapeutic competencies.

New therapeutic approaches have demonstrated improved outcomes through psychological therapy. Some NSW Local Health Districts provide specific services for the treatment of personality disorder, but issues remain around the capacity of mainstream mental health services to manage this population and to offer services that are specifically helpful to this particular group of people.

**Implementation and evaluation**

At the commencement of the project the team undertook a series of research and evaluation studies to determine the shape of the implementation plan. These included collecting data from front-line clinical staff involved in the treatment of personality disorders,\(^{14}\) conducting focus groups on the need for change,\(^{15}\) reviewing the literature,\(^{16}\) seeking the views of experts on the advisory committee, obtaining peer review from an international audience,\(^{17}\) and ensuring the proposals met national and international guidelines.\(^{18}\) In addition, key findings from implementation science studies were incorporated, including the need for working with managers, key ‘champion’ clinicians, and ensuring that families, carers and consumers played a role in reviewing the proposals. The project has developed and integrated key international collaborations with leading scientists in the field, including Professor John Gunderson from Harvard, Professor Roger Mulder from Otago, and Associate Professor Shelley McMain from Toronto.

A whole of service approach was chosen. Training all mental health staff was designed to reduce stigma and therapeutic nihilism surrounding this client group and to facilitate the adoption of more hopeful and evidence-based attitudes towards treatments. Therefore, working with managers was also important to

---


ensure support for the project. Including families, carers and consumers in the service redesign and offering specific education provided an opportunity to overcome previous barriers to support.

Developing easy to learn brief interventions also worked to help health services manage the large volumes of clinical demand from this client group. Specialist longer-term treatments in the implementation sites were struggling with waiting lists of one to two years length, with little prospect of effectively meeting the demands of the large numbers of this treatment seeking group. Step-down services with rapid follow up that provided diversion from emergency and inpatient units was a key innovation of the model developed. The central role of assessment and care planning provided individuals with a sense of direction and purpose that integrated the large number of community options available to them both from government and non-government service providers including the mental health service.

Six related strategies were identified and implemented, with 12 associated components as follows. The 6 key strategies are: Strategy A. Redesigning services; Strategy B. Upgrading mental health staff skills; Strategy C. Evaluating outcomes; Strategy D. Connecting with families, carers and consumers; Strategy E. Improving awareness and information; Strategy F. Enhancing quality of clinical services. Each of these 6 strategies and the 12 components are shown in the following figure and described in more detail below.
**Strategy A. Redesigning services**

The project has developed clinical guidelines and a blueprint for change to assist managers to provide more focused, personality disorder-specific services to meet the needs of the community. Along with the guidelines, the strategy has worked to inspire service leaders to implement and support new service models.

Services now provide a more streamlined and effective pathway to clinical care for clients with personality disorder following presentation to emergency and inpatient units, comprising:

- Adult brief and longer-term personality disorder clinics with clear criteria between acute services and the personality disorder clinic.
- Youth personality disorder clinics with clear criteria between acute services and the personality disorder clinic.

MH Directors are responsible to ensure staffing resources are adequate to meet the needs of this high prevalence condition (approx. 25% of all acute mental health clients). MH Directors and Project Air Strategy have consulted to achieve the desired clinical impact.

**Component 1. Providing managers with systems to build change**

The project implemented the strategy to LHDs in 5 phases. The first phase involves 3 months of extensive interaction with senior managers in regards to the essential tasks of implementation. The 5 phases are:

- **Phase 1 - Consultation: Months 1-3** Senior Manager Consultation
- **Phase 2 - Set up: Months 4-6** Consultation with likely 'champions' with personality disorder interest and expertise. Establish advisory committee (reports to Director and State-wide Project Air Advisory Committee)
- **Phase 3 - Training: Months 7-9** Targeted training. Levels 1-2 and Levels 3-4.
- **Phase 4 - Implementation: Months 10-12** Open clinics. Commence Level 5.
- **Phase 5 - Establishment: Months 13-24.**

The Project Air Strategy integrative collaborative model is delivered through a pyramid of personality disorders care. The model expands the Collaborative Recovery Model developed at Wollongong into personality disorders, aimed at developing a partnership between the consumer and clinician to promote a healthy sense of self, effective interpersonal relationships, and independence from the health service.
Component 2. Engaging and inspiring service leaders

Service leaders are provided resources and training to effect clinical change in their district. The model is a key strategy in mitigating against therapeutic nihilism and stigma associated with this client group. A system of care is provided to encourage and facilitate connection with the treatment team and clear and consistent use of policies around admission and referral pathways. Service leaders assist staff to change practice and develop personality disorder-specific care plans to coordinate and integrate services including GP, public and private psychiatry, community, emergency and crisis services, NGO, Lifeline, housing and other relevant services based on a collaborative assessment of needs. Treatment guidelines form a significant resource for managers to guide service development.

Evaluation of effectiveness:

Six new personality disorder clinics have been established in the trial sites (Nowra; Wollongong; Sutherland; St George, Prince of Wales and Justice Health). Project Air Strategy has also supported training and enhancements to more intensive programs (Dialectical Behaviour Therapy).
**Strategy B. Upgrading mental health staff skills**

The project has worked with the whole service to deliver better training based on new evidence for effectiveness. The project has implemented and evaluated 5 levels of training within adult and adolescent Mental Health services.

One of the drivers of stigma and prejudice against this client group is ignorance of the more recent evidence-based practice informing clinical efficacy. The training component delivers a more hopeful message about the capacity to successfully treat personality disorders and provides expert clinical tools and techniques.

**Component 3. Whole of service training**

Penetration of training is an important component of the strategy; therefore training was provided to all mental health staff. Level 1-2 training aimed to promote the use of clinical guidelines and to change attitudes (stigma and prejudice) about personality disorders. All mental health staff were trained in Levels 1-2 in order to develop specific personality disorders-focused skills over 2-hours. Skills addressed include engagement, assessment of urgent needs, establishment of systems of safety, orientation to services, education and support, and the development of a care plan.

**Component 4. Specialist skills training**

There are specific staff within a mental health service that have the skills, training and capacity to benefit from more specialist training to be applied to treat this client group. These are provided Level 3-4 training to improve clinician skills in the application of intensive evidence-based interventions for personality disorders treatment. The target audience are core clinical staff (inpatient and community), for one-day of intensive training. Components of training include step-down or clinical staging - assessment, guidelines-based practice, brief and longer-term interventions, and working with family and carers. Specific training and resources have been developed that are appropriate for clinicians from a range of disciplines and skill sets, applied to a diverse multicultural group of clients ranging from 12-85 years. Interventions reflect the expertise of the project team and the current evidence-base. The overall model however prioritises integration and collaboration of care over theoretical rigidity.

Level 5 training is provided as in-service sessions. These regular 2-hour consultations to teams on-site integrate and elaborate the clinic model within the service. Clinician support and supervision is integral to clinical redesign (complex care reviews, on-site training, service implementation sessions, skills training, and family and carer integration).

**Evaluation of effectiveness:**

There has been 893 staff that attended a minimum of 1 and up to 11 sessions of training during 2011–2013, making a total of 1836 training places taken over the pilot project. From those, 37.4% were from the Illawarra Shoalhaven, 22.1% from Sutherland, 15.9% from St George, 17.0% from Prince of Wales, and 7.6% from Justice Health. There was also 74.7% of staff that consented to be part of the research side of the project and provided data on their knowledge, attitudes, confidence and skills in working with people with a personality disorder. The mean age of participants was 41.1 years ± 11.5 (SD) of which 69.8% were female. The table below shows the number of participating staff for each level of training in 2011 and 2012. Inspecting the characteristics of all participating staff in the training reveals that 449 (53.8%) were nursing staff, with a smaller mixture of psychiatry, psychology and allied health staff comprising the others trained.
The training workshop topics and learning outcomes

<table>
<thead>
<tr>
<th>Treatment of Personality Disorders Research Project – Training Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1-2 Training: Essential Skills of Personality Disorders (2hrs)</td>
</tr>
<tr>
<td>This 2-hour mandatory training is for all mental health staff, which includes: 1. Understanding personality disorder complexity, 2. Key principles for effective service delivery 3. Application and training in essential skills.</td>
</tr>
<tr>
<td>Level 3a* Training: Essential Skills of Personality Disorder Assessment (6 hours)</td>
</tr>
<tr>
<td>This 4-hour workshop includes: 1. Assessment of personality disorders using structured interviews and self-report measures, 2. Differential diagnosis from psychotic disorders and bipolar and other complex disorders and syndromes including managing risk. This workshop will particularly suit acute mental health staff (emergency, assertive teams, psychiatry-liason, inpatient, and intake) and other psychiatry, medical, psychology and nursing staff responsible for assessing patients.</td>
</tr>
<tr>
<td>Level 3b* Training: Essential Skills in Pharmacotherapy of Personality Disorders (2 hours)</td>
</tr>
<tr>
<td>This 2-hour workshop outlines the evidence-base for using pharmacotherapy for personality disorders and allied conditions and includes medication protocols and managing risk. This workshop will particularly suit medical, psychiatric and intake and acute mental health staff.</td>
</tr>
<tr>
<td>Level 4 Training: Essential Skills of Personality Disorder Treatment (8 hours)</td>
</tr>
<tr>
<td>This one-day workshop includes 1. Care planning, psycho-education, and psychological treatments, 2. Working with risk, 3. Working with young people, 4. Working with families and carers. This workshop will particularly suit all staff that work with personality disorders either in inpatient settings, consultation-liason settings, or community case management settings.</td>
</tr>
<tr>
<td>Level 5 Training: Essential Skills in Psychotherapy for Personality Disorders (8 hours)</td>
</tr>
<tr>
<td>This is a one-day workshop that includes: 1. Specific treatment skills and phases of psychotherapy, 2. Working in the relationship, including skills in repairing ruptures, dyad and role-play exercises, 3. Group treatment, 4. Setting up a consultation and supervision team, 5. Managing difficult issues including termination and clients with special needs. This workshop will particularly suit community staff that provide ongoing care coordination and case management for this client group.</td>
</tr>
<tr>
<td>Level 3 – Booster (6 hours)</td>
</tr>
<tr>
<td>This 6-hour workshop provides a 1.5hr review of previous 3a training, and then goes on to apply this knowledge to complex case consultations.</td>
</tr>
<tr>
<td>Level 3b – Booster (2 hours)</td>
</tr>
<tr>
<td>This 2-hour workshop provides a 1hr review of previous 3b training and then goes on to apply this knowledge in complex case consultations.</td>
</tr>
<tr>
<td>Level 4 – Booster (8 hours)</td>
</tr>
<tr>
<td>This one-day workshop provides a 1.5hr review of previous Level 4 training and then goes on to apply this knowledge in complex case consultations.</td>
</tr>
<tr>
<td>Level 5 – Care Review (8 hours)</td>
</tr>
<tr>
<td>This workshop provides complex case consultations.</td>
</tr>
</tbody>
</table>

Number of participating staff for each level of training in 2011, 2012 and 2013

<table>
<thead>
<tr>
<th>No. of Attendees</th>
<th>Total No. of Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WOLL</strong></td>
<td><strong>SUTH</strong></td>
</tr>
<tr>
<td>Level 1-2</td>
<td>254</td>
</tr>
<tr>
<td>Level 3</td>
<td>39</td>
</tr>
<tr>
<td>Level 4</td>
<td>42</td>
</tr>
<tr>
<td>Level 5</td>
<td>37</td>
</tr>
<tr>
<td>Total L1-2, L3, L4, L5</td>
<td>372</td>
</tr>
<tr>
<td>Level 3 – Booster</td>
<td>27</td>
</tr>
<tr>
<td>Level 4 – Booster</td>
<td>26</td>
</tr>
<tr>
<td>Level 5 – Booster</td>
<td>43</td>
</tr>
<tr>
<td>GCC &amp; Supervisions</td>
<td>149</td>
</tr>
<tr>
<td>All Levels</td>
<td>617</td>
</tr>
</tbody>
</table>

WOLL = Illawarra Shoalhaven; SUTH = Sutherland; STG = St George; POW = Prince of Wales; JH = Justice Health
* Total excluding JH
The following tables show the characteristics of all participating staff in the training including; age, sex, area and profession.

### Characteristics of participating staff

<table>
<thead>
<tr>
<th></th>
<th>No. of attendees (% of total)</th>
<th>Mean age in yrs (± SD)</th>
<th>Gender F / M (% of F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Staff</td>
<td>480 (54.0%)</td>
<td>42.8 (11.7)</td>
<td>334 / 146 (69.6%)</td>
</tr>
<tr>
<td>Psychiatrist / Registrar</td>
<td>82 (9.2%)</td>
<td>40.7 (9.5)</td>
<td>35 / 47 (42.7%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>91 (10.2%)</td>
<td>37.2 (9.1)</td>
<td>73 / 18 (80.2%)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>61 (6.8%)</td>
<td>35.3 (10.6)</td>
<td>53 / 8 (86.9%)</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>54 (6.0%)</td>
<td>40 (12.1)</td>
<td>42 / 12 (77.8%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>71 (8.0%)</td>
<td>41.4 (12.3)</td>
<td>56 / 15 (78.9%)</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>27 (3.0%)</td>
<td>40.3 (7.0)</td>
<td>9 / 18 (33.3%)</td>
</tr>
<tr>
<td>Not Specified</td>
<td>20 (2.2%)</td>
<td></td>
<td>6 / 1 (85.7%)</td>
</tr>
<tr>
<td><strong>Total No. (% of Total)</strong></td>
<td><strong>893 (100%)</strong></td>
<td><strong>41.0 (11.5)</strong></td>
<td><strong>620 / 273 (69.4%)</strong></td>
</tr>
</tbody>
</table>

### Positions of participating staff for each area

<table>
<thead>
<tr>
<th>Position</th>
<th>WOLL (% of total)</th>
<th>SUTH (% of total)</th>
<th>STG (% of total)</th>
<th>POW (% of total)</th>
<th>JH (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>15 (4.5%)</td>
<td>9 (4.5%)</td>
<td>13 (9.2%)</td>
<td>15 (9.9%)</td>
<td>2 (3.2%)</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>16 (4.7%)</td>
<td>5 (2.5%)</td>
<td>1 (0.7%)</td>
<td>1 (0.7%)</td>
<td>4 (6.3%)</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>223 (66.2%)</td>
<td>86 (43.0%)</td>
<td>65 (45.8%)</td>
<td>78 (51.7%)</td>
<td>28 (44.4%)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>11 (3.3%)</td>
<td>18 (9.0%)</td>
<td>9 (6.3%)</td>
<td>13 (8.6%)</td>
<td>10 (15.9%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>31 (9.2%)</td>
<td>29 (14.5%)</td>
<td>10 (7.0%)</td>
<td>15 (9.9%)</td>
<td>6 (9.5%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>12 (3.6%)</td>
<td>18 (9.0%)</td>
<td>24 (16.9%)</td>
<td>15 (9.9%)</td>
<td>2 (3.2%)</td>
</tr>
<tr>
<td>Psychiatrist / Registrar</td>
<td>23 (6.8%)</td>
<td>17 (8.5%)</td>
<td>17 (12.0%)</td>
<td>14 (9.3%)</td>
<td>11 (17.5%)</td>
</tr>
<tr>
<td><strong>Total No. (% of Total)</strong></td>
<td><strong>337 (37.7%)</strong></td>
<td><strong>200 (22.4%)</strong></td>
<td><strong>142 (15.9%)</strong></td>
<td><strong>151 (16.9%)</strong></td>
<td><strong>63 (7.1%)</strong></td>
</tr>
</tbody>
</table>

WOLL = Illawarra Shoalhaven; SUTH = Sutherland; STG = St George; POW = Prince of Wales; JH = Justice Health
Staff professions for all training

![Staff Professions Chart]

Training Evaluation Surveys
The evaluation survey for each training or consultation session was collected and analysed. There were 1573 surveys (85.7%). The results are shown in the following figures and tables below.

Characteristics of participating staff in the training evaluation surveys

<table>
<thead>
<tr>
<th></th>
<th>No. of Surveys (% of total)</th>
<th>Mean age in yrs (± SD)</th>
<th>Gender F / M (% of F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wollongong</td>
<td>514 (32.7)</td>
<td>44.7 (10.7)</td>
<td>328 / 180 (63.8%)</td>
</tr>
<tr>
<td>Sutherland</td>
<td>383 (24.3)</td>
<td>38.2 (9.8)</td>
<td>271 / 105 (70.8%)</td>
</tr>
<tr>
<td>St George</td>
<td>429 (27.3)</td>
<td>37.9 (11.7)</td>
<td>343 / 84 (80.0%)</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>128 (8.1)</td>
<td>40.9 (12.5)</td>
<td>88 / 38 (68.8%)</td>
</tr>
<tr>
<td>Justice Health</td>
<td>119 (7.6)</td>
<td>37.2 (9.2)</td>
<td>71 / 47 (59.7%)</td>
</tr>
<tr>
<td>Total No. (% of Total)</td>
<td>1573 (100%)</td>
<td>40.4 (11.3)</td>
<td>1101 / 454 (70.0%)</td>
</tr>
</tbody>
</table>
Responses by participants to the following statements:

"Would you recommend this training to a colleague?"

"Please rate how satisfied you were with the training"

"How helpful do you think this training is in improving outcomes for people with personality disorders?"
MH-Kids

The project has collaborated with the child and adolescent mental health service (MH-Kids) providing training and complex care review sessions. The key components of the training were as follows:

- Introduction to Project Air model, guidelines and clinical resources
- Early Intervention, episodic treatment, family involvement, flexibility vs. limits, consultation, liaison, supervision
- Assessment and screening for personality disorders in young people
- Brief intervention and care planning
- The challenges of working with and responding appropriately to complex and challenging presentations in young people
- Managing deliberate self-harm and suicidal behaviour
- Working with reluctant or aggressive young people
- Working with families, carers, schools and communities
- Managing transitions to other services

The following table shows the sample characteristics of participating staff in the training.

**Characteristics of participating staff - Sydney initial training**

<table>
<thead>
<tr>
<th></th>
<th>No. of attendees (% of total)</th>
<th>Mean age in yrs (± SD)</th>
<th>Gender F / M (% of F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Staff</td>
<td>44 (40.4%)</td>
<td>42.1 (10.2)</td>
<td>35 / 9 (79.5%)</td>
</tr>
<tr>
<td>Psychiatrist / Registrar</td>
<td>6 (5.5%)</td>
<td>38.8 (3.0)</td>
<td>2 / 4 (33.3%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>17 (15.6%)</td>
<td>37.7 (7.9)</td>
<td>13 / 4 (76.5%)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>10 (9.2%)</td>
<td>33.4 (7.5)</td>
<td>8 / 2 (80.0%)</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>15 (13.8%)</td>
<td>38.0 (9.0)</td>
<td>13 / 2 (86.7%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>9 (8.3%)</td>
<td>37.1 (13.1)</td>
<td>6 / 3 (66.7%)</td>
</tr>
<tr>
<td>Not Specified</td>
<td>8 (7.3%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5 full days of training was provided in Sydney (2 trainings), Coffs Harbour, Orange, and Queanbeyan with over 350 attending. Follow-up complex care reviews were conducted in Gosford, Lismore, Orange, Albury, Hornsby, Penrith, Campbelltown, Wollongong and Parramatta, with over 130 attending.
Training Evaluation Surveys

The evaluation survey for each training or case review session was collected and analysed. There were 166 surveys from case review session and 109 from training sessions. The results are shown in the following figures and tables. Also all participants would recommend the training / case review session training to their colleagues (100%)

Number and the area of participating staff in complex case reviews - followup

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albury</td>
<td>10</td>
</tr>
<tr>
<td>Bathurst</td>
<td>1</td>
</tr>
<tr>
<td>Chatswood</td>
<td>1</td>
</tr>
<tr>
<td>Coffs Harbour</td>
<td>4</td>
</tr>
<tr>
<td>Concord</td>
<td>3</td>
</tr>
<tr>
<td>Deniliquin</td>
<td>5</td>
</tr>
<tr>
<td>Gosford</td>
<td>26</td>
</tr>
<tr>
<td>Goulburn</td>
<td>1</td>
</tr>
<tr>
<td>Grafton</td>
<td>2</td>
</tr>
<tr>
<td>Lismore</td>
<td>25</td>
</tr>
<tr>
<td>Newcastle</td>
<td>2</td>
</tr>
<tr>
<td>Orange</td>
<td>9</td>
</tr>
<tr>
<td>Penrith</td>
<td>11</td>
</tr>
<tr>
<td>Queanbeyan</td>
<td>14</td>
</tr>
<tr>
<td>Richmond</td>
<td>1</td>
</tr>
<tr>
<td>Ryde</td>
<td>5</td>
</tr>
<tr>
<td>Taree</td>
<td>8</td>
</tr>
<tr>
<td>Tweed</td>
<td>1</td>
</tr>
<tr>
<td>Wagga</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>136</strong></td>
</tr>
</tbody>
</table>

Male = 36   Female = 100
Responses by participants to the following statements:
"Please rate how satisfied you were with the training"

"Please rate how satisfied you were with the case review session"

"Would you recommend this training / complex care review to a colleague?"
Strategy C. Evaluating Outcomes

Component 5. More confident and skilled staff

Detailed evaluation from the pilot study has shown that the strategy leads to significant improvements in staff confidence and clinical skills pre (baseline) and post (12 months) training.

Staff 12 month follow-up

75 trained staff members were actively involved in specific personality disorder programs at 12 month follow-up. Their mean age (±SD) was 42.9 (10.8), with an average of 12.0 (± 9.5) years’ work experience and 9.7 (± 8.0) years’ experience working with personality disorder clients. The following figures show the changes in staff confidence and clinical skills pre (baseline) and post (12 months) training:

Component 6. Better patient outcomes

Evaluations of patient outcomes from the pilot study indicates participants significantly reduced their (a) hospital admissions; (b) days spent in hospital; and (c) emergency department visits.

In addition, pilot data indicates that participants were more productive. The number of days that clients were totally unable to carry out their usual activities or cut-back or reduced their usual activities due to their health conditions decreased significantly.

Evaluation of effectiveness:

Participation of Consented Clients

The project has aimed to provide more systematic structured programs to meet the various needs of clients of the health service presenting with personality disorders. This has included providing more skills and resources for individual clinicians (such as those working on inpatient units), but also to instigate where possible both brief and longer term services or programs. The brief interventions have been structured as ‘Gold Card Clinics’, based on the St Vincent’s model19, and have been developed on the recognised fact that the prevalence of these disorders far outstrips the possible supply of places in long-term treatments. In addition, many clients are not able to make use of a longer-term intervention, and responding rapidly to personality-triggered crises with a personality disorders-friendly service may reduce pharmacotherapy and inpatient interventions along with helping to build skills to reduce re-presentation in crisis. The project has also aimed to strengthen existing services (usually DBT programs) through support, training and consultation. Establishing the clinical governance and business rules regarding referrals to the Gold Card Clinic has been an ongoing process in all areas including establishing sound pathways of care from inpatient, emergency, and acute teams to community brief and longer-term services.

A pool of trained and supervised staff with skills and interest in treating personality disorders both in brief and longer-term interventions has been developed in each service. There have been 6 Gold Card Clinics

---

This report shows the characteristics of 300 clients who have consented to participate in having their data included in this evaluation. There were 93 (31.0%) clients in Illawarra (WOLL), 109 (36.3%) in Sutherland (SUTH), 71 (23.7%) in Prince of Wales (POW) and 27 clients (9.0%) in St George (STG).

The Illawarra Shoalhaven area had more female clients (83.9%) compared to other areas. The mean age of clients was 34.0 years ± 13.9 SD. The following figure shows the age distribution of consented clients.

### Characteristics of consented clients for each area (N=300)

<table>
<thead>
<tr>
<th>Area</th>
<th>Mean age in yrs (± SD)</th>
<th>Gender F / M (% of F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wollongong</td>
<td>31.2 (15.2)</td>
<td>78 / 15 (83.9%)</td>
</tr>
<tr>
<td>Sutherland</td>
<td>36.4 (13.4)</td>
<td>60 / 49 (55.0%)</td>
</tr>
<tr>
<td>St George</td>
<td>34.4 (12.8)</td>
<td>17 / 10 (63.0%)</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>34.1 (12.7)</td>
<td>47 / 24 (66.2%)</td>
</tr>
<tr>
<td>All</td>
<td>34.0 (13.9)</td>
<td>202 / 98 (67.3%)</td>
</tr>
</tbody>
</table>

In the Illawarra Shoalhaven more clients completed 3 sessions of GCC compared to other areas. The following figure shows the details of client attendance ranging from 1 to 3 GCC sessions. In some cases clients did not require the 3rd session, or they choose not to attend. Data on the 4th family and carer session is in progress. Note: the data only reflects consented clients with data available to the project; estimates are that only about half of clients have consented to have their outcomes included, and at one clinic the consent rate is much smaller.

### Gold Card Clinic attendance rates per session, by area (at Aug 2013)

<table>
<thead>
<tr>
<th></th>
<th>1 session</th>
<th>2 sessions</th>
<th>3 sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISLHD</td>
<td>30 (100%)</td>
<td>24 (80%)</td>
<td>18 (60%)</td>
</tr>
<tr>
<td>SESLHD</td>
<td>36 (100%)</td>
<td>19 (53%)</td>
<td>14 (39%)</td>
</tr>
<tr>
<td>All</td>
<td>66 (100%)</td>
<td>43 (65%)</td>
<td>32 (48.5%)</td>
</tr>
</tbody>
</table>

ISLHD = Illawarra Shoalhaven; SESLHD = Sutherland, St George and Prince of Wales


These data show attendance at clinics was strong – with about 50% completing all 3 sessions. This is in comparison with outcomes from the Wilhelm study reporting 21% completion of all 3 sessions.
Client Outcomes

Reduction in hospital use

The Project Air Strategy has significantly reduced inpatient use. 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 \( t(360) = 13.87, p = .000; \frac{t}{t(360)} = 4.74, p = .000 \) respectively.

The Project Air Strategy has also significantly reduced Emergency Department (ED) presentations. Before Project Air, 100 clients (subset of N=361) had on average 1.17 presentations to ED over 18 months (Oct 2009 – March 2011). Post Project Air (April 2011 – Sept 2012) this average dropped to .31 presentations \( t(99) = 8.3987, p = .000 \). More detailed data has been collected on the characteristics of 182 clients involved in more specific treatments. There were 73 (40.1%) clients in Illawarra Shoalhaven, 56 (30.8%) in Sutherland, 39 (21.4%) in Prince of Wales, and 14 clients (7.7%) in St George.

20
**Follow-ups**

The consented clients were interviewed by phone at 12 months and at 18 months. The following table shows the number of clients who were followed-up. The Project Air Strategy is continuing to collect data by interview when possible. Some clients have moved out of area and some are not contactable. The completed result will be available at later stage.

Total number of clients contacted for follow-up interview (at Aug 2013)

<table>
<thead>
<tr>
<th>Location</th>
<th>12 Months</th>
<th>18 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wollongong</td>
<td>15</td>
<td>N/A</td>
</tr>
<tr>
<td>Sutherland</td>
<td>10</td>
<td>N/A</td>
</tr>
<tr>
<td>St George</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>38</td>
<td>23</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>93</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

The following data is for the first 57 who have been followed-up after 12 months. This data collection is ongoing and will be the subject of future peer review reports. The following information was collected using: 1) Specific Borderline Personality Disorder assessments at intake and 12 months, 2) Mental Health Assessment Scale (SF-36), 3) WHO World Health Organization ratings (QOL/DAS), and 4) Beck ratings of suicidal ideas and intent.

*Improvements in personality disorder symptoms*

Most clients at intake had at least 7 symptoms of Borderline Personality Disorder, which had dropped to 4 after 12 months, as measured by clinical interview based on DSM-IV psychiatric criteria \[t(45) = 6.81, p = .000\].

*Reductions in depression*
Most clients at intake had significant symptoms of depression (measured by the clinical cut-off on the mental health inventory SF-36), which had significantly reduced after 12 months [t(43) = 4.34, p = .000].

**Thoughts of suicide reduced**

Clients ratings of suicidal thoughts from the Beck suicide assessment significantly reduced after 12 months [z(42) = -3.633, p = .000].

**Quality of life improved**

Clients rating of quality of life increased significantly over 12 months, as did their satisfaction with their health, and ratings of overall health, as measured by the WHO-QOL [z(46) = -3.972, p = .000].

**People were more productive, with fewer days unable to work**

The number of days that clients were totally unable to carry out their usual activities, or cut-back or reduced their usual activities, due to their health conditions decreased significantly, as measured by the WHO-Disability Assessment Scale: Disability days: t(40) = 2.867, p = .007, Cut-back days: t(37) = 2.323, p = .026.
Cost-effectiveness

The project has aimed to provide improved services to personality disorders without additional costs to LHDs. The strategy has therefore been to develop staff skills and clinical resources to enable delivery of more effective treatments without increasing staff or workloads within mental health services.

The project has demonstrated significant cost savings in two particular ways:

1. The reduction in inpatient use and days in hospital
2. The improvement in work productivity for treated patients

Reductions in particular types of treatments provides significant savings. It is known that people with personality disorders that seek treatment (e.g. present to Emergency Departments, require outpatient and inpatient care) pose a high economic burden on society; a burden substantially higher than that found for other mental illnesses such as depression and generalised anxiety. A study conducted in the Netherlands ($N = 1740$) found that the direct medical costs per patient with a personality disorder were AUD$10,760 (€7,398) per year. While the indirect cost per patient with a personality disorder and a paying job was an additional AUD$10,309 (€7,088) per year. The total days lost because of absence from work or inefficiency at work was found to be 47.6 per patient per year. BPD was associated with increased direct and indirect costs. According to the Australian National Survey of Mental Health and Well-Being, 4.8% of the Australian full-time workforce has a personality disorder, with a personality disorder being predictive of work impairment. A current mental illness was associated with an average of one lost day from work, and three days of reduced performance in the month prior to the survey. Lost work productivity due to mental disorders, such as personality disorders and substance-related disorders, contributes a loss of AUD$2.7 billion each year.

The high societal costs of personality disorders suggest the importance of prioritising the development and implementation of effective personality disorder treatments. Research has established a significant cost benefit of implementing appropriate psychosocial treatments for people with BPD. One year of psychotherapy was associated with an average decrease in inpatient costs of AUD$21,431 per patient with BPD. Findings suggest a suitable psychotherapy treatment course for BPD will save the State at least AUD$8,000 per patient a year following therapy. The Project Air Strategy will continue to monitor outcomes and will report other cost-savings as follow-ups are completed.

Qualitative reports of consumers

**Self-discovery**

“The sessions are most useful. It helps me understand myself as a person, because that’s one of my big problems. I don’t know myself”.

“… about relationships and how to understand and improve them … oh, I wouldn’t say there was anything least helpful, because everything has been”.

“I’ve got my son living with me. My niece is pregnant and I’m going to be godmother. Um, there’s a few little good things”.

**A sense of hope for the future**

“I think the most helpful part was, for me, the reassurance that I wasn’t, the only person that was going through these things and had issues and more making myself relatable and making it in my head more that I was capable”.

“At the moment I’m going through a bit of a new stage, opening up … going back to TAFE and actually going back into a normal life pattern”.

“I’ve been a bit withdrawn from actually living my life … for once I’m confident that it’s actually going to go somewhere”.

…and returning to a normal life

“… the stuff we talk about is important but then also the skills of learning how to manage and deal with things is also important … talking about skills and trying to put them in practice”.

“… and recently, the last couple of days, I’ve spoken to Mum and been like quite open and honest in like a lot of the things that I’ve been hiding from her. So that’s just really good like I feel, a great relief that I’ve been able to - to do that”.

“… I enjoy going to work and colleagues that I have at work are good and I have a good, understanding boss as well”.

---


**Strategy D. Connecting with families, carers and consumers**

Families and partners are often the most isolated and burdened in their role as carers for a person with personality disorders.

**Component 7. Education sessions**

The strategy provides public education sessions for the community and works with mental health services to better connect with consumers and carers and integrate them into treatment planning.

**Component 8. Group support meetings**

The strategy works with mental health staff and NGO services to provide support and education groups/workshops designed specifically to assist carers of people with personality disorders.

Full day education sessions have been regularly provided for the community, advertised through carer groups, community newspapers, and health services. Group support meetings, consisting of four sessions of specific support based on the Project Air Strategy DVD *Staying Connected*, have also been trialled and evaluated.

**Evaluation of effectiveness:**

Ninety-one carers have completed workshop evaluations to date:

- satisfaction with workshops – 95%
- helpfulness of workshops - 91%
- levels of willingness to remain carers - 93%
- optimism for the person with personality disorder - 77%
- enthusiasm for caring for the person with personality disorder - 85.5%
- confidence in caring for the person with personality disorder - 78.2%

**Carer Intervention – Gold Card Carer**

In August, 2011, the Project Air Strategy consulted with key stakeholders regarding carers of people with personality disorders, including carer representatives, ARAFMI and the South Eastern Sydney Local Health District Family and Carer Mental Health Program team (including Dr Annemaree Bickerton, Toni Garretty and Janice Nair). During this meeting it was established that there is potential to work with families and carers of people with personality disorder, both to support the carer in their role, and to improve outcomes for the consumer.

Since this time, the Project Air Strategy and the Family and Carer Mental Health Program team have partnered to develop and deliver training and resources for carers of people with personality disorder based on the Project Air Strategy relational model. The training involves a manualised one session intervention for carers of consumers engaged in the Gold Card Clinic, a full day workshop and psycho-educational groups.

The educational workshops for families and carers has been developed and facilitated by the Family and Carer Mental Health team in collaboration with Project Air Strategy in Wollongong, Nowra, Sutherland, St George, Gymea, and Bondi Junction. To date, 162 relevant carers (of whom 126 consented to the research) have been trained through the workshop. Details on the evaluation of the workshop are below.

During the workshops, relevant and interested carers were invited to attend four fortnightly two hour group sessions (total of 8 hours). Those who attended were randomized into either the group (2 groups) or a waitlist who would be provided the intervention at a later date (2 groups). The groups are being evaluated by a Randomised Control Trial, which will provide evidence as to whether the intervention has been
effective in improving carer wellbeing. 100% of carers who responded to the question endorsed that they would recommend the group training to a relative or friend.

**Attendees found useful:**

- The interaction of the group
- Developing and putting into place a safety plan
- Hearing what others had to say about their experiences (normalising)
- Not becoming over-involved when the situation was not life threatening
- Strategies for supporting the person and maintaining self-care

Attendees found the four fortnightly two hour group sessions to be both helpful in their specific circumstances and satisfying for their own needs as shown in the following graph. The smaller group size and interactive nature of the four sessions facilitates a sharing mode that attendees found helpful. Within this format there is room for attendees to work on their own specific issues and, for example, to work on and discuss their own safety plan and to compare and contrast this with others in similar circumstances, and to get feedback from the experienced facilitators.
Demographic profile of carers of persons with personality disorder

<table>
<thead>
<tr>
<th>Carer (n=162)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: F (M)</td>
</tr>
<tr>
<td>109 (53)</td>
</tr>
<tr>
<td>Mean age in years: (range)</td>
</tr>
<tr>
<td>53.6 (15 – 81 years)</td>
</tr>
</tbody>
</table>

**Employment Status:**
- Full-time: 34%
- Part-time: 28%
- Unemployed: 35%
- Not stated: 8%

**Carer relationship (to the consumer):**
- Mother: 51%
- Father: 17%
- Spouse / Partner: 16%
- Child: 6%
- Sibling: 2%
- Significant Other: 9%

**Duration of caregiving relationship in years: (range)**
9.6 (0 – 33 years)

Responses by carers to the statement: "Please rate how satisfied you were with the workshop"
Strategy E. Improving awareness and information

Component 9. Public events and conferences

The strategy has been very active in raising the public profile of personality disorders in the community and among health workers. The strategy has developed a highly successful Annual Conference (attracting world leaders) to act as a catalyst for leadership and professional development. The strategy has also presented regularly at other important conferences (e.g. Royal Australian and New Zealand College of Psychiatrists conference). The project is an inaugural supporter of Borderline Personality Disorder Awareness Day and has run events each year in conjunction with mental health awareness month.

Newsletters

The project has published an e-newsletter (Air Notes) for mental health staff working in the NSW Health pilot sites (Illawarra Shoalhaven and South Eastern Sydney) that have obtained training. There have been four newsletters: Summer 2011 (December), Autumn (March) 2012, and Winter (August) 2012, and Summer 2012 (December). Available at: http://ihmri.uow.edu.au/projectairstrategy/newsletters/index.html

Community Outreach

The project is collaborating to promote awareness and quality treatments for personality disorders. It has hosted community awareness events on October 5th for Borderline Personality Disorders Awareness Day: 2011 in Canberra and Wollongong; 2012 at St George Hospital; 2013 in conjunction with ARAFMI in Sydney. The project is also working to promote awareness through the online web and social marketing strategies. Key people in the team are regularly involved in national and international conferences and other workshops, including the International Society for the Study of Personality Disorders. The project has hosted many meetings during the project period. The project also maintains a collegial relationship with the Spectrum Personality Disorders Service for Victoria.

Evaluation of effectiveness:

Conferences
2010 Conference
On Friday 5th November 2010 the project held the 4th Annual Conference on the Treatment of Personality Disorders with the theme “Consolidating Collaboration” at the University of Wollongong. 80 mental health staff from across NSW who specialise in the treatment of personality disorders attended.

2011 Conference
The 2011 conference was held at the University of Wollongong on 4th November on the theme "Engaging Carers and Services" with 159 mental health staff from across NSW who specialise in the treatment of personality disorders attending. Speakers were Associate Professor John Allan, NSW Chief Psychiatrist; Ms Janne McMahon, Private Mental Health Consumer Carer Network (Australia); Dr Michael Paton, Clinical Director Mental Health Drug and Alcohol Northern Sydney Local Health District and Central Coast Local Health District; Jane Morton, Spectrum - the Personality Disorder Service for Victoria; Eileen McDonald, MHCA National Register MH Consumer and Carer Representatives; Associate Professor Andrew Chanen, Orygen Youth Health and University of Melbourne; Professor Brin Grenyer, Illawarra Health and Medical Research Institute, and short papers by Claudia Mendez, Matt Frize, Susan Coleman and Dr Andrew Phipps.

2012 Conference
The 2012 conference was held on 9th November at the University of Wollongong, followed by a workshop on the 10th and attracted 180 mental health professionals. The conference theme was “Guidelines-based practice”. Opened by the Director of MH-Kids (NSW Health), Associate Professor Beth Kotze, the keynote address, entitled ‘Rethinking personality disorder diagnosis’ was given by a Professor Roger Mulder, Chair of Psychiatry at the University of Otago, NZ, editor of *Personality and Mental Health*, co-chair of the WHO Committee on Personality Disorders and a member of the ICD-11 Classification Committee for Personality Disorders. Other speakers were Dr AnneMaree Bickerton, occupational and family therapist, Jan Giffin, consultant psychiatrist and President of the International Society for the Study of Personality Disorders, Associate Professor Andrew Chanen, Orygen Youth Health and University of Melbourne; Professor Brin Grenyer, Illawarra Health and Medical Research Institute, and short papers by Dr David Hawes and Dr Rebekah Helyer, University of Sydney researchers and University of Wollongong researcher, Rachel Bailey. A focused workshop with Professor Mulder and Professor Brin Grenyer on the following day attracted 170 participants. The participants at the workshops were happy to recommend these workshops to their colleagues (93.8%).

2013 Conference
The 2013 conference was held on 5th–6th July with the lecture format presentations on Friday 5th July on the theme "Intervention Models" with 311 attendees and Associate Professor Shelley McMain’s workshop on Saturday 6th July with 163 attendees; in total 350 persons were involved in the conference.

Speakers were Associate Professor Shelley McMain, Head of the Borderline Personality Disorder (BPD) Clinic at the Centre for Addiction and Mental Health (CAMH) in Toronto, Canada and Associate Professor in the Department of Psychiatry at the University of Toronto; Professor Russell Meares, the Emeritus Professor of Psychiatry at the University of Sydney, Dr Christopher Lee, Senior Lecturer in the School of Psychology, Murdoch University Perth, Associate Professor Andrew Chanen, Orygen Youth Health and University of Melbourne; Dr Michael Daubney, Clinical Director of a Brisbane Child and Adolescent service and Ms Stuchbery, a Senior Clinical Psychologist at Karitane, Dr Carla Walton from University of Newcastle and Professor Brin Grenyer, Illawarra Health and Medical Research Institute.

Feedback on the day and via the feedback sheets indicated that the conference was a success and well received by those who attended.

The following two graphs show that the participants were more satisfied with the 2013 conference compared to the year before and would recommend the workshops to their colleagues (96.2%).
Responses by participants to the question: “Would you recommend this training to a colleague?”

**Component 10. Website, fact sheets and guidelines**

The project has developed a website, fact sheets and guidelines for clinicians, consumers and carers. [www.projectairstrategy.org](http://www.projectairstrategy.org) provides people with personality disorder, families and carers, and health professionals an extensive amount of information on personality disorders. The project has developed free to download clinical guidelines, information of workshops and seminars, and 18 free to download fact sheets for people with personality disorders and carers.

**Fact Sheets**

The project has developed over 18 Fact sheets for consumers and carers. In addition, for health professionals the website has available the developed Care Plan (to be used by health professionals with people with personality disorders) and the Carer Plan (to be used by health professionals working with families, partners and carers of people with personality disorders).
Example fact sheets for people with personality disorders:

- What is a "personality disorder"?
- What treatment is available to me?
- Relationship difficulties, arguments & conflicts
- Self-harm: what is it?
- The importance of self-care
- Managing anger
- Managing distress
- Managing emotions

Example fact sheets for families, partners & carers of people with personality disorders:

- For families, partners & carers: The basics
- For families, partners & carers: Helpful tips for challenging relationships
- For families, partners & carers: Managing anger
- For families, partners & carers: Looking after yourself
- For families, partners & carers: Strategies for effective communication & healthy relationships

For further information on the fact sheets please visit the Project Air Strategy website at:

Project Air Strategy Website

The web-based approach at www.projectairstrategy.org provides: (a) patient-relevant information and support, including treatment information, personal stories by consumers, relevant treatment handouts, and online care options; (b) carer and family information and support strategies; (c) information for health professionals involved in treatment; (d) research information and news on latest treatment advances and invitations to conferences and professional development events; and (e) a referral directory to specific personality disorder services in NSW and across Australia. The website went live on the 5th June 2011. There are also social networking sites: Facebook, Twitter, and YouTube. The site has had 7870 visits and 22,973 page views originating from 10 countries around the globe during the six-month period from 1 Feb 2013 until 31 July 2013.

Website Usage Statistics

5,595 individuals visited the Project Air Strategy website in the past 6 months (Feb – July 2013) with 22,973 page views. 43% of people return to the site again after the first visit.
Strategy F. Enhancing quality of clinical services

The project has developed and implemented three specific interventions: brief interventions, extended community interventions, and expert consultations with regards complex care issues. The impact of the training and clinical redesign has been monitored and evaluated and data provided to services.

**Component 11. Early intervention and psychological treatment**

The project has developed and works with services to implement specific interventions, including:

1. **Brief interventions**: The ‘Gold Card Clinic’ offers 3 sessions of rapid follow-up, support, care planning and skills training for clients presenting in distress and crisis, plus a further session connecting with carers, partners and families. Clients get an appointment within 1-3 days of referral and are managed in the community. These clinics provide an alternative to less effective and more expensive emergency and inpatient services, and they address the person in crisis in a timely way to meet their needs.

2. **Extended community interventions**: An evidence-based model for longer sessions of individual and/or group sessions addresses the principal personality deficits to enable and consolidate relationship skills and work readiness. These include strengthening pre-existing and new specially designed personality disorder-specific programs.

---

**Component 12. Complex care reviews**

It is known that a small proportion of clients account for a significant proportion of costs in health care delivery. Such cases frequently come to the attention of senior managers, LHD executives and ministers. Providing specific targeted review sessions for complex cases is a specific benefit of engaging in the strategy. Such case reviews provide an external independent opinion to manage risk, and can change the trajectory of an individual’s recovery. The case reviews are also used as opportunities for teams to review and streamline processes and create efficiencies in clinical services.
Conclusion

Improving services for consumers with a personality disorder and their families and carers is both a challenge and a priority, as emphasised by the recent NHMRC clinical guidelines for the treatment of borderline personality disorder (2013). The Project Air Strategy represents an innovative and comprehensive whole of service response to meeting that challenge.

The 3-year pilot project (2010 – 2013) has also developed resources to support the implementation of a broader strategy, including:

- Clinical guidelines for the treatment of personality disorders
- Clinical manuals for both brief and more specialist interventions and family and carer interventions
- Extensive training and DVD resources
- A public dissemination strategy through the project website www.projectairstrategy.org

The pilot project outcomes have been reported to the Minister for Mental Health (May 2013), the NSW Mental Health Commissioner (December 2012 and June 2013), and peer review has been obtained through presentations to key stakeholder groups (Royal Australian and New Zealand College of Psychiatrists Annual Conference May 2013; Society for Psychotherapy Research International Meeting, July 2013; 7th Annual Treatment of Personality Disorders Conference, July 2013).

The pilot study has also provided an opportunity to improve understanding with regards the key ingredients for success in implementing such a project within LHDs. The findings have identified some key strategies including: (1) the need for clear and accountable leadership commitment within LHDs at the level of the Director and senior clinical staff; (2) the need to support service change to establish and support clinical pathways for personality disorders into specific treatment clinics in the community; and (3) the need for management to ensure sufficient penetration of training to all staff, including the need for online as well as face to face training options. When these three ingredients were present within the pilot sites, the study implementation has been highly successful.

The pilot project has provided proof of concept and a specific approach to state-wide implementation. This project has shown it is possible to improve the capacity of mainstream mental health services to manage and treat personality disorders and to improve specialist treatment options, including better referral pathways between generic and specialist treatment. The project has demonstrated how to deliver well-constructed and supported education and supervision programs in addition to the provision of expert interventions. It also has evaluated specialist intervention models and thereby this pilot provides guidance for future service development in NSW.
Appendix 1: Sample Project Poster

What is Project Air Strategy?

*Project Air Strategy* is a state-wide program for the treatment of personality disorders being piloted across SESLHD and ISLHD. The project has five main parts.

- **Service-wide training** and support for mental health staff.
- **Clinical consultation**, supervision and complex case review.
- **Provision of treatment guidelines** for personality disorders, and clinical resources such as fact sheets and therapy cards.
- **Research** – into the current treatment pathways of clients with a personality disorder or significant personality disorder traits. We are currently recruiting participants for the research arm of the project.
- **Service models** – the **Gold Card Clinic** is a brief intervention focused on reducing crisis-related hospital presentations, increasing compliance with follow-up interventions, improving consumer self-directed crisis management skills. We also support **extended interventions (such as DBT)** for personality disorders.

---

*For more information, contact the researcher for the project at your site:*

- POW Hospital – Melissa Pigot ([Melissa.pigot@sesiahs.health.nsw.gov.au](mailto:Melissa.pigot@sesiahs.health.nsw.gov.au))
- St George Hospital – Terry Rae ([Terry.rae@sesiahs.health.nsw.gov.au](mailto:Terry.rae@sesiahs.health.nsw.gov.au))
- Sutherland Hospital – Jessica O’Garr ([Jessica.ogarr@sesiahs.health.nsw.gov.au](mailto:Jessica.ogarr@sesiahs.health.nsw.gov.au))

For general enquiries please contact Kelly Hutchison on (02) 4298 1571 or email [info-projectair@uow.edu.au](mailto:info-projectair@uow.edu.au)

Appendix 2: Sample Gold Card Clinic Poster

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?

Talk to your clinician about a referral to the **THE GOLD CARD CLINIC**

**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 an appointment, call the nearest service for information on how to refer.

**to contact the GOLD CARD CLINIC**
FOR YOUNG PEOPLE, contact the Wollongong Child and Adolescent Mental Health Team
1 Atchison Street, Wollongong, Ph: (02) 4264 1800

FOR ADULTS call for an assessment on 1800 011 511.
Contact the nearest service for information on how to refer:
Wollongong Community Mental Health: Ph: (02) 4264 1800,
Lake Illawarra Community Mental Health: Ph: (02) 4252 0700,
Nowra Community Mental Health: Ph: (02) 4424 6430

NSW Health
PROJECT AIR: A HANDS-ON APPROACH TO MENTAL HEALTH
### Appendix 3: Example Gold Card Clinic Business Rule

**Prince of Wales - Brief Lifeworks Intervention Program (BLIP)**

**BUSINESS RULE:**
Eastern Suburbs Mental Health Service

<table>
<thead>
<tr>
<th>Name</th>
<th>Gold Card Clinic (GCC) intake, allocation and discharge processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Rating</td>
<td>High</td>
</tr>
</tbody>
</table>

#### What it is
An outline of the procedures involved in making referrals to the GCC, the intake and allocation of referrals within the GCC, and the process by which consumers are discharged or transferred to other services.

#### What to do
**Overview**
The Gold Card Clinic is a brief intervention service for people in the SESLHD catchment area who have recently experienced a mental health crisis involving self-harm and/or suicidal thoughts or behaviours.

The GCC aims to offer an appointment within 1-3 working days of referral and offers an initial 3 sessions that focus upon identifying and addressing psychological and lifestyle factors that contributed to the crisis. An additional session for carers, partners and family members is included in the intervention.

The key aims of this intervention are to:
- provide a timely and rapid response to people seeking treatment in crisis
- provide an alternative to hospitalisation or facilitate early discharge
- provide brief interventions to help manage the client's immediate needs
- provide brief clinical services aimed at helping the client solve their problems
- provide assessment and psycho-education to help the client understand their problems
- provide tools and strategies to help the client prevent and better manage future crises
- provide an opportunity to assess the client's needs, including the possible need for other services where necessary
- provide an opportunity to connect with the person's family, partner or carer where desirable
- provide treatments with an evidence-base that are effective with personality disorders

The GCC will operate during the usual opening hours of SESLHD community health services (Monday-Friday, 0830-1700) and will not be available to receive referrals or meet with consumers or carers on weekends or public holidays.

#### Referrals
Referrals to the ESMHS Gold Card Clinic can be made by a range of services, including:
- Emergency Department (ED)
- Psychiatric Emergency Care Centre (PECC)
- Kiloh Centre
- Mental Health Intensive Care Unit (MHICU), from early 2013
- Community Mental Health Team
- Community Rehabilitation Team
- Aboriginal Community Health Centre, from early 2013
- Early Psychosis Program (EPP)
- Acute Care Team (ACT)

#### Eligibility criteria
- Adults (aged 18 and upwards) with primary problems such as suicidal thoughts or plans, recent episodes of self-harm behaviours or suicide attempts, and/or a personality disorder.
- Referral is designated at triage by Central Intake as non-urgent (as defined by the Mental Health Triage Policy)

#### Exclusion criteria:
- Urgent referrals (as defined in the Mental Health Triage Policy). **Action:** contact emergency services/refer to Central Intake who will consider referring on to the ACT or emergency services
- Evidence of psychosis. **Action:** refer to Central Intake to access the ACT/EPP
- Evidence of a primary alcohol/drug dependence disorder. **Action:** refer to Central Intake to access ACT and appropriate drug and alcohol services
- The person could be more appropriately supported by the ATAPS Suicide Prevention Service (see Business Rule 12/001)

Referral to GCC over the ATAPS Suicide Prevention Service is preferable when:
- The consumer is already being or is about to be supported by NSW Health community mental health services
- A diagnosis of a personality disorder has already been made or is being considered, and an explicitly personality disorder-friendly service may be more helpful
- There are carers/family members/partners who are in need of information and support
- The consumer prefers to access the GCC rather than the ATAPS scheme
Referral procedure

If the referrer feels that a consumer meets the criteria for the GCC they should make their referral by telephoning Central Intake (9382 2950) and asking to make a referral to the Gold Card Clinic.

The Central Intake Clinician will triage as usual, making a careful assessment with the referrer as to the urgency of the referral and whether the GCC is the most appropriate option at that time.

Should the consumer’s presenting difficulties not fit with the GCC’s referral criteria, or if any of the exclusion criteria are met, the Central Intake Clinician will refer on to other services as appropriate.

If the Central Intake Clinician decides that the referral is appropriate for the GCC they should:

1. Ask the referrer to inform the consumer that a GCC clinician will contact them to arrange an appointment and they will be seen by the GCC within 1-3 working days of the time of the original referral to Central Intake
2. Ask the referrer to provide the consumer with the Gold Card Clinic Information Leaflet, which provides information about the service and ‘crisis contacts’ in case of an escalation of risk
3. Ask the referrer to forward any appropriate documentation, including the Mental Health Assessment form
4. Forward the following information to the GCC Co-ordinator:
   a. Gold Card Clinic Referral Form
   b. Mental Health Triage form
   c. Mental Health Assessment form
   d. Any other relevant documentation
5. The information should be sent to the GCC Co-ordinator first via fax to the GCC’s designated fax number (see the GCC-Unconfirmed White Board, located at Central Intake) with the hard copies of the paperwork to follow via the internal mail along with the consumer’s community file (existing or newly made-up).
6. Place the consumer’s details on the GCC-Unconfirmed White Board until the GCC-Co-ordinator has confirmed acceptance of the referral.
7. If the GCC Co-ordinator or designated deputy has for any reason not confirmed receipt/acceptance of the referral within 1 working day of the referral being sent to them, attempt to make contact with the GCC directly via telephone.
8. If you are unable to make contact with the GCC at this point: Central Intake Officer to discuss at ACT handover to agree the next appropriate follow-up as per the usual ACT procedure and in accordance with the degree of urgency assigned at triage.

Intake into the GCC

The GCC Co-ordinator (or the ‘designated deputy’, who will follow the same procedure in their absence) checks for referrals on a daily basis.

Upon receiving a referral the GCC Co-ordinator will review the information to check that the referral appears appropriate and that none of the exclusion criteria are present.

Once the GCC Co-ordinator has decided that the referral is appropriate and is to be accepted they will telephone Central Intake to confirm receipt and acceptance of the referral.

If the GCC Co-ordinator is concerned for any reason that the referral may actually be urgent rather than non-urgent, or better served by an alternative service, they will discuss this further with Central Intake when they call to confirm receipt of the referral and consider whether the ACT or another service should be involved.

The GCC Co-ordinator allocates appropriate referrals to GCC clinicians so that the first session of the brief intervention can be offered within 1-3 working days of the original referral to Central Intake.

The allocated GCC Clinician contacts the consumer to inform them of the appointment time and the location for the appointment.

If the consumer is not contactable for any reason the GCC Clinician contacts Central Intake to discuss concerns and consider a referral to the ACT for more assertive follow-up.

Non-attendance of GCC appointments

If a consumer fails to attend a GCC appointment without having called to reschedule, the allocated GCC Clinician should:

1. Call the person to ascertain their reason for non-attendance
   a. If they answer:
      i. carry out a brief assessment of why they were unable to attend, being vigilant for any signs of increasing risk
      ii. should increasing risk be identified consider referring the person to crisis services (see below)
      iii. otherwise offer the person another appointment at a time that is suitable.
   b. If there is no answer:
      i. where possible leave a message asking the person to contact the GCC and remind the person of the crisis contacts should these be needed
      ii. contact the referrer to assess the person’s motivation and check for any changes in the person’s situation that might account for non-attendance
2. Wherever the person’s non-attendance has involved an escalation in risk or it has not been possible to make contact with them to reschedule, liaise with the GCC Co-ordinator, the GCC Consultant Psychiatrist and the ACT to determine what is the most appropriate action to be taken, which may include considering a referral to the ACT for more assertive follow-up.

3. Clearly document details of all attempts to contact the consumer, telephone calls made to professionals and significant others, decisions made, actions taken and outcomes achieved.

**Referral to crisis services**

If the GCC Clinician assesses at any time that the level of risk requires an extremely urgent response they should always contact the emergency services immediately.

If the level of risk appears to require a response of any other level of urgency (i.e. low, medium or high urgency) the GCC Clinician should contact Central Intake to consider a referral to the ACT.

If a GCC Clinician identifies any risk to a child they should consult appropriately with the GCC Consultant Psychiatrist, social work colleagues, and the Child Wellbeing Unit (1300 480 420). They can also use the NSW Health Online Mandatory Reporter Guide to aid decision-making in relation to any child protection concerns.

**Discharge procedure**

As a GCC Clinician is approaching the end of their work with a consumer they will bring the case to the GCC Review Meeting for discussion and discharge planning in consultation with the GCC Consultant Psychiatrist, who will ultimately authorise the person’s discharge from the service and where appropriate arrange a transfer of care to another SESLHD mental health service.

If, as the consumer approaches the end of the GCC brief intervention, there are concerns about safety and a judgement that a further mental health response of some level of urgency is required, the GCC Consultant Psychiatrist will, in consultation with GCC Clinicians, consider making a referral to appropriate services, including the ACT and inpatient mental health services.

As a central part of the discharge procedure the GCC Clinician will carry out a careful and collaborative consideration of further treatment and support options with the consumer and, where possible, with carers, family members and partners. This may involve a variety of actions, including but not limited to:

- Provision of resources and information about services and supports
- Signposting to specific resources, supports, services and local specialist clinicians
- Formal referrals to specific services and local specialist clinicians
- Liaison with identified local specialist clinicians to facilitate transition into longer-term treatments
- Liaison with GPs to facilitate arrangements for follow-up in primary care and access to ATAPS and Better Access Initiatives

**Documentation**

There are 4 key documents which are to be completed and filed appropriately for any consumer accessing the GCC:

- The Mental Health Assessment form must have been completed prior to the consumer’s entry into the GCC. It is expected that this document will have usually been completed by the referring clinician/service prior to the original referral to Central Intake and this form should be forwarded to the GCC Co-ordinator when the initial referral is passed to the GCC by the Central Intake Clinician.
- The Mental Health Triage form will be completed by the Central Intake Clinician as they receive the referral and forwarded to the GCC Co-ordinator when the initial referral is passed to the GCC by the Central Intake Clinician.
- The Mental Health Review form will be completed for all cases discussed at the GCC Review Meeting.
- The Mental Health Transfer/Discharge Summary form will be completed by the GCC Consultant Psychiatrist for all consumers when they are discharged or transferred from the GCC.

**When to use it**

At each stage of a consumer’s pathway into and through the GCC: at the point of referral, at triage, when passing a referral from Central Intake to the GCC, at the point of entry into the GCC, and when discharging the consumer from the GCC.

**Why the rule is necessary**

To ensure consistency is applied to the processes underpinning the GCC and to promote safe and effective clinical practice.

**Who is responsible for (Stakeholders)**

Service Managers and Team Leaders are responsible for disseminating the Business Rule and all clinical staff referring to or working for the GCC are responsible for implementing the Business Rule.

**Developed by (Author)**

Clinical Psychologist, Kiloh Centre

**NSW Ministry of Health / SESLHD reference**

1. Service Director, Eastern Suburbs Mental Health Service, attest that this business rule is not in contravention of any legislation, industrial award or policy directive
Appendix 4: Key Personnel
The Director of the Project Air Strategy is Professor Brin Grenyer, Illawarra Health and Medical Research Institute. The project is overseen by an expert advisory committee chaired by the NSW Chief Psychiatrist.

The following table shows the list of staff who have been involved in the project:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
<th>FTE</th>
<th>Position</th>
<th>Contract Start</th>
<th>Contract End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mahnaz</td>
<td>Fanaian</td>
<td>1</td>
<td>Project Manager</td>
<td>01-Nov-10</td>
<td>31-Oct-13</td>
</tr>
<tr>
<td>Kelly</td>
<td>Hutchison</td>
<td>1</td>
<td>Project Assistant</td>
<td>18-Oct-10</td>
<td>17-Oct-13</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Bargenquist</td>
<td>1</td>
<td>Clinical Psychologist</td>
<td>04-Mar-13</td>
<td>30-Jun-14</td>
</tr>
<tr>
<td>Rebekah</td>
<td>Helyer</td>
<td>0.6</td>
<td>Clinical Psychologist</td>
<td>01-Oct-12</td>
<td>30-Jun-14</td>
</tr>
<tr>
<td>Heidi</td>
<td>Jarman</td>
<td>0.4</td>
<td>Clinical Psychologist</td>
<td>01-Aug-12</td>
<td>31-Oct-13</td>
</tr>
<tr>
<td>Phoebe</td>
<td>Carter</td>
<td>0.4</td>
<td>Research Officer</td>
<td>01-Nov-10</td>
<td>31-Oct-13</td>
</tr>
<tr>
<td>Michael</td>
<td>Matthias</td>
<td>0.8</td>
<td>Research Officer</td>
<td>03-Dec-12</td>
<td>3-Sep-13</td>
</tr>
<tr>
<td>Jessica</td>
<td>O’Garr</td>
<td>0.6</td>
<td>Research Assistant</td>
<td>23-May-11</td>
<td>27-Sep-13</td>
</tr>
<tr>
<td>Melissa</td>
<td>Pigot</td>
<td>0.4</td>
<td>Research Assistant</td>
<td>21-Nov-11</td>
<td>11-Aug-13</td>
</tr>
<tr>
<td>Terry</td>
<td>Rae</td>
<td>0.2</td>
<td>Research Assistant</td>
<td>21-Nov-11</td>
<td>11-Aug-13</td>
</tr>
<tr>
<td>Krystal</td>
<td>Sattler</td>
<td>0.2</td>
<td>Research Assistant</td>
<td>10-Apr-13</td>
<td>31-Oct-13</td>
</tr>
<tr>
<td>Kate</td>
<td>Lewis</td>
<td>0.6</td>
<td>Research Assistant</td>
<td>Casual</td>
<td></td>
</tr>
<tr>
<td>Romina</td>
<td>Rabbani</td>
<td>0.8</td>
<td>Research Assistant</td>
<td>Casual</td>
<td></td>
</tr>
<tr>
<td>Nabil</td>
<td>Hashemi</td>
<td>0.6</td>
<td>Administration Assistant</td>
<td>Casual</td>
<td></td>
</tr>
<tr>
<td>Adib</td>
<td>Mansoori</td>
<td>0.4</td>
<td>Administration Assistant</td>
<td>Casual</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resigned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rachel</td>
<td>Bailey</td>
<td>0.6</td>
<td>Research Assistant</td>
<td>23-May-11</td>
<td>14-Dec-12</td>
</tr>
<tr>
<td>Andreas</td>
<td>Comninios</td>
<td>0.6</td>
<td>Research Assistant</td>
<td>02-Jul-12</td>
<td>8-Jan-13</td>
</tr>
<tr>
<td>Bernadette</td>
<td>Jenner</td>
<td>0.6</td>
<td>Research Officer</td>
<td>01-Nov-10</td>
<td>30-May-12</td>
</tr>
<tr>
<td>Shilpa</td>
<td>Madiwale</td>
<td>0.4</td>
<td>Research Assistant</td>
<td>21-Nov-11</td>
<td>11-Jan-12</td>
</tr>
<tr>
<td>Gabrielle</td>
<td>Meadley</td>
<td>0.2</td>
<td>Research Assistant</td>
<td>10-Apr-13</td>
<td>30-Jul-13</td>
</tr>
<tr>
<td>Pascale</td>
<td>Pougnet</td>
<td>0.2</td>
<td>Research Assistant</td>
<td>23-May-11</td>
<td>01-Jun-12</td>
</tr>
</tbody>
</table>
Training Consultants

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Annemaree Bickerton</td>
<td>Child, Adolescent and Family Psychiatrist</td>
</tr>
<tr>
<td>Associate Professor Andrew Chanen*</td>
<td>Orygen Youth Health and University of Melbourne</td>
</tr>
<tr>
<td>Dr Louise McCutcheon*</td>
<td>Orygen Youth Health and University of Melbourne</td>
</tr>
<tr>
<td>Janice Nair</td>
<td>Social Worker and Family Therapist</td>
</tr>
<tr>
<td>Ms Toni Garretty</td>
<td>Family &amp; Carer Clinical Coordinator, Mental Health Services</td>
</tr>
<tr>
<td>Professor Brin Grenyer*</td>
<td>University of Wollongong</td>
</tr>
<tr>
<td>Ms Bernadette Jenner</td>
<td>Clinical Psychologist (Spectrum, Victoria)</td>
</tr>
<tr>
<td>Mr Simon Milton</td>
<td>Clinical Psychologist</td>
</tr>
</tbody>
</table>

* Note: Consultant fees provided to institution, not individuals.

Coordinators of Gold Card Clinics at the time of this report:

- Nicholas Barrington – St George Hospital
- Peter Griffiths – Sutherland Hospital
- Ian Knight – Wollongong / Shellharbour Hospitals
- Andre Morris – Prince of Wales Hospital
- Trish Kenny – Shoalhaven Hospital, Nowra
- Sil Lemme – Wollongong Adolescent Unit

Coordinators of Family and Carer programs:

- Dr Annemaree Bickerton
- Tony Garretty
- Janice Nair