



State-wide
**Borderline
Personality Disorder
Collaborative
Model of Care**

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Government
of South Australia

SA Health



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Acknowledgement

This Model of Care was developed through a process of extensive consultation and collaboration with multiple stakeholders across South Australia (SA) and interstate.

We would like to thank all of the organisations and individuals and in particular, the people with lived experience of BPD, who gave generously their time, expertise, commitment and enthusiasm to contribute to the development of this project. We would also like to thank, in particular, Ms Janne McMahon, OAM for her expert contribution to this document. We have listened to all stakeholders, learned from them and incorporated their views and expertise into this Model of Care.

This Model of Care describes the BPD service development in SA, which will be implemented over time.

The BPD Co will work collaboratively with the LHNs to develop this evidence-based, sustainable, recovery focused BPD clinical service, which is predicated on the needs of consumers, carers and clinicians and will continue to evolve, according to local requirements and quality improvement processes.

Traditional lands of the Kurna people

We acknowledge that the hub of the new BPD service is located on the traditional lands of the Kurna people and pay respect to their spiritual relationship with this country. The state-wide BPD service will provide care for Aboriginal people from other communities across Australia.

A note on language

In SA at the present time, there is no established consensus regarding the preferred designation of people using mental health services. Within this document people who suffer from BPD are referred to as consumers, clients, patients or people with lived experience of BPD.

Further information on this issue can be found at <http://www.ourconsumerplace.com.au/consumer/glossary>

People in relationship with those with BPD are referred to as carers or families.

It is critical to the effective functioning of the new BPD service that consumer and carer representatives be engaged respectfully as active participants and partners throughout the process of design and implementation of the service, including evaluation and quality improvement processes.

The rights and responsibilities of consumers are described in 'A Framework for Active Partnership with Consumers and the Community' (SA Health, June 2016).

Guidelines for carer engagement in mental health systems are to be found in the 'Practical Guide for Working with Carers of People with a Mental Illness' (Private Mental Health Consumer Carer Network Australia 2016).

At times, the views, experiences and perspectives of consumers and carers may be in close agreement, but it is acknowledged that there may also be differences in perspectives, needs and wishes.

The term Aboriginal is used respectfully throughout this document to refer both to Aboriginal and Torres Strait Islander people, although it is acknowledged that this encompasses a large number of diverse communities.

Table of contents

- 1. Vision4**
- 2. Executive summary4**
- 3. The borderline personality disorder context.....5**
 - 3.1. Description of borderline personality disorder5
 - 3.1.1. Diagnostic classification of BPD.....5
 - 3.1.2. Prevalence of BPD in South Australia.....6
 - 3.1.3. Comorbidities associated with BPD6
 - 3.1.4. Course of BPD6
 - 3.1.5. Health service utilisation6
- 4. Evidence base regarding BPD treatment7**
 - 4.1. Links to national policy directives and plans8
 - 4.2. Background.....8
- 5. The state-wide service9**
 - 5.1. Overview9
 - 5.1.1. Staffing9
 - 5.1.2. Location9
 - 5.1.3. Target groups9
 - 5.2. Governance of the state-wide BPD service10
 - 5.3. Hub and spoke model outline10
 - 5.3.1. Hub and spoke service governance principles.....11
 - 5.3.2. Services provided outside SA Health.....11
 - 5.3.3. Roles and responsibilities within the hub and spoke service.....12
 - 5.3.3.1. Evidence based care12
 - 5.3.3.2. Capacity building and training.....13
 - 5.3.3.3. Research and evaluation.....13
 - 5.4. Potential risks.....14
 - 5.4.1. The health system.....14
 - 5.4.2. The characteristics of BPD.....14
 - 5.4.3. The BPD service risks.....14

6. Model of care	15
6.1. Key principles.....	15
6.2. Current landscape.....	15
6.3. The stepped model of care	16
6.3.1. Acute crisis pathways through care.....	16
6.3.1.1. Entry	16
6.3.1.1.1. The Assessment and Brief Intervention Clinic (ABiC).....	17
6.3.1.1.2. Other services offered at all steps through the process	17
6.3.1.1.3. Collaborative decision-making following Step One.....	17
6.3.1.2. Getting extra help	19
6.3.1.2.1. Collaborative decision-making following Step Two.....	19
6.3.1.3. Working towards recovery.....	19
6.3.1.3.1. Collaborative decision-making following Step Three.....	19
6.3.2. Severe and complex shared care	20
6.3.2.1. Entry	20
6.3.2.2. Assessment and care planning.....	20
6.3.2.3. Care implementation.....	20
6.3.2.4. Discharge or referral to ongoing care.....	20
6.4. Special populations and BPD	21
6.4.1 Country areas.....	21
6.4.2. Aboriginal communities.....	22
6.4.3. Early years and new parents	22
6.4.4. Youth	23
6.4.5. The criminal justice system.....	25
6.5. Training and capacity building	26
6.6. Research and evaluation.....	28
7. Implementation of the BPD Co Model of Care	29
8. References	30
Appendix One – Links to mental health policy and strategic plans.....	33
Appendix Two – Glossary.....	34

1. Vision

A state-wide community service that offers an evidence-based, recovery-focussed system of care to people living with borderline personality disorder in South Australia.

2. Executive summary

Borderline Personality Disorder (BPD) is a common mental illness which is associated with a significant degree of distress and impairment, including the risks of self-harm and suicide. Carers also experience high levels of distress and concern for the safety and wellbeing of their loved ones.

Historically, BPD has been associated with significant levels of stigma and negative discrimination within the health and mental health systems.

Yet people with BPD can and do recover, particularly when they are provided with appropriate evidence-based treatments, namely structured psychotherapies.

The state-wide BPD Collaborative (BPD Co) initiative has been developed in response to the demonstrated need for enhanced, evidence-based BPD service development in SA, tailored to the needs of consumers, carers and clinicians. There will be active, ongoing partnership with consumers and carers throughout the design and implementation of this service. This process of ongoing engagement with consumers and carers at every level of the service, will be facilitated by peer workers, located in the hub.

BPD Co has been established by Country Health SA Local Health Network and will be administered by Barossa Hills Fleurieu LHN as of 1 July 2019.

A hub and spoke service model will facilitate the operation of an integrated BPD service across the state, offering consistent, high quality care close to where people live.

In this model, 'hub' clinicians become agents of BPD clinical and cultural change, by promoting and facilitating evidence based BPD service development in the Local Health Networks (LHNs), as well as offering direct therapy for consumers with the most severe and complex BPD.

This integrated system of care will also interface with a range of private practitioners and community based services, including non-government organisations (NGOs) and Primary Health Network (PHN) funded services.

The hub, or central office, will be located on the fringe of the city of Adelaide, and the 'spokes' refer to the public health BPD services within Local Health Networks.

The state-wide BPD service will include direct clinical care focussing on people with severe and complex BPD, family and carer engagement, an early years and new parents program, a young person's program, a criminal justice program and a program focussed on the needs of Aboriginal people.

Evidence-based care initiatives will be developed, including the pilot of acute crisis Assessment and Brief Intervention Clinics in one or two LHN locations, to be determined through a process of LHN self-identification. These clinics will be modelled on the Gold Card approach developed in NSW by Project Air and will be evaluated, with a view to rolling out across the LHNs. There will be an expansion of evidence-based group therapies and further development of clinical pathways and therapeutic options for people with the most complex and severe BPD.

In addition to these BPD clinical services, training and capacity building across the state will be led by a hub Training Coordinator, research and evaluation processes led by a Research Lead and facilitated by a hub Research Project Officer. This will ensure commitment to quality assurance processes and encourage innovation within an evidence-based framework.

In this way, the sustainability of the state-wide BPD service will be optimised.

3. The borderline personality disorder context

3.1. Description of borderline personality disorder

Borderline personality disorder (BPD) is a common disorder characterised by difficulties with emotions and impulses, unstable interpersonal relationships and unstable self-image (Lieb et al, 2004).

People with BPD experience significant distress and impairment due to difficulties in relating to other people and the world around them. BPD is associated with disruption to relationships, work life and social problems. It is highly stigmatised among health professionals (Bonder et al, 2011) and is also associated with patient 'self-stigma' (Lawn and McMahon, 2015).

BPD is associated with severe and persistent impairment of psycho-social function, high risk for self-harm and suicide, significant burden of co-existing mental health illnesses (co-morbidities), and heavy use of healthcare resources (ten Have, 2016., Bender et al, 2001, Zanarini et al, 2001, Cailhol et al, 2013). International data confirms that the suicide rate among people with BPD is higher than that of the general population. Estimated rates of completed suicide among people with BPD range up to 10% (American Psychiatric Association, 2001). Individuals with BPD can have significant difficulties maintaining interpersonal relationships often affecting work, families and children (Miano et al, 2017). (NH&MRC Clinical Practice Guideline, 2012).

Symptoms of BPD typically emerge during adolescence and early adulthood (Zanarini et al, 2011). Following symptomatic remission (amelioration of symptoms), severe and continuing functional disability can remain, which is comparable to or greater than that associated with many of the major mental illnesses (Zanarini et al, 2018).

People living with BPD and experiencing comorbidities appear to be much more likely to come into contact with the criminal justice system particularly when combined with Substance Use Disorder, low cognitive functioning and Antisocial Personality Disorder (Black et al, 2007, Sansone and Sansone, 2009).

3.1.1. Diagnostic classification of BPD

The diagnostic criteria for BPD are evolving.

The fifth edition of the Diagnostic and Statistical Manual (DSM- V) requires 5 of 9 criteria to be met for diagnosis but has recently also added a dimensional construct.

DSM-V diagnostic criteria for BPD:

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- > Frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5);
- > A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation;
- > Identity disturbance: markedly and persistently unstable self-image or sense of self;
- > Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating) (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5);
- > Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour;
- > Affective instability due to a marked reactivity of mood (e.g. Intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days);
- > Chronic feelings of emptiness;
- > Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights);
- > Transient stress-related paranoid ideation or severe dissociative symptoms (DSM-V p.663).

ICD 10 diagnostic criteria for emotionally unstable personality disorder, borderline type. Emotionally unstable personality disorder is characterised by:

- > A definite tendency to act impulsively and without consideration for consequence;
- > Unpredictable and capricious mood;
- > Liability to outbursts of emotion and incapacity to control the behavioural explosions;
- > Tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.

The 'borderline type' is characterised by disturbances in self-image, aims and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships and by a tendency to self-destructive behaviour, including suicidal gestures and suicide attempts.

The ICD 11 classification of emotionally unstable personality disorder, borderline type, is due for release in 2019.

3.1.2. Prevalence of BPD in South Australia

In South Australia (SA), reliable information regarding the prevalence of BPD is not currently available. Estimated population prevalence of BPD is from 1 to 4 % (NHMRC, 2012). This equates to between 17,000 and 68,000 South Australians living with BPD.

It is important to note that some people with BPD are high functioning and do not seek treatment (Coid et al, 2009).

It is estimated that up to 23% of psychiatry outpatients (Korzekwa et al, 2008) and 43% of psychiatry inpatients (Widiger and Weissman, 1991) have the diagnosis of BPD.

The community prevalence of BPD is the same in men and women, but the patterns of presentation to services differ ((Zanarini et al, 2015, Grant et al, 2008, Bayes and Parker, 2017). In Australia, 90% of admissions to hospital with a primary diagnosis of BPD are female (cited in Mental Health Commission, 2017).

No reliable statistical or clinical information regarding the population prevalence and severity of BPD in Aboriginal populations could be found in SA.

3.1.3. Comorbidities associated with BPD

There is a high degree of co-morbidity with BPD and many mental illnesses, particularly post-traumatic stress disorder (Pagura et al, 2010) and substance use disorder (Gibbie et al, 2011, Grant et al, 2008). There is also increased risk of co-morbidities with other personality disorders. Where co-morbidities do exist, the evidence suggests a poorer outcome overall.

There is also increasing evidence regarding the negative impact of personality disorder on physical health, with increased risks of many major physical illnesses with BPD, including cardiovascular diseases, arthritis and obesity. Life expectancy has been shown to be reduced by as much as 27.5 years in people with BPD and suicide contributes a small effect to this reduction in years (Cailhol et al, 2017, Shen et al, 2017).

3.1.4. Course of BPD

Spontaneous improvement of BPD symptoms is common as people age, but treatment accelerates the speed of remission or amelioration of symptoms and good treatment leads to even faster remission (Meuldijk et al, 2017).

There is a difference between remission and recovery however, where recovery includes good social and vocational functioning as well as symptomatic remission. Sustained recovery occurs at a substantially lower rate than sustained remission (Zanarini et al, 2012). Neither remission nor recovery are an endpoint and relapse can occur.

3.1.5. Health service utilisation

Patients with BPD frequently seek care in health services and this help-seeking behaviour contributes significantly to overall health care utilisation costs (Meuldijk et al, 2017). It has been repeatedly demonstrated in a number of studies, including Australian studies, that these health care costs are significantly reduced in the context of people with BPD receiving appropriate evidence-based treatment (Grenyer, 2014).

4. Evidence base regarding BPD treatment

This model of care outlines an evidence-based, stepped approach to care and makes subsequent recommendations. The following summarises this foundational evidence:

- > All forms of specialised BPD therapies (e.g. DBT, TFP and MBT) have been shown to demonstrate approximately equal therapeutic efficacy for people with BPD in randomised clinical trials.
- > No one form of specialised BPD therapy has been shown to be consistently superior to any other (Leichsenring et al, 2011).
- > Severity of personality disorder, frequency of sessions and length of treatment offered have no obvious relation in the scientific literature with outcomes (Bateman et al, 2015) .
- > Evidence for pharmacological treatment of BPD is poor with variable results. There may be benefit for pharmacological treatment of acute comorbidities, but there is no current consensus around the efficacy of pharmacotherapy for the core symptoms of BPD.
- > Dismantling studies seek to define the minimal essential elements of a specialised package of care which can still bring about significant clinical improvement. These studies have shown clinical effectiveness of partial elements of specialised therapies, in particular DBT (Choi-Kain et al, 2016).
- > Recent efforts to simplify evidence-based BPD therapies include distillation of the essential therapeutic elements common to all specialised effective BPD therapeutic approaches (Weinberg et al, 2011). These include:
 - > A focus on the therapeutic relationship, which is critical to success;
 - > An active therapist stance towards the client;
 - > Specific attention on affect;
 - > The use of exploratory change oriented interventions.
- > The following characteristics are shared by all evidence-based treatment approaches and constitute the basis for 'good clinical care' for people with BPD (Bateman et al, 2015):
 - > Structured (manual directed) approaches to prototypic BPD problems;
 - > Patients are encouraged to assume control of themselves, that is, a sense of agency;
 - > Therapists help connections of feelings to events and actions;
 - > Therapists are active, responsive and validating;
 - > Therapists discuss cases, including personal reactions, with others.
- > General or good psychiatric management (GPM) and structured clinical management (SCM), which are structured, manualised but generic forms of BPD therapy, have shown in clinical trials approximately equivalent clinical outcomes to the specialised resource intensive therapy packages for people with BPD (McMain et al, 2009).
- > There is no current evidence that any long-term therapy is superior to briefer interventions. Even brief interventions that involve psychoeducation can yield symptom reduction (Zanarini, 2009).
- > A recent clinical trial demonstrated that a package of short-term therapy (12 weeks) of group and individual therapy for people with acute symptoms of BPD resulted in significant improvements in most symptom measures (LaPorte et al, 2018).
- > Similarly, when extended therapy was offered to people with severe and chronic BPD, there was no significant difference in symptom improvement between the cohort receiving treatment for 6 to 12 months and that receiving treatment for 18 to 24 months (LaPorte, et al, 2018).
- > It is suggested, therefore, that longer treatments need not be routinely prescribed but can be reserved for those who do not respond to briefer interventions (Paris, 2013).
- > There are workforce challenges to providing coverage of psychological therapies across Australia (Grenyer, 2017).
- > A recent randomised clinical trial compared outcomes and health costs of the Project Air Gold Card Clinic personality disorder care versus treatment as usual (TAU) in one health service in NSW over two equivalent sites. This trial was conducted in a resource neutral environment utilising current clinical resources. Significant service benefits of the Gold Card model of care were found, including a significant reduction of presentation of BPD patients to emergency departments, significant reduction in hospital length of stay and significant reduction in health costs (Grenyer et al, 2018).

4.1. Links to national policy directives and plans

The following national policies and plans inform and underpin this document. Links to these documents can be found in appendix one.

- > National Safety and Quality Healthcare Standards 2nd Edition;
- > National Standards for Mental Health Services (these are being phased out);
- > 5th National Mental Health and Suicide Prevention Plan;
- > National Suicide Prevention Strategy;
- > A national framework for recovery-oriented mental health services;
- > National Mental Health Strategy;
- > National Mental Health Policy;
- > Mental Health Statement of Rights and Responsibilities;
- > Australian Charter of Healthcare Rights;
- > National Practice Standards for the Mental Health Workforce;
- > National safety priorities in mental health: a national plan for reducing harm;
- > National Aboriginal and Torres Strait Islander suicide prevention strategy;
- > National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing;
- > Pathways of recovery: 4As framework for preventing further episodes of mental illness;
- > Report: Mental Health of Young People in Australia;
- > Practical Guide for Working with Carers of People with a Mental Illness.

4.2. Background

Over the past ten years, there has been an increasing awareness within South Australian BPD community that public mental health services across the state have not been able to provide routine, consistent access to evidence-based therapies for BPD. South Australians did not have access to BPD specialised therapeutic services such as Spectrum and HYPE in Victoria and Project Air in NSW. The Australian NH&MRC guidelines regarding BPD, published in 2012, had not been implemented in SA.

BPD consumers, carers and clinicians worked together over time to raise the profile of BPD and to highlight the need for specialised BPD services.

Significant reports (Borderline Personality Disorder: An overview of current delivery of Borderline Personality Disorder services in the public sector across South Australia and a proposed way forward [2014] and the South Australian Action Plan for people living with BPD 2017-2020) were commissioned in SA by SA Health and the state Mental Health Commission respectively. These reports were published but not implemented.

Following a coronial inquest into the deaths by suicide of two young women with BPD in SA, the South Australian government committed resources to develop a state-wide, evidence-based system of care for people with BPD.

BPD Co. will have four elements:

1. Clinical services for people with severe and complex BPD;
2. Enhanced access to treatment for people living with BPD to mainstream acute and specialist outpatient and therapeutic services, including group programs across South Australia;
3. An early years program to increase services available to parents who have infants and young children and have been diagnosed with BPD;
4. Develop system capacity to support young people at-risk of developing BPD, or with early signs of BPD (including self-harming behaviour) through inpatient, outpatient and therapeutic resources.

The outcomes to be achieved over time include:

- > improved access to appropriate early intervention services;
- > improved access to appropriate evidence-based services;
- > improved access to recovery-focussed services;
- > reduction in the level of suicide and deliberate self-harm by those who suffer from BPD;
- > decreased presentations to hospitals, including emergency departments, by BPD clients;
- > decreased experience of stigma and discrimination faced by those with a diagnosis of BPD.

The service will be co-designed with people with lived experience, their carers and clinicians, in consultation with stakeholders including other government and non-government agencies.

5. The state-wide service

5.1. Overview

BPD Co will work together with the South Australian mental health system to improve care for people living with BPD wherever they seek mental health services. This will involve working in close partnership with the Local Health Networks (LHNs), where some services will continue to be provided by LHNs, some by BPD Co and some in partnership.

5.1.1. Staffing

The centre will be staffed by clinicians with strong skills, knowledge and experience in providing mental health care for people with BPD. Lived experience project officers will be included within this staffing cohort, as will staff with research and training expertise.

5.1.2. Location

The hub will be located on the fringe of Adelaide's central business district and will have clinical consultation and group work rooms, as well as office space for hub staff.

5.1.3. Target groups

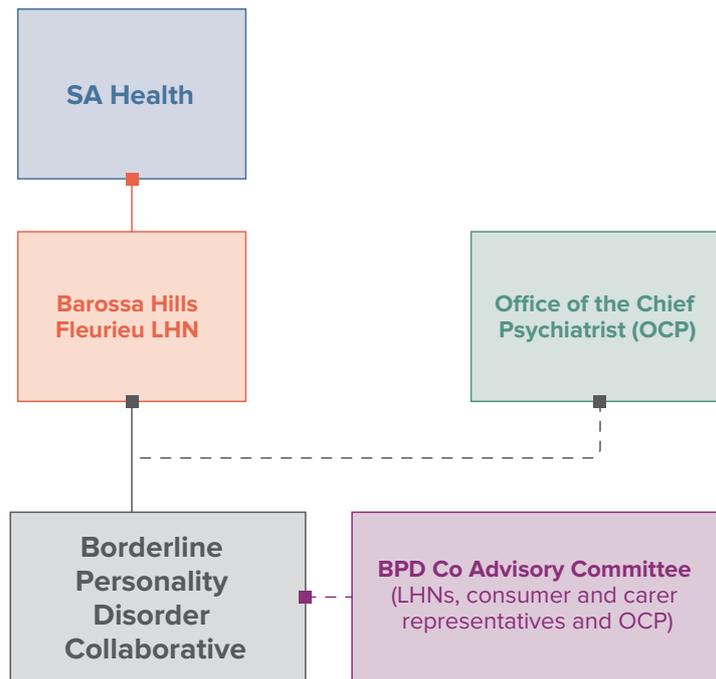
People in South Australia living with BPD, with a particular focus on:

- > People with the most severe and complex BPD;
- > Young people with emerging BPD;
- > Mothers with BPD parenting infants and very young children;
- > People with BPD in the criminal justice system.

5.2. Governance of the state-wide BPD service

The organisational governance of BPD Co will alter as Country Health SA LHN (CHSALHN) is devolved into six LHNs. The overarching proposed governance, once the service is established, is included below. BPD Co will sit under the Barossa Hills Fleurieu Local Health Network, which will be represented alongside all 10 LHNs on a state-wide steering committee. Barossa Hills Fleurieu LHN will report to SA Health. The Office of the Chief Psychiatrist (OCP), as the overarching clinical governance body for mental health services, will continue to carry this role for BPD Co as it does for other state-wide services. The OCP is also represented on the steering committee.

Figure 1: Borderline Personality Disorder Collaborative Governance



5.3. Hub and spoke model outline

The BPD Co will operate as a hub and spoke model, where BPD Co will be the hub, and LHNs the spokes. These include the three metropolitan LHNs (Northern Adelaide LHN (NALHN), Central Adelaide LHN (CALHN) and Southern Adelaide LHN (SALHN)) and the Women's and Children's Health Network (WCHN), which is state-wide.

The current CHSALHN will be subdivided from 1 July 2019 into six locally-governed country areas, each with its own independent administrative health organisational structure. As BPD Co is being established by CHSALHN, governance arrangements with the six new country LHNs will be developed to ensure smooth operation of the service for country consumers and carers.

The hub clinicians will be employed and managed by BPD Co, but will spend the majority of their time located in the LHNs with weekly attendance at the hub for purposes of supervision, support and training. Hub clinicians may provide direct clinical service in LHNs or at the hub.

In the LHNs, hub clinicians will act as local change agents, consulting with, leading and promoting the development of the model of care locally.

Mental health services in each LHN provide care for people with BPD, including some specialised evidence-based one-on-one therapy and group treatment. BPD Co acknowledges the extensive time, energy and commitment undertaken by LHN clinicians who have developed these specialised evidence based approaches to care for people with BPD, often within resource-neutral environments. It will be important that BPD Co works together with the LHNs to support and augment, not replace or duplicate, these services.

LHNs will allocate clinicians locally to be networked clinicians. Networked clinicians will work together with the hub clinicians to support their LHNs implementation of the model of care (see section 5.3). Networked clinicians may be those who already work intensively with people with BPD, which they will continue but with additional complementary supports from hub clinicians. However, network clinicians may also be people with an interest in developing this area of work and can be trained in evidence-based therapies for the treatment of BPD.

Partnership and cooperation between LHN networked clinicians, LHN management and the hub clinicians will be essential. Formal agreements regarding governance, communication, roles and responsibilities will be developed (see sections 5.3.1 and 5.3.2, below).

5.3.1. Hub and spoke service governance principles

The following governance principles have been developed to guide BPD governance and clinical service development across the state and to inform service agreements between BPD Co and LHNs.

Whilst the governance principles reflect a shared view expressed by clinical and executive leaders across LHNs in the planning phase of the BPD Co, it is acknowledged that further development and refinement will be required over time, with active, collaborative involvement of all parties.

The hub and spoke governance principles are as follows:

- > The LHNs will support the model of care proposed by BPD Co and will commit to move that forward;
- > An advisory committee will be formed with representation from the LHNs, and BPD Co will provide overarching governance (see overleaf for proposed model for discussion with LHNs);
- > Key performance indicators will be discussed, agreed upon and established by BPD Co and the LHNs;
- > Agreed resolution processes will be developed for managing differences between the hub and the spokes;
- > Clinical governance responsibility for consumers' care remains with the LHNs;
- > BPD Co clinical staff recruitment processes will consider specific and unique LHN needs and requirements wherever possible;
- > Clarification of the roles of hub clinicians will be determined in consultation between BPD Co and the LHNs;
- > Each LHN will identify local networked clinicians and case-load volume, and will seek to match internally the level of clinical resource provided by BPD Co;
- > Most referrals to BPD Co will come via the LHNs;
- > LHNs will develop triage pathways for BPD clients and their carers.

5.3.2. Services provided outside SA Health

These services include private practitioners, general practitioners (GPs), private psychiatrists, psychologists and allied health practitioners, and a variety of health and mental health community organisations, including non-government organisations (NGOs) and Primary Health Network (PHN) funded mental health services. BPD Co will consult, collaborate and partner with these organisations. BPD Co will support evidence-based care for people with BPD in this domain through access to research and capacity building.

5.3.3. Roles and responsibilities within the hub and spoke service

The following summary of the arrangement of roles and responsibilities shared and distributed between the hub and spoke elements of the BPD Service is intended as a general description. Adaptation will be required to match local LHN conditions and modification over time will occur in accordance with quality improvement and evaluation processes.

- > The hub clinicians will provide care in accordance with the BPD Co model of care, in the hub and when working in the LHNs. Each LHN identifies networked clinicians with an interest in BPD.
- > Networked clinicians are mental health clinicians with a commitment to providing care for people with BPD and to receiving additional training from BPD Co in evidence-based therapeutic interventions (one-to-one or group). Networked clinicians will remain under the operational management of the LHNs.

5.3.3.1. Evidence-based care

Hub clinicians will:

- > provide one-to-one therapy for severe and complex BPD clients in the hub or in the LHN;
- > provide a group facilitator role in conjunction with LHN clinicians;
- > offer case reviews, including development and management of care plans and crisis plans;
- > liaise with private practitioners, GPs and NGOs;
- > be champions for stepped care;
- > initially function as clinic coordinators for the Assessment and Brief Intervention Clinics.
This role is later intended to be transferred to LHN clinicians.

Networked clinicians will, by agreement with the LHNs:

- > provide a specialised LHN service for clients with BPD (including care coordination);
- > deliver a limited-session Assessment and Brief Intervention model;
- > may be identified as the Assessment and Brief Intervention Clinic Coordinator once this role is established;
- > deliver evidence based therapeutic interventions (one-to-one and group) in line with the BPD Co model of care;
- > be BPD local change agents.

Lived experience project officers will:

- > Provide or support specific evidence-based group treatments e.g. Family Connections, Service User Network;
- > Provide psychoeducation for carers and parents;
- > Develop and maintain consumer and carer engagement mechanisms for BPD Co;
- > Provide advocacy for consumers and carers.

5.3.3.2. Capacity building and training

Clinical supervision and support will occur on a regular planned basis for every BPD clinician, whether located in the hub or the LHN. It should include discipline-specific as well as therapy-specific requirements. Supervision may occur individually (including via video-conference) or within a group setting. If no suitable local supervision can be accessed, it may be appropriate to source expert supervision from further afield, including interstate supervision via e.g. telephone or video-conference.

Hub clinicians:

- > are trained to an expert level and receive appropriate high-level supervision, coaching and training from the clinical lead or other specifically trained supervisors;
- > will offer a capacity building, supervision, coaching and consultation role to the LHN networked clinicians and other LHN clinicians, focussing on core competencies;
- > will assist in the development and delivery of training in the LHNs and in other locations.

Networked clinicians will:

- > support and deliver (where appropriate) training, coaching and supervision;
- > identify and implement local capacity building needs as they arise, and develop partnerships with local relevant services.

Lived experience project officers will:

- > assist in the development and delivery of training in the LHNs for clinicians, consumer and carer groups, and NGOs;
- > engage in the development of partnerships with carer and consumer groups, and NGOs to increase awareness of BPD care and continue to develop community among consumers and carers;
- > receive appropriate reflective supervision by hub clinicians and support by the trainer.

The training coordinator will:

- > broker training in evidence-based therapeutic treatments and core therapeutic competencies training from the preferred provider panel;
- > be trained in generic training delivery as well as some BPD specific evidence-based treatment;
- > deliver generic BPD training to LHN clinicians and a variety of stakeholders including the South Australian Ambulance Service, South Australian Police, NGOs and GPs.

5.3.3.3. Research and evaluation

- > The research lead will develop and monitor an overarching BPD Co research program and work closely with the research project officer.
- > The hub will collect system-wide data in accordance with relevant key performance indicators e.g. emergency department presentations, hospital bed days, assessment timeframes, waiting lists, BPD specific services use, requests for assistance from BPD Co etc.
- > The hub and LHN networked clinicians will participate in research projects supported by the research project officer.
- > The research project officer will gather and analyse outcomes data across training interventions and treatments provided.
- > Research partners, including academic partners, will develop and deliver specific research projects in-line with the BPD Co program.
- > Consumers and carers will be encouraged to participate in the research program as participants and as researchers.

5.4. Potential risks

5.4.1. The health system

There are significant challenges and complexities inherent in a health system where multiple agencies and clinicians work independently of each other. This results in the potential for fragmentation, gaps and duplications in the system of care.

The hub and spoke model, in addition to the arrival of a new BPD service, further increases this risk potential.

5.4.2. The characteristics of BPD

The nature of the BPD illness itself adds to the risk of self-harming, aggressive and suicidal behaviours by the consumer.

There are also the risks of acute and sustained stress and distress to carers.

Clinicians are at risk of burn-out and injury through clinical stress and strain, and aggressive behaviours.

5.4.3. The BPD service risks

Associated BPD service risks include:

- > Financial risks;
- > Legal risks, including coronial investigations;
- > Reputational risks where clinical and service targets are not being met;
- > Implementation risks, which threaten the effective performance of the BPD system of care overall;
- > Lack of genuine consumer and carer engagement in the development and operation of the BPD system of care, adding to poor quality outcomes;
- > Limited access of the BPD service by those from Aboriginal and culturally, linguistically and sexual and gender diverse backgrounds;
- > Difficulties in meaningful implementation of the hub and spoke model across LHNs resulting in inconsistencies in service availability or provision;
- > Ineffectiveness of the training program, risking reduction of clinical outcomes for consumers and carers, and negatively impacting cultural change across the system of care;
- > Inadequate research, intervention evaluation and monitoring, threatening quality improvements within the service.

It will be important to anticipate, monitor and mitigate these risks over time, wherever possible.

6. Model of care

6.1. Key principles

- > We believe that people with BPD can and do recover to engage in meaningful lives.
- > We will promote person-centred care, validating trauma if disclosed, and tailoring the therapeutic approach to individual needs.
- > We will work in partnership with families and carers, supporting them in their caring role and providing them with information about BPD.
- > We will promote evidence-based care in local communities.
- > We will partner with other providers to ensure equitable, accessible and timely service.
- > We will match our BPD care to windows of opportunity across the life span.
- > We will sustain clinicians through ongoing learning, support and supervision.
- > We will provide a safe and responsive service for Aboriginal people, culturally and linguistically diverse groups and LGBTQIA+ clients.
- > We will encourage innovative, flexible approaches responsive to local community needs across the state.
- > We will take a long-term view, together with our community, to build a sustainable BPD service.

6.2. Current landscape

The development of pathways through care in the South Australian state-wide BPD service is influenced to a significant degree by the recent historical development, and hence current arrangement, of local mental health and community BPD services in each LHN.

It will be important to take each of these local BPD services into account when developing local pathways, maintaining an attitude of valuing and preserving those community BPD services, which have been developed over the years with passion, commitment and clinical skill. The challenge will be to dove-tail the new BPD service with existing local BPD services as they vary within the LHNs and to build on these BPD services and support them.

BPD Co will consult, collaborate and partner with a variety of South Australian specialist private and public community organisations and services. This reflects, in part, the high prevalence of co-morbid disorders with BPD. Clinical consultation relationships with services such as the State-wide Eating Disorder Service (SEDS), DASSA (Drug and Alcohol Services of SA) and the criminal justice system, will require ongoing active development and maintenance.

In addition, local clinicians and private practitioners, as well as clinical organisations in the local community will require sustained, functional referral and consultative pathways with the BPD service. This could include local GPs, private psychologists and psychiatrists, allied health practitioners, NGOs and Public Health Network funded services, as well as SA Police, SA Ambulance Services and homeless services. Linkages and mechanisms of partnering will occur at both hub and spoke levels of BPD Co and involve managerial and clinical staff.

6.3. The stepped model of care

This model of care will be rolled out across SA over time.

It includes the development of new Assessment and Brief Intervention Clinics (ABiCs) and short-term follow up, as well as further development of pathways of care for people with severe and complex BPD.

Stepped care is described in the National Health and Medical Research Council *Clinical Practice Guideline for the Management of Borderline Personality Disorder* as 'beginning with the least intensive treatment that is likely to be effective, then monitoring response to increase or reduce the intensity of the intervention according to the person's needs' (NHMRC, 2012, p 102).

This approach to care has been recommended for disorders such as BPD, which have high community prevalence but variable intensity and prognosis. It is particularly appropriate for BPD services across the community, where demand for treatment exceeds supply of evidence-based therapies.

It offers a patient centred pathway with a variety of evidence-based therapy choices, as well as carer engagement and support.

Stepped care in the model developed by Project Air, has been shown to be an effective, evidence-based approach to BPD care in Australia.

6.3.1. Acute crisis pathways through care

The following stepped care consumer pathway diagram outlines the system of care for people with BPD who present in acute crisis in SA (see figure 1 overleaf). While presented within this document as a linear sequence, it is anticipated that consumers will be referred at each point to the level of care that best meets their needs and that some consumers may repeat elements of the pathway, where appropriate.

6.3.1.1. Entry

There are multiple referral points available for people with BPD who seek help in acute crisis.

These include mental health triage and Emergency Triage and Liaison Service (ETLS), hospital emergency departments and inpatient units, private practitioners including GPs, mental health teams and other services and individuals, including consumers.

Project Air recommends the following entry criteria for their evidence-based Assessment and Brief Intervention Community Clinics in the context of acute crisis, which may be used as a guide for referrals in SA:

- > impulsive and self-destructive behaviours;
- > changing emotions and strong overwhelming feelings;
- > problems with identity and sense of self;
- > thoughts of suicide and self-harm;
- > challenging personality features.

6.3.1.1.1. The Assessment and Brief Intervention Clinic (ABiC)

In the Project Air model, this service is provided locally within three days of referral and offers a maximum of four sessions, with services and therapeutic tools including:

- > assessment including standardised diagnostic and baseline measures;
- > psychoeducation;
- > problem solving and care plan development;
- > engagement of carers;
- > planning of next steps.

This is a model which will be replicated in SA across the LHNs, however, initially it will be necessary to establish a pilot ABiC program in SA in one or two LHNs. Assuming successful and positive outcomes, over time each LHN will develop appropriately located hospital or community-based ABiCs. This will require initial leadership and training by the local BPD Co hub clinicians in structured, evidence-based, core competency therapeutic approaches, but in time these clinics will be run by LHN networked clinicians with appropriate BPD Co supports in place.

Evaluation processes will be embedded from the outset to monitor the effectiveness of this intervention.

In the remote areas of CHSALHN, ABiCs could be provided by country health allocated clinicians from the BPD Co hub via video-conference together with LHN clinicians, thus providing 'virtual clinics' in the context of limited availability of local BPD-skilled clinicians.

6.3.1.1.2. Other services offered at all steps through the process

Evidence-based family / carer psychoeducation and support will be provided at the BPD Co hub or other accessible locations, whether the consumer continues with further therapy or not.

In the community, further support groups could be developed for consumers and carers.

6.3.1.1.3. Collaborative decision-making following step one

– entry (see Figure two: Stepped Care Consumer Pathway)

At the conclusion of consumer engagement with the ABiC, the consumer may then be discharged from care or may wish to seek further therapy.

In the Project Air model, approximately 50% of consumers choose discharge after the conclusion of engagement with the ABiC.

6.3.1.2. Getting extra help

For those consumers who seek further therapy, short-term evidence-based group therapy (such as a 12 week, skills-based DBT group therapy program) will be offered.

Group therapy programs may refer to existing evidence-based therapies or to groups established collaboratively between LHNs and the hub.

If required and requested by the consumer, short-term care coordination in accordance with care and crisis plans will be offered by multidisciplinary clinicians in the LHNs.

Individual and/or group BPD therapy may also be accessed by the consumer in the NGO sector or from private practitioners.

6.3.1.2.1. Collaborative decision-making following step two – getting extra help (see Figure two: Stepped Care Consumer Pathway)

Collaborative evaluation of the consumer's wishes, need or degree of recovery at this stage with hub or LHN clinicians will determine whether further therapeutic engagement is required.

6.3.1.3. Working towards recovery

For those consumers who wish to engage further in BPD therapy, the following options will be available:

- > Individual therapy (which may be differing therapeutic modalities). This therapy will be time limited, goal-focused and may work in parallel with group therapy. It will be offered by trained clinicians, primarily in the LHN (including the possibility for private practitioners and PHN funded organisations).
- > Evidence-based group therapy programs, either existing or new. These groups will be led by suitably trained clinicians either from the hub or from within the LHNs. The location of these groups may be within the LHN (including NGOs and PHN-funded organisations) or at the hub.
- > Care coordination may be requested or required, and will be provided by mental health workers within the LHN. Where care coordination is offered, case reviews will be conducted every 3 months and as required, utilising a genuinely collaborative process involving relevant hub and spoke clinicians, peer workers, the consumer and wherever possible, carers.
- > Brief goal-focused hospital inpatient admission in the LHN may be indicated as a planned element of care and/or in response to acute co-morbid illness, according to the collaboratively developed care plan. It is desirable, wherever possible, for regular individual and/or group therapy to continue during hospital admission.
- > Secondary consultations as requested by GPs, private practitioners or community organisations, will be provided by hub or networked clinicians. These will occur principally in the LHNs, with care and crisis plans developed as part of the secondary consultation process.
- > Development of partnerships and linkages with community agencies and services (including NGOs and PHN-funded organisations) by hub and LHN clinicians will be required to provide clinical leadership for implementation and expansion of BPD evidence-based services.

6.3.1.3.1. Collaborative decision-making following step three – working towards recovery (see Figure two: Stepped Care Consumer Pathway)

Case reviews and/or evaluation at the end of the group therapy or individual therapy (or as needed) will clarify the best pathway collaboratively with the consumer. Some consumers will request discharge. Some, most likely to be consumers with the more severe and complex needs, will require and request further time-limited intensive therapy as per Figure 3, and severe and complex BPD shared care.

6.3.2. Severe and complex shared care

The BPD service will offer a shared care model for LHNs working with people with the most complex and severe BPD.

6.3.2.1. Entry

Referrals to shared care between the LHN and BPD Co will be considered for:

- > people with BPD who present in recurrent crisis;
- > people with BPD who experience high level complexities or co-morbidities;
- > people with BPD who display persistent difficulty in engaging with the system of care;
- > carer referrals where there is a high level of concern for the consumer;
- > service provider referrals where there is a high level of concern regarding the consumer with BPD.

6.3.2.2. Assessment and care planning

A detailed assessment or second opinion of the consumer will be conducted by a hub or networked clinician, including wherever possible, separate face to face interviews with the consumer and carers. This interview process will include collaborative development or review of the care and crisis plans. It will be followed by a case conference, which should include the consumer and/or carer, the care team and other individuals and agencies as appropriate and agreed to by the consumer.

6.3.2.3. Care implementation

Care options to be offered will include:

care coordination and/or advocacy (by LHN BPD clinicians or peer workers) with assistance to the consumer and/or carer to navigate and find a coordinated and consistent approach within multiple service systems which may be involved;

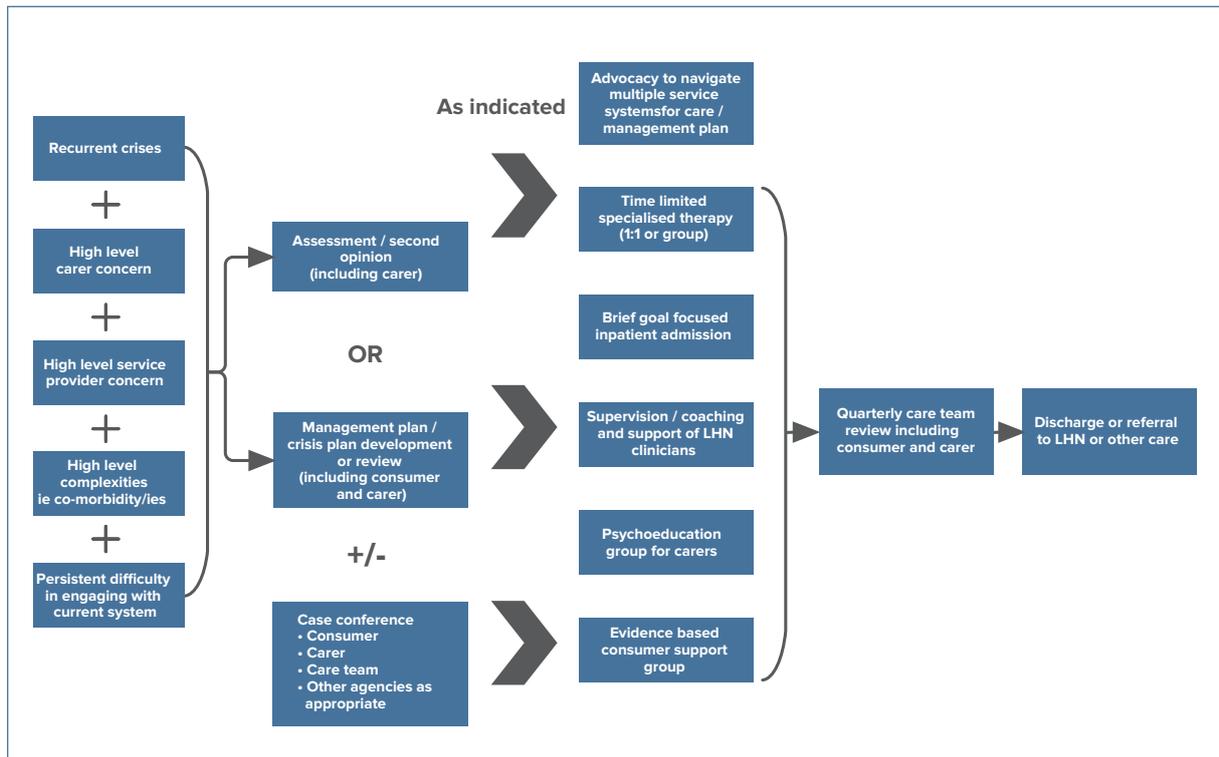
Care coordination will require regular quarterly collaborative case reviews (see above in acute section);

- > brief goal-focused hospital admissions in the LHN may be required as part of the care plan, for purposes of brief respite for the consumer and/or for treatment of acute co-morbid illness, as has been offered at times in LHNs. It is desirable, wherever possible, that ongoing individual and group therapy be accessed during hospital admission;
- > Time-limited specialised evidence-based individual and/or group therapy, conducted by BPD trained therapists. These therapists may be sourced from the hub, from the LHN or from private practice or elsewhere;
- > Supervision/ coaching and clinician support by trained BPD therapists (in the hub or the LHN);
- > Evidence-based consumer support group, such as the Service User Network, for example (in the hub or the LHN);
- > Evidence-based psychoeducation or carer support group (in the hub or the LHN).

6.3.2.4. Discharge or referral to ongoing care

Case reviews every three months (or as needed) will clarify the best pathway, to be decided collaboratively with the consumer. Some consumers will request discharge, while some, most likely to be the more severe and complex consumers, will require and request further therapy or other supports delivered by private, public or NGO sector.. Some consumers will cease to engage with the process and, following assertive attempts at engagement, may be discharged.

Figure 3: Proposed Severe and Complex BPD Shared Care



6.4. Special populations and BPD

Special populations have been identified as the following:

- > Country areas
- > Aboriginal communities
- > Early years and new parents
- > Youth
- > The criminal justice system

6.4.1. Country areas

There are obvious challenges inherent in delivering a health-related service to country areas. These include the paucity of available clinical resources in many areas in general and the large distances involved in delivering services. To some extent these have been compensated for by the use of telemedicine (video-conference) facilities.

Despite these challenges, in some areas local DBT clinical services have been developed. In Mount Gambier, these services have been the subject of a randomised control trial evaluation, which have contributed to this state-wide implementation model (Packham, 2016).

This model of BPD care, modified to include the stepped care acute crisis approach, may be particularly appropriate to country health services across SA.

Country hub BPD clinicians will be appointed to build capacity of country BPD services directly, with travel to country locations, as well as utilisation of hub video-conference facilities.

6.4.2. Aboriginal communities

National data indicates that 29% of Aboriginal people have a diagnosed mental illness (ABS, 2017), Aboriginal people are twice as likely to die from intentional self-injury and Aboriginal young people made up a quarter of all youth suicides in the period 2013 to 2017 (ABS, 2018).

However, no information relating to BPD prevalence, diagnosis or associated clinical information could be found for Aboriginal communities in this state.

Preliminary consultation with Aboriginal communities in SA has revealed that, by and large, Aboriginal communities are not familiar with the concept of BPD and do not have an accepted language to describe this condition.

This may reflect the cultural differences between western individualised medical models of mental health and Aboriginal people's 'holistic concept of mental health which encompasses the social, physical, emotional and cultural wellbeing of not just the individual but of the whole community' (SA Health, 2010).

There are significant issues in accessing appropriate health care for mental illness in Aboriginal communities, and significant stigma regarding mental health distress and mistrust of mainstream services. A key barrier to accessing mental health care is the concern that children may be at risk of removal from the family if mental illness is acknowledged in a parent. Barriers previously highlighted also include the impact of systemic and structural racism, lack of culturally appropriate settings, lack of culturally safe staff, accessibility and lack of understanding of the social, familial, cultural and community context for Aboriginal people (Department of Health, 2017). Moreover, cultural context has not always been well understood in mainstream health services, including the misinterpretation of self-harm associated with traditional grieving practices.

Consultation indicates community concern regarding suicide, cumulative experiences of trauma, post-traumatic stress disorder and substance abuse. The intersection of BPD with these mental health issues in the Aboriginal culture is therefore likely to be complex and patterns of distress among some individuals in Aboriginal communities may mean they meet diagnostic criteria for BPD, whether or not they seek help or are offered specialised care.

There is no published evidence that effective therapeutic treatment for BPD is culturally appropriate or applicable to Aboriginal people. It will be critical for BPD Co to work in close partnership with Aboriginal people, and to build on holistic models of social and emotional wellbeing that locate the experience of distress for the individual within the context of family, community and spiritual connection to culture, kin and country. Further research may also be required to explore treatment for BPD symptoms that have been effective in analogous first nation's populations such as in New Zealand and North America.

While it is expected that all hub clinicians will provide culturally safe and responsive care, it is planned that the allocation of hub BPD clinicians should include at least 0.5 FTE dedicated to fund an Aboriginal clinician.

The role of this worker should include consultation with the Aboriginal Health Council of SA (AHCSA) and Aboriginal Community Controlled Health Organisations (ACCHOs) with support from the training coordinator and the research project officer in BPD Co.

The requirement for trauma-informed care in any Aboriginal BPD clinical or capacity building approach is likely to be of paramount importance.

6.4.3. Early years and new parents

Providing an evidence-based therapeutic service to new parents with BPD and their infants or young children, offers an opportunity for early intervention at a time when many parents are highly motivated to seek help in order to mitigate the potential effects of their symptoms of BPD on their child's health and well-being.

Services for women with BPD parenting infants and very young children are provided by the Women and Children's Health Network via Child and Adolescent Mental Health Service (CAMHS), but also by other LHNs including a small number of perinatal/infant mental health practitioners.

There are a variety of therapeutic approaches relating to new parents and BPD that have developed over the years in SA.

- > Helen Mayo House (the state-wide inpatient service for perinatal infant mental health) has developed an MI-DBT program which is being replicated with PHN funding in the northern and southern areas of Adelaide and is currently under evaluation.
- > Child and Family Health Service (CAFHS) is also in the process of implementing Lighthouse mentalisation based therapy (MBT) parenting programs, which, although not BPD specific, focus on enhancing parental skills and have demonstrated efficacy in reducing child maltreatment (Byrne et al, 2018).
- > CAMHS also works with Department for Child Protection to provide an MBT informed model through its Infant Therapeutic Reunification Service (ITRS). While MBT is an evidence-based treatment for BPD, the ITRS is not specific to women with BPD and is focused most predominantly on the needs of infants for safe and responsive parenting in their critical attachment period.

In general, WCHN is looking to develop their early years therapeutic program more broadly.

Stakeholders within the early years working group emphasised the need to establish a strong stable leadership role that incorporated:

- > support and capacity building for existing therapeutic groups and evidence-based practice;
- > the development of clear pathways through the mental health system;
- > consistency in assessment, data collection and outcomes measurement;
- > promotion of perinatal and infant MH evaluation, research and training;
- > the development of connections and partnerships with clinicians and associated services including CAFHS, Children's Centres, Department for Child Protection and the Early Intervention Research Directorship.

6.4.4. Youth

Young people can experience distress associated with BPD symptomatology including self-harm and suicidality (eg Jopling et al, 2016, Goodman et al, 2017). There has traditionally been reluctance among child and adolescent mental health services to diagnose BPD for fear of incorrectly attributing developmentally consistent emotional volatility to BPD pathology, where symptoms and behaviours may decrease over time (see Winsper et al, 2015), and stigmatising young people across their lifespan. However, over the last 10 – 15 years, prominent advocates, including Professor Andrew Chanen of Orygen Youth Mental Health Services, have argued the case for correct diagnosis to promote evidence-based care for young people with BPD (Chanen, et al, 2014). It is argued that appropriate early care has the potential to alleviate the significant distress that adults with BPD experience and re-connect young people with their developmental, vocational and relational trajectory.

In SA, mental health care for young people from age 12 onwards is provided by a range of agencies, following the differential implementation of Youth Mental Health Services (YMHS) across the state. There are local variations depending on age, condition and severity of mental health distress (see Table 1 next page). This amalgam of services can be difficult for young people, their families and clinicians to navigate, creating an additional stress when help-seeking.

Table 1: Mental health services in South Australia for young people

Age	12 – 15 years	16 – 24 years
SALHN	Mild – moderate: headspace Complex: CAMHS Early psychosis: headspace Youth Early Psychosis Program (HYEPP)	Mild – moderate: headspace Complex :16 – 24 years Youth Mental Health Service (YMHS) 20 – 24 years: community mental health teams (CMHT) Early psychosis: HYEPP
CHSALHN	Mild – moderate: headspace (where available) Complex: CAMHS	Mild – moderate: headspace (where available) Complex: 16 – 24 years youth clinicians in CMHT supported by Youth Consultation Liaison Clinicians Complex: CAMHS
CALHN	Mild – moderate: headspace Complex: CAMHS Early psychosis: HYEPP	Mild – moderate: headspace ¹ Complex: 16 – 24 years CMHT by youth clinicians Early psychosis: HYEPP
NALHN	Mild – Moderate: headspace Complex: CAMHS Early psychosis: HYEPP	Mild – Moderate: headspace ² Complex: 16 – 17 years CAMHS 18 – 24 years: CMHT Early psychosis: HYEPP

¹ Some headspace organisations have recently won commonwealth funding for care of young people with complex needs.

² See above.

Currently, there are emerging evidence-based therapies available for young people in some areas:

- > SALHN outer south Dialectical Behaviour Therapy (DBT) group provides a DBT skills group for young people aged 16 to 24 years, while DBT groups in other areas are only available to young people 18 years and older as an adult service;
- > headspace (and a youth clinician) in the CALHN western area are piloting a DBT for their teen group, as is headspace in Mount Barker and Murray Bridge;
- > CAMHS offers individual MBT on a limited basis to young people with severe and complex trauma history (largely young people subject to child protection orders) but has few group programs;
- > schema-focused therapy is also provided on a one-to-one basis by a limited number of clinicians;
- > DBT Skills groups (DBT for Teens) are being provided within youth mental health services, headspace and some community mental health teams.

Stakeholders on the Emerging BPD working group highlighted the following priorities, and BPD Co hub clinicians could support further roll out of these programs through supervision, coaching and support of clinicians providing these groups, where it is needed:

The need to develop a clear, baseline model of practice for care for young people that could be implemented in a number of areas. This would include:

- > Clear consistent responses to young people presenting in crisis;
- > Consistent approaches to diagnosis of young people with BPD;
- > A common language to discuss distress for young people that would facilitate communication across agencies;
- > Clear handover and escalation criteria.

Provision of collaborative support for clinicians across all agencies, including:

- > Support for diagnosis;
- > Assessment and input into care planning for young people with complex needs;
- > Advice and support for frontline workers in emergency departments, education, child protection, particularly residential care;
- > Coordination of services across agencies for young people with complex needs;
- > The establishment of high-quality reflective practice and supervision supports for clinicians working with young people with BPD;
- > Supporting clinicians to manage risk in difficult circumstances and to feel confident in their decision-making and support systems.

The Women's and Children's Health Network have proposed an approach to young people who may be at risk of BPD, working in conjunction with BPD Co. This would include:

- > an early response to young people presenting with self-harm, relational distress and risk through an ABiC clinic, run by CAMHS and/or headspace clinicians;
- > An additional group intervention, the Service User Network for Adolescents (SUN-A) is being considered as a pilot program. SUN-A is a network based therapy informed by MBT, coping theory and psychoanalytic theory. The introduction of SUN-A, as a short term group program of moderate intensity, would complement CAMHS' existing individual and family therapy approach.

6.4.5. The criminal justice system

A significant proportion of people residing in prisons qualify for a diagnosis of personality disorder in general, and BPD in particular, although no accurate current data is available regarding the prevalence of BPD in prison populations in SA.

Multiple concerns have been raised regarding the system of mental health care for prisoners with a history of BPD. The mental health care offered to prisoners in general takes place within the context of a custodial environment of strictly applied rules and regulations, focused on safety but not intended to be therapeutic in nature. The response to any behavioural disturbance therefore is likely to include seclusion to enable safety monitoring and to isolate potential impact on the security of the broader prison population. This approach, however, is reported to be experienced as punitive and likely to generate greater distress and behavioural disturbance, including self-harm, in people with BPD. Consultation with stakeholders indicates that hospital mental health inpatient or James Nash House admission for prisoners with BPD in acute crisis is often not available or practicable. Moreover, when a client from the public mental health system is admitted to a correctional institution, he/she is usually discharged from public mental health care. Upon discharge from prison, many are homeless which mitigates against effective mental health follow-up and handover of care.

Some BPD related services are currently offered in the correctional system, including:

- > James Nash House offers DBT, cognitive behavioural therapy (CBT) and is in the early stages of developing a sensory modulation program;
- > general group and individual programs including emotional regulation, violence prevention and sexual behaviour clinic;
- > co-morbidity care with drug and alcohol worker;
- > trauma informed care (TIC) training;
- > the High Dependency Unit at Yatala Labour Prison with DBT-based therapeutic programs and some schema focused therapy, delivered largely over short periods of time;
- > DBT groups for women in Port Augusta Prison;
- > the step-down Opal and Ruby units at the Adelaide Women's Prison;
- > employment of psychologists who provide high risk brief assessments in prison;
- > planning for a local women's prison, five-bed mothers and babies unit, that could also be used for women with mental health crisis, when available;
- > planning for a high dependency unit in the Adelaide Women's Prison.

It is intended that a hub BPD clinician will be allocated to correctional BPD service needs.

The priorities for this BPD Co worker, together with the training coordinator and research project officer, will include:

- > development of a criminal justice system, BPD database and needs analysis;
- > development of referral and communication pathways across the public mental health and correctional systems, with a liaison person or team to provide an accessible contact point and encourage continuity of care in general across the systems;
- > a focus on increased public mental health system awareness and understanding of the criminal justice system context;
- > development of a model of practice for intensive correctional BPD services, including a response to the risk of self-harm;
- > development of a program of short-term evidence-based therapeutic interventions such as Systems Training for Emotional Predictability and Problem Solving (STEPPS) or general BPD core competency training, which will be accessible to people with BPD in the criminal justice system;
- > increased training and support for Department of Correctional Services staff in prisons, including those in the South Australian Prison Health Service, around BPD and trauma-informed care;
- > education for the judiciary around BPD in general, and culpability in particular, including the option of court advocacy for the person with BPD, wherever possible.

6.5. Training and capacity building

The training coordinator will organise the state-wide BPD training program as well as engage in direct training provision. This role will include brokerage of appropriate trainers or training organisations via a preferred provider panel, as well as development of 'train the trainer' options to facilitate local clinician upskilling and education.

Staff training needs across the mental health, health and stakeholder sectors will be analysed to develop training packages that meet clinician and stakeholder needs. Strategies to support uptake will include engagement of LHN management and clinical leaders, tailoring training content to local environments and co-delivery with local staff where appropriate.

Multiple levels of training with multiple groups of people, in the health, mental health and other systems (e.g. SAPOL, SAAS) as well as in the community, will be required to promote a more psychologically-informed, compassionate and evidence-based therapeutic practice towards people with BPD and their carers.

The BPD training program will foster the evidence-based understanding that BPD is a mental illness that responds well to appropriate psychological treatments that people can and do recover and that it is core business of the health, mental health and community systems of care in day-to-day clinical practice.

This evidence-based therapeutic practice includes not only specialised therapies but also 'good clinical care' or core competencies, which can be readily learnt and applied by all clinicians and agencies across the board.

Consumers and carers will participate in the development of all BPD training programs, both in terms of content development as well as delivery of the training.

Evaluation of all training initiatives will be conducted.

The following eight levels of training will be rolled out by BPD Co:

a. Whole of service training

This psychoeducational, generic or core competencies BPD training is seen as an essential mechanism to bring about a reduction in BPD-related stigma and negative discrimination and to encourage positive cultural change towards people with BPD.

- > In the experience of Project Air, one day of training is required to accomplish the relevant BPD training goals.
- > This whole of service training should include people with BPD and carers in the training team, to contribute their experience and perspective to training content as well as delivery.
- > All trainers should be engaged in ongoing clinical work, if they are to be regarded by the recipients as offering a legitimate clinical perspective.

- > The training will be offered in the first instance, to front line mental health and health workers and to those mental health clinicians and managers who are interested.
- > It will then be rolled out on a voluntary basis across the health services as a whole and offered regularly over time, as clinicians come and go within the health services.

For this training process to be successful, it is necessary that management and senior clinicians in the local health areas understand the need for, and are supportive of this training initiative.

b. Assessment and Brief Intervention Clinic training

This training will teach the ABiC model of care to clinicians working in the clinics. The content of this training will be specific to the structured, therapeutic approach utilised in the clinics, which is psychoeducational, problem-solving and generic in nature.

Clinic coordinators will also meet regularly with clinic staff to provide capacity-building support and supervision.

c. Specialty BPD therapy training

Regular training opportunities will be offered by BPD Co on an ongoing basis for hub and networked BPD clinicians who wish to develop, maintain or enhance their BPD specialist therapy training competencies, whether for group, individual therapeutic work or supervision skills.

Ongoing training programs will be required in a variety of different therapeutic modalities.

Some of this training will be accessed locally in SA and this option is to be preferred.

Some training will require regular access to trainers who are located interstate or overseas.

d. Primary (mental) health care

Training will be available for GPs, private practitioners, NGO and PHN funded clinicians, focusing initially on BPD core competencies and good clinical care, as well as information on pathways to care in the mental health system.

There will be local opportunities for more specialised BPD therapy training, upon request.

e. Service specific training

This training offers content which is particularly shaped by, and directed towards, the specific BPD-related needs of the staff of that service e.g. the criminal justice system, DASSA, police and ambulance services, home support services etc.

It will be offered by BPD Co wherever possible, on a regular basis, but may also be requested by particular agencies or community groups of practitioners.

f. Carer and family/parent training (eg psychoeducation)

This training offers significant potential direct benefits and supports to family members and loved ones, as well as indirect therapeutic benefit to the person with BPD.

BPD Co will support and train clinicians and carers to provide evidence-based carer/family/parent support and psychoeducation groups.

g. Consumer psychoeducation and support groups

The BPD Co will train clinician and consumer leaders in evidence base for consumer psychoeducation and support groups.

h. General community

BPD psychoeducation training oriented towards the needs of schools and community organisations will be offered by BPD Co.

There is also a range of online BPD training modules currently under development by Project Air, the National BPD Foundation, Mental Health Professionals Network and the National Mental Health Commission. These can be freely accessed online, will provide a useful BPD training resource into the future and will be recommended by BPD Co.

Both Project Air and Spectrum websites also provide a range of freely accessible information regarding BPD for consumers, carers and clinicians on their websites.

6.6. Research and evaluation

The research program for BPD Co will be led by a senior psychiatrist and academic researcher with an established interest in BPD research. This clinical academic position or research lead will be responsible for creating, directing, coordinating and overseeing the body of research associated with the state-wide BPD service, in collaboration with the clinical lead. There will also be the role expectation and requirement that further research funding be sought, in order to encourage development of new BPD research opportunities and partnerships.

A research project officer will also be appointed whose role is to develop and implement the body of research for the state-wide BPD service, in association with the research lead, the clinical lead and BPD clinicians in the hub and the LHNs.

It is essential for the sustainability of the state-wide BPD service into the future that this service delivers the outcomes outlined by the government. This is desirable in any case, as it reflects good clinical care, but it also offers evidence for value of public monies spent and strengthens the argument for maintenance of public funding of the state-wide system of BPD care into the future.

There are multiple exciting research opportunities inherent in this new SA BPD service initiative. It is most desirable that people with BPD and carers participate actively in the research process, not only as clients but also as active research participants, wherever possible.

The following areas of research will therefore be prioritised in the first years of the BPD service development:

- a. Accurate BPD diagnostic assessment with clinical and functional measures at baseline and post-intervention to facilitate accurate and ongoing diagnosis, evaluation and hence quality improvement processes;
- b. Improved coding of BPD caseness including diagnosis of co-morbidities and complications including rates of suicide;
- c. Collection of health system-wide BPD service data to inform development and monitoring of appropriate service related key performance indicators;
- d. Frequent presenter analysis for patients who present frequently to hospitals or mental health services and/or demonstrate high hospital bed occupancy. It is expected that a significant proportion of these patients will qualify for the diagnosis of severe and complex BPD, with an associated high likelihood of co-morbidities;
- e. Research and financial support for a PhD student(s) to develop an innovative, clinically relevant PhD project in the area of BPD service development in SA, in association and partnership with a local university professorial academic unit(s);
- f. Evaluation of the planned pilot Assessment and Brief Intervention Clinics in terms of clinical outcomes and health service utilisation and costs in SA;
- g. Evaluation of training and capacity building initiatives as they are rolled out across SA;
- h. Evaluation of BPD-related cultural change;
- i. Health economic evaluations as they pertain to the development of the new BPD service in SA;
- j. Conceptual BPD research in SA, including translational research;
- k. The development of research partnerships with specialised BPD units, located interstate and overseas, to facilitate consistency of clinical evaluation measures for comparative research purposes and to contribute to building a national BPD research data base as well as Australia-wide BPD research initiatives.

7. Implementation of the BPD Co Model of Care

The scope of the new BPD Co is broad, complex and multi-faceted involving multiple systems, organisations and practitioners across all LHNs and the state and with a primary focus on change and development, yet building on and supporting BPD services which already exist.

This model of care will be implemented over the course of four years to 2022, in a staged approach to establish a leadership role, commence quality therapeutic services, build capacity across the mental health system, initiate cultural change and establish evaluation and monitoring mechanisms.

An implementation and service sustainment framework will be developed outlining the stepwise development of the service.

In the first year, the service will undertake the following tasks:

- a. establish governance and accountability mechanisms, including service level agreements with LHNs and the Office of the Chief Psychiatrist;
- b. establish the shared care approach for BPD Co to support LHNs with care of people with the most complex and severe BPD;
- c. support and re-invigorate DBT group service provision where needed;
- d. work with stakeholders including consumers, carers and LHNs to establish the program of work for care of people in specialist populations;
- e. pilot and commence evaluation of the Assessment and Brief Intervention Clinics in two locations across South Australia with LHNs and other partners;
- f. pilot and commence evaluation of a group program with WCHN;
- g. establish recommended assessment, outcomes measurement, data collection and reporting processes to enable collection of key performance measures and comparison across treatments;
- h. develop a training plan that addresses the capacity building needs across the whole mental health service system for BPD;
- i. commence training in specialist psychotherapeutic approaches for hub clinicians, where this is required to provide diverse treatment options for people with the most severe and complex BPD;
- j. develop or purchase and adapt training for frontline mental health, health and emergency staff and commence a structured roll out of this training across SA;
- k. establish a webpage that provides information on services available across SA and supports consumers, carers and clinicians to navigate this system;
- l. establish consumer and carer participation structures that provide feedback on clinical services provision, inform implementation of the model of care and service development for BPD Co, embed lived experience workers in delivery of training and connect the service with the broader carer and consumer community.

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Appendix one – Links to mental health policy and strategic plans

National Safety and Quality Healthcare Standards 2nd Edition

<https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition/>

National Standards for Mental Health Services (these are being phased out)

[https://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/\\$File/servst10v2.pdf](https://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf)

5th National Mental Health and Suicide Prevention Plan

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-fifth-national-mental-health-plan>

National Suicide Prevention Strategy

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-nsps>

A National framework for recovery-oriented mental health services

<https://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc>

National Mental Health Strategy

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-strat>

National Mental Health Policy

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-pol08>

Mental Health Statement of Rights and Responsibilities

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-rights2>

Australian Charter of Healthcare Rights

<https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

National Practice Standards for the Mental Health Workforce

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-wkstd13>

National safety priorities in mental health: a national plan for reducing harm

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-safety>

National Aboriginal and Torres Strait Islander suicide prevention strategy

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pub-atsi-suicide-prevention-strategy>

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples'

Mental Health and Social and Emotional Wellbeing

https://pmc.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf

Pathways of recovery: 4As framework for preventing further episodes of mental illness

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-frame>

Report: Mental Health of Young People in Australia

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-young>

Practical Guide for Working with Carers of People with a Mental Illness

<http://pmhccn.com.au/Resources/Practicalguideforworkingwithcarersofpeoplewithamentalillness.aspx>

Appendix Two – Glossary

Abbreviations and Acronyms	
ABiC	Assessment and Brief Intervention Clinic
ACT	Acceptance and Commitment Therapy
AMBIT	Adolescent Mentalisation Based Integrative Therapy
BPD	Borderline Personality Disorder
BPD Co	Borderline Personality Disorder Collaborative
CAFHS	Child and Adolescent Family Health Services
CALHN	Central Adelaide Local Health Network
CAMHS	Child and Adolescent Mental Health Service
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behaviour Therapy
CHSALHN	Country Health South Australia Local Health Network
CMHT	Community Mental Health Team
DECD	Department of Education and Child Development
DCP	Department of Child Protection
DCS	Department of Correctional Services
DASSA	Drug and Alcohol Services of South Australia
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual
DTN	Digital Telehealth Network
ED	Emergency Department
ETLS	Emergency Triage and Liaison Service
GP	General Practitioner
GPM	Good or General Psychiatric Management
ICD	International Classification of Disorders
ITRS	Infant Therapeutic Reunification Service
LHN	Local Health Network
MBT	Mentalisation Based Therapy
MH	Mental Health
MHPN	Mental Health Professionals Network
MI-DBT	Mother – Infant Dialectical Behaviour Therapy
NALHN	Northern Adelaide Local Health Network
NH & MRC	National Health and Medical Research Council
NGO	Non-Government Organisation
PHN	Primary Health Networks
PTSD	Post-Traumatic Stress Disorder
SA	South Australia
SAAS	South Australian Ambulance Service
SALHN	Southern Adelaide Local Health Network
SAPOL	South Australian Police Service
SCM	Structured Clinical Management
SFT	Schema Focused Therapy
STEPPS	Systems Training for Emotional Predictability and Problem Solving
SUN	Service User Network
TAU	Treatment as usual
TFP	Transference Focused Psychotherapy
WCHN	Women's and Children's Health Network



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