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 evidence-based interventions have 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 failure to engage 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, 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) (e.g. cognitive behavioural and psychodynamic therapies), involving weekly sessions for 1 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 are, 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 in outer regional and remote areas (Australian Institute of Health...
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 its 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.

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 National Health and Medical Research Council (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 long-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). Long-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 US$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 long-term intervention services around Australia are 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).

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 are conducive to improving outcomes (Chanen et al., 2009). The NHMRC clinical practice guidelines (National Health and Medical Research Council, 2012) make 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 provides 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
Improve awareness of depression and not dissimilar to those designed to
is limited. The development of popu-
acy in regard to personality disorder
community level, mental health liter-
for all pre-workforce clinicians. In the
edge regarding personality disorder
incorporate evidence-based knowl-

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 bur-
den, 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 dec-
ade with the development of organi-
sations such as the Australian BPD
Foundation. These organisations play
an instrumental role in advocating for
consumers, carers and family mem-
bers, and increasing community
awareness of personality disorder.
Despite this work, considerable
stigma and discrimination continue 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 per-
petuated by the attitudes and limited
knowledge on personality disorders
held by health practitioners. Alongside
an imperative to educate clinicians
already within the workforce, empha-
sis should also be placed on tertiary
and vocation education settings to
incorporate evidence-based knowl-
dge regarding personality disorder
for all pre-workforce clinicians. In the
community level, mental health liter-
acy in regard to personality disorder
is limited. The development of popu-
lation-based awareness campaigns,
not dissimilar to those designed to
improve awareness of depression and
schizophrenia, which involve individu-
als with personality disorder and their
carers, may address stigma and
increase awareness.
Research is also needed that
includes multiple perspectives to pro-
vide a greater insight into the experi-
ces of consumers (Ng et al., 2016).
This could be achieved through the
incorporation of differing methodolo-
gies in collective data, such as narra-
tive 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.

Accurate and representative collection
and reporting of data

Improving the quality of health ser-
ices and understanding outcomes
for Australians living with personality
disorder are 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 inten-
tional 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 hospi-
talisations in individuals under 25 years
of age (Australian Institute of Health
and Welfare, 2016). Given population
data estimate the prevalence of per-
sonality disorders in 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, these data are more than
15 years old and require updating to
reflect current trends.
Rates of suicide for people with
personality disorder have been estab-
lished through examining longitudi-
 nal 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 dis-
order, 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 are avail-
able for Australia. Also, the data
reflect individuals who have received
treatment, and it is unknown how this
translates to individuals who are not
engaging in treatment. The establish-
ment 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 con-
sistent national approach involving
ongoing commitment from govern-
ment. We outline some of the perti-
nent issues surrounding personality
disorder; however, it is important to
recognise that ongoing changes as
part of national reform are required
in order to improve services and out-
comes for individuals with personality
disorder and their carers and their
families.

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