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Personality disorder: A mental health priority area

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Abstract
Personality disorders have received limited recognition as a public health priority, despite the publication of treatment guidelines and reviews showing effective treatments are available. Inclusive approaches to understanding and servicing personality disorder are required that integrate different service providers. This viewpoint paper identifies pertinent issues surrounding early intervention, treatment needs, consumer and carer experiences, and the need for accurate and representative data collection in personality disorder as starting points in mental health care reform.

Keywords
disorder:, mental, priority, area, health, personality

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

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

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

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

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

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

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

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

1. Improving Treatment for Individuals with Personality Disorder

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

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

2. Assessing and Intervening Early

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

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

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

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

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

The consumer voice in personality disorder has emerged in the past decade with the development of organisations such as the Australian BPD Foundation. These organisations play an instrumental role in advocating for consumers, carers and family members, and increasing community awareness of personality disorder. Despite this work, considerable stigma and discrimination continues to be reported by both individuals with lived experience and their carers, within the community and the health system (Lawn and McMahon, 2015). This has been suggested to be perpetuated by the attitudes and limited knowledge on personality disorders held by health practitioners. Alongside an imperative to educate clinicians already within the workforce, emphasis should also be placed on tertiary and

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

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

4. Accurate and representative collection and reporting of data

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

In the recent report on Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14, the other category includes: BPD; Unspecified delirium Eating disorders and Sleep disorders (Australian Institute of Health and Welfare, 2016). There is a clear need to understand more about this 'other group' particularly given they represent close to a fifth of all hospitalisations and 34% of all hospitalisations in individuals under 25 years (Australian Institute of Health and Welfare, 2016). Given population data estimates the prevalence of personality disorders at 6.5% of the Australian population (Jackson and Burgess, 2000), it is likely a significant proportion of other is represented by individuals with personality disorder. However, this data is more than 15 years old and requires updating to reflect current trends.

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

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

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