

## 1 **Personality Disorder: A Mental Health Priority Area**

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7 Personality disorder is a complex and severe mental illness, associated with high usage of  
8 services and treatment cost (Leichsenring et al., 2011), where the economic benefits  
9 associated with the provision of evidenced-based interventions has recently been established  
10 (Meuldijk et al., 2017). Globally, personality disorders are estimated to affect approximately  
11 6% of the population (Huang et al., 2009). Despite this, the disorder has received limited  
12 recognition as a public health issue. Left untreated, individuals with the disorder may  
13 experience disadvantage, including failing to be engaged in education or work (Ng et al.,  
14 2016), have a high risk of suicide and experiencing comorbid mental health disorders  
15 (Leichsenring et al., 2011).

16

17 Internationally, best practice guidelines have been published in a number of countries  
18 acknowledging challenges associated with service provision, aiming to improve services for  
19 individuals with personality disorder. Guidelines were first developed in 1999 in New  
20 Zealand (Krawitz and Watson, 1999) followed by the United States of America, United  
21 Kingdom and Australia (National Health and Medical Research Council, 2012). These  
22 clinical practice guidelines provide a roadmap for reform and consistently recommend  
23 psychological interventions as the first line of treatment. It is recommended that clinical  
24 practice guidelines for the management of personality disorder should be read in conjunction  
25 with the Royal Australian and New Zealand College of Psychiatrists practice guidelines for  
26 mood disorders (Malhi et al., 2015) and deliberate self-harm (Carter et al., 2016), given the  
27 high comorbidity.

28

29 There is an evidence base for the effectiveness of various psychological treatments for  
30 Borderline Personality Disorder (BPD) (for example cognitive behavioural and  
31 psychodynamic therapies), involving weekly sessions for one year, all with similar outcomes  
32 (Cristea et al., 2017). Most health workers indicate a need for greater training in these  
33 treatments for personality disorder (McCarthy et al., 2013). The underlying general skills that  
34 are effective in all these models have been described and tested (Bateman et al., 2015;

1 Beatson and Rao, 2014), meaning any psychologist or psychiatrist can implement effective  
2 care with support.

3

4 There is however workforce challenges to providing coverage of psychological therapies. For  
5 example, in Australia access to psychiatrists is limited, with 17 private psychiatrists per 100  
6 000 population practising in major cities, 6.2 per 100 000 in inner regional areas, 4.4 per 100  
7 000 in outer regional areas and only 3 per 100 000 for outer regional and remote areas  
8 (Australian Institute of Health and Welfare, 2014). Mental health nurses are a significant part  
9 of the workforce but often are not trained in psychological therapies thus improving access to  
10 funding psychologists is the most viable option. There is greater onus is placed on  
11 psychologists to provide treatment and support to individuals with personality disorder, yet  
12 the burden often falls to public services which may struggle to provide the community  
13 services required for effective evidence-based care.

14

15 Consumers and carers have both reported the difficulties in identifying and accessing services  
16 (Lawn and McMahon, 2015). Current mental health schemes offered as part of universal  
17 health care in Australia, such as the Better Access to Mental Health Scheme or the Access to  
18 Allied Psychological Services (ATAPS) subsidises only 10 – 18 individual and 10 - 12 group  
19 sessions per calendar year, which clinical guidelines and research considers insufficient for  
20 meeting the treatment needs of some individuals with personality disorder (Beatson and Rao,  
21 2014; National Health and Medical Research Council, 2012). More concerning, at present  
22 personality disorders are not recognised on the general practitioner's mental health care  
23 Medicare items list, suggesting that current universal mental health schemes are not suitably  
24 designed to support the treatment of personality disorder. Other treatment access pathways  
25 such as Australia's National Disability Insurance Scheme may not be a good match for most  
26 people with personality disorder. The majority of people with personality disorder respond  
27 well if provided effective evidence-based psychological treatment and therefore, recovery  
28 and living a contributing life is achievable. Long term disability would mostly represent a  
29 failure to access and receive evidence-based community psychological treatment. The  
30 implementation of an alternative model for accessing community based treatment when  
31 warranted by individuals is required.

32

33 At present, different state based initiatives in Australia – such as the Project Air Strategy in  
34 New South Wales and Spectrum Personality Disorders Service in Victoria are available.

1 South Australia, through their state Mental Health Commission, has commenced the process  
2 of reform. We outline a number of areas of priority which require careful consideration at this  
3 time of reform.

#### 4 5 1. Improving Treatment for Individuals with Personality Disorder

6  
7 Individuals with personality disorder often access a variety of services, both clinical and  
8 psychosocial, to assist with their recovery. A national commitment is needed to re-orient  
9 clinical services to implement the NHMRC clinical practice guidelines. Stepped care models  
10 for personality disorder have been developed using brief interventions to intervene rapidly at  
11 the acute stage of illness, followed by additional longer term treatment as clinical need  
12 dictates (Grenyer, 2014). The stepped care approach also acknowledges individuals who have  
13 personality disorder who do not require or wish to engage in long term care, but can benefit  
14 from immediate crisis care that provides specific focused personality disorder interventions  
15 (Grenyer, 2014). Longer term evidence-based interventions designed for the treatment of  
16 BPD have demonstrated their effectiveness in terms of outcomes and cost. A recent  
17 systematic review identified the benefits of providing evidence-based interventions, with an  
18 average cost saving of USD \$2987.82 per patient per year (Meuldijk et al., 2017).

19  
20 Training all mental health staff in Australia to effectively work with individuals with  
21 personality disorder and the implementation of brief and longer-term intervention services  
22 around Australia is an urgent priority as such these models can lead to significant reductions  
23 in inpatient hospitalisation and emergency department presentations (Grenyer, 2014). The  
24 need to improve skills and knowledge of mental health staff has been supported by the need  
25 for a whole of system approach such that staff working in specialist and non-specialist  
26 organisations need to be equipped with the skills and knowledge in order to work with  
27 individuals with personality disorder (Grenyer, 2013).

#### 28 29 2. Assessing and Intervening Early

30  
31 Increasing evidence has suggested that early intervention and diagnosis prior to the age of 18  
32 and intervening with individuals who have emerging personality disorder is conducive to  
33 improving outcomes (Chanen et al., 2009). The NHMRC clinical practice guidelines  
34 (National Health and Medical Research Council, 2012) makes two pertinent

1 recommendations; first young people with emerging symptoms should be assessed for  
2 possible BPD; and second, adolescents should receive structured psychological therapies. Yet  
3 despite this clear guidance, there is ongoing reluctance from health professionals in  
4 diagnosing individuals with BPD prior to the age of 18 years. This has potential to not only  
5 limit the types of services individuals can access but also delays access to effective treatment.  
6 Primary care that is well connected to schools and families provide good opportunities to  
7 identify, intervene, and source additional support for individuals with these emerging  
8 problems (Grenyer, 2013). Mental health staff working with adolescents similarly have the  
9 skills to assess and treat young people with emerging symptoms if they are trained in  
10 contemporary personality disorder treatment. Sadly, most experienced staff identify training  
11 and knowledge gaps in treating these disorders (McCarthy et al., 2013).

12

13 One innovative example of early intervention in Australia is the HYPE (Helping Young  
14 People Early) clinic based at the ORYGEN Youth Health (Chanen et al., 2009). This model  
15 provides integrative care for adolescents between 15-25 years of age, offering psychotherapy,  
16 case management, crisis care and support for families and carers.

17

### 18 3. Improving the experience of consumers, families, carers and partners

19

20 There is a need to support all those who embark on the treatment and recovery journey from  
21 personality disorders, which includes the family, carers and partners of individuals with  
22 personality disorder. Significant burden, higher rates of psychological distress, and reduced  
23 levels of wellbeing have been associated with caring for loved ones with personality disorder  
24 (Bailey and Grenyer, 2014).

25

26 The consumer voice in personality disorder has emerged in the past decade with the  
27 development of organisations such as the Australian BPD Foundation. These organisations  
28 play an instrumental role in advocating for consumers, carers and family members, and  
29 increasing community awareness of personality disorder. Despite this work, considerable  
30 stigma and discrimination continues to be reported by both individuals with lived experience  
31 and their carers, within the community and the health system (Lawn and McMahon, 2015).

32 This has been suggested to be perpetuated by the attitudes and limited knowledge on  
33 personality disorders held by health practitioners. Alongside an imperative to educate  
34 clinicians already within the workforce, emphasis should also be placed on tertiary and

1 vocation education settings to incorporate evidence based knowledge regarding personality  
2 disorder for all pre-workforce clinicians. In the community level, mental health literacy in  
3 regards to personality disorder is limited. The development of population based awareness  
4 campaigns, not dissimilar to those designed to improve awareness of depression and  
5 schizophrenia, which involve individuals with personality disorder and their carers may  
6 address stigma and increase awareness.

7  
8 Research is also needed that includes multiple perspectives to provide a greater insight into  
9 the experiences of consumers (Ng et al., 2016). This could be achieved through the  
10 incorporation of differing methodologies in collective data, such as narrative methods,  
11 ethnography, case studies, and participatory action research. The development of a peer  
12 workforce for personality disorder may provide a unique opportunity for the co-production of  
13 knowledge.

14

#### 15 4. Accurate and representative collection and reporting of data

16

17 Improving the quality of health services and understanding outcomes for Australian's living  
18 with personality disorder is driven by the accurate collection and reporting of data. Currently,  
19 personality disorders are often not specifically reported upon within national reports  
20 including those from the Australian Institute of Health and Welfare, but rather classed within  
21 the 'other' category. Internationally, personality disorders have been excluded when reporting  
22 on mental health morbidity (Tyrer et al., 2010).

23

24 In the recent report on Healthy Communities: Hospitalisations for mental health conditions  
25 and intentional self-harm in 2013–14, the other category includes: BPD; Unspecified delirium  
26 Eating disorders and Sleep disorders (Australian Institute of Health and Welfare, 2016).

27 There is a clear need to understand more about this 'other group' particularly given they  
28 represent close to a fifth of all hospitalisations and 34% of all hospitalisations in individuals  
29 under 25 years (Australian Institute of Health and Welfare, 2016). Given population data  
30 estimates the prevalence of personality disorders at 6.5% of the Australian population  
31 (Jackson and Burgess, 2000), it is likely a significant proportion of other is represented by  
32 individuals with personality disorder. However, this data is more than 15 years old and  
33 requires updating to reflect current trends.

34

1 Rates of suicide for people with personality disorder have been established through  
2 examining longitudinal studies of individuals who have sought treatment and have been  
3 estimated to be at approximately 10% (American Psychiatric Association, 2001). The  
4 national calls for suicide prevention in Australia are silent on personality disorder, despite  
5 this diagnosis being associated with a higher risk of self-harm and suicidal behaviours  
6 (National Health and Medical Research Council, 2012). Where they exist, studies have  
7 predominately been based within North America and no data is available for Australia. Also,  
8 the data reflects individuals who have received treatment and it is unknown how this  
9 translates to individuals who are not engaging in treatment. The establishment of a national  
10 suicide registry may assist to understand mortality rates in Australia - if mental health  
11 diagnoses that include personality disorder are linked.

12

13 Reforming the manner in which personality disorder is serviced, and viewed in Australia will  
14 require a consistent national approach involving ongoing commitment from government. We  
15 outline some of the pertinent issues surrounding personality disorder, however it is important  
16 to recognise that ongoing changes as part of national reform is required in order to improve  
17 services and outcomes for individuals with personality disorder and their carers and their  
18 families.

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