Private Mental Health
Consumer Carer Network (Australia)
engage, empower, enable choice in private mental health

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Senator Claire Moore,
Chair,
Senate Community Affairs Committee,
Inquiry into Mental Health,
PO Box 6100,
Parliament House,
CANBERRA. ACT 2600 via Email: community.affairs.sen@aph.gov.au

Attention Ms. Lisa Fenn.

Dear Senator Moore,

Key Issues and ways forward

Thank you for the opportunity of reaffirming firstly the four key issues and secondly the actions recommended by the clinicians at the meeting with members of the Senate Community Affairs Committee of Thursday 28 August, 2008.

We have set out hereunder:

Key Issue 1

1.1 Greatest area of unmet need

People with the diagnosis of Borderline Personality Disorder are among those with the highest levels of unmet need in Australian mental health services. Borderline Personality Disorder affects over 120,000 Australian youth and over 200,000 Australian adults. It is common in clinical practice, occurring in at least 10% of outpatients and 20% of inpatients. It is associated with high levels of additional mental health problems (such as depression and drug and alcohol use) and severe and continuing disability across a broad range of domains of interpersonal and social functioning, poor quality of life, high usage of mental health and general health resources, and high mortality. The suicide rate for this disorder is 10%, the same as for schizophrenia.

1.2 Recommended actions

1. Borderline Personality Disorder must be identified as a public health priority at both the National and State levels.

2. Borderline Personality Disorder must be identified as a specific National Health Priority Area for the National Health and Medical Research Council.

Key Issue 2

2.1 Prejudice

Regrettably, people with Borderline Personality Disorder experience the worst prejudice, discrimination and stigma from health professionals. They are treated in the main within mental health services with hostility, non-acceptance and in a

dismissive manner. They are subjected to 'double discrimination' by lack of recognition of Borderline Personality Disorder as a mental disorder within the community, and secondly from within the mental health system as people who have behavioural problems or are 'morally defective', rather than having a genuine and complex mental disorder.

2.2 Recommended Actions

1. As above, provide specific education and training to mental health professionals and primary healthcare professionals that aim to change attitudes and behaviours toward individuals with Borderline Personality Disorder.

2. Conduct a public 'mental health literacy' campaign to improve recognition of the disorder and to increase consumer demand for appropriate services. *beyondblue* is a good example of this kind of campaign.

3. On April 1st 2008, the United States House of Representatives took action by declaring each May to be Borderline Personality Disorder awareness month. Australia must follow this initiative if the issue of prejudice is to be addressed.

Key Issue 3

3.1 Lack of access to and provision of specialised services

There is now strong research evidence for the effectiveness of a range of treatments for Borderline Personality Disorder. However, the vast majority of people with this diagnosis go untreated. This is largely because of the uninformed and discredited belief that Borderline Personality Disorder is untreatable. This has given rise to written or unwritten policies that these people should be denied services and this practice is common among Australian mental health services. Moreover, specialised programs to treat people with Borderline Personality Disorder are scarce in all jurisdictions and where these services do exist, they are often isolated from the mainstream of mental health services.

3.2 Recommended actions

1. Establishment of specialised public mental health **outpatient** services in each capital city together with major rural regions in all jurisdictions. The purpose of these services would be to offer assessment, therapy (in terms of both one to one and group therapies) consultation, teaching, training, research and clinical supervision.

2. Establishing dedicated services in all Australian jurisdictions that would provide treatment for the most severely affected individuals and families, along with training for mental health service providers. The '*Spectrum*' service in Victoria is an example of this.

3 A person with Borderline Personality Disorder must have explicit and defined pathways of care throughout their engagement with mental health services, provided in a true multi-disciplinary team approach.

4. Mandating that state-based mental health services provide services for young people and adults with Borderline Personality Disorder.

5. Provide early intervention services for young people (12-25 years-old) with Borderline Personality Disorder. The 'HYPE' service at ORYGEN Youth Health in Victoria is an example of this and is supported by published scientific evidence.

6. Making State Directors of Mental Health more accountable for the lack of specialised Borderline Personality Disorder services.

Key Issue 4

4.1 Workforce

One reason for the scarcity of services for Borderline Personality Disorder is the limited training that the mental health workforce receives in understanding and managing the disorder. This leads to lack of confidence in managing this disorder. When combined with the fear and apprehension that many mental health professionals experience when dealing with individuals with Borderline Personality Disorder, this often leads to refusal of services. Workforce development is urgently needed. This should focus upon knowledge and attitudes, intervention skills, as well as coordination of the multitude of services used by individuals with Borderline Personality Disorder.

4.2 Recommended actions

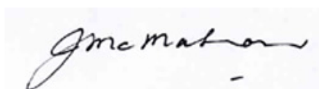
1. Provide specific education and training to mental health professionals and primary healthcare professionals that aim to change attitudes and behaviours toward individuals with Borderline Personality Disorder. Provide specific training to the adult and youth mental health workforce in a range of interventions for Borderline Personality Disorder.

2. Provide resources to facilitate the coordination of the numerous healthcare, government and non-government agencies involved with the individual and/or family/carers.

On behalf of the coalition of the national mental health consumer and carer advocacy peak bodies, it is our hope that the above issues can be addressed.

Thank you for the opportunity of clarifying further the discussions that took place at the meeting of the 28 August, 2008.

Yours faithfully,



Ms Janne McMahon OAM
Spokesperson for the Coalition
5 September, 2008