Government of **Western Australia**
Department of **Health**

Personality Disorders Mental Health Sub Network Establishment Report

Including outcomes of the Personality Disorders Mental Health Sub Network inaugural Open Meeting

30 August 2016

better health ▪ better care ▪ better value

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Executive Summary

Personality Disorders Mental Health Sub Network

The Mental Health Sub Networks were established to support the Mental Health Network (MHN) in engaging with and delivering outcomes for specific cohorts of mental health service users.

This report outlines the process of establishment of the Personality Disorders Mental Health Sub Network Steering Group, with a focus on the outcomes of the Open Meeting that will inform the Group's work.

Open Meeting

The MHN in conjunction with the Mental Health Commission (MHC) hosted the Personality Disorders Mental Health Sub Network Open Meeting on 30 August 2016.

The Open Meeting was attended by 53 people, including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The Open Meeting program is available in Appendix A.

The panel members spoke to a number of issues and possible solutions highlighting the following:

- Personality Disorders is a challenging sector to work in due to stigma, discrimination, funding and conflicts between clinical policy, governance and practice.
- Treatment, training and early intervention are the key to support people before they reach a crisis situation.
- Cooperation, connection of services, early implementation of intervention therapies and collaborative pathways will support transitions in times of crisis.

The workshop session captured the common issues raised by the participants, as identified by the Open Meeting facilitator:

- A need for increased training and education on personality disorders across the workforce.
- Lack of cooperation and collaboration within the sector, including acute, inpatient, community, outpatient, non-government organisations and private services.
- Need for more early intervention, assessment and diagnosis through education of health professionals and the public, and adequate funding.
- Inequitable access to services caused by restrictive criteria and postcode limitations.
- Need for a specialist personality disorders service in Western Australia.
- Need for specific targeted services (e.g. Perinatal and Parenting).
- Certain personality disorders (e.g. Emotionally Unstable Personality Disorder) or treatments (e.g. Transference-Focused Psychotherapy) not given as much recognition as other conditions and treatments.
- Need for more effective data collection and research on the cost of treatment and to inform clear evidence based, best practice guidelines.
- Lack of adequate supervision for clinicians and staff.

The themed outcomes from the workshop session are outlined under Workshop outcomes with the detailed participant input available in Appendix B.

Steering Group

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN Executive Advisory Group for final approval. A list of the Inaugural Steering Group for the Personality Disorders Mental Health Sub Network is available in Appendix C.

The information collected from the Open Meeting workshop will be used to guide the Personality Disorders Mental Health Sub Network Steering Group in the development of their work plan and to inform and support the MHC in the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Personality Disorders Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health on the planning of health services.

Introduction

Mental Health Network

The establishment of the Mental Health Network (MHN) was undertaken by the Department of Health with the support of Professor Bryant Stokes, Acting Director General, Department of Health in partnership with Mr Timothy Marney, Mental Health Commissioner, Mental Health Commission (MHC).

The MHN was launched during Mental Health Week in October 2014. The MHN is led by Co-Leads Dr Helen McGowan and Ms Alison Xamon.

The MHN Executive Advisory Group (EAG) membership includes consumer and carer representatives as well as representatives from the Department of Health, MHC, Office of Mental Health, Primary Care, Mental Health Clinician Reference Group, Office of the Chief Psychiatrist, Western Australian Primary Health Alliance (WAPHA) and the Western Australian Association of Mental Health.

The objective of the MHN EAG is to support and guide the MHN to undertake the following:

- Contribute to improving the mental health and wellbeing of Western Australians.
- Draw upon a community of practice approach to share information, engage with the sector and community, foster collaboration and develop partnerships.
- Engage with organisations and individuals to support innovation and change.
- Develop an agreed set of strategic priorities across the mental health sector.
- Promote system change including continued development of a person-centred and recovery orientated culture, with better integrated and connected services.
- Promote adoption of recognised best practice across the sector.

The Mental Health Sub Networks structure was created to support the MHN to meet these objectives.

Mental Health Sub Networks

The Sub Networks are intended to focus on the needs of a particular cohort, be task orientated and to deliver products by bringing together the right people, from the community sector, Health, consumers, carers and other interested parties. A structured approach was taken to engagement and the establishment of each of the Sub Networks

A prerequisite to the establishment of each Sub Network included confirmed sponsorship from a health service, identified co-ordinators and support of key stakeholders within the sector prior to progressing the development of the Sub Networks.

The MHN Co-Leads took a leadership role in networking with individuals and organisations to identify and establish the Sub Networks.

An Implementation Group of key stakeholders was then formed to assist in the organisation of an Open Meeting, including the selection of appropriate panellists to provide snapshots of key sector issues. The aim of the Open Meeting was to give the broad community the opportunity to actively participate in the formation of the Sub Network and provide critical input to shape its priorities moving forward.

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

Each Mental Health Sub Network Steering Group was required to have representation from:

- consumers
- carers or family members
- community managed organisations

- public community mental health services
- inpatient public mental health services
- inpatient and community private mental health services
- primary health services
- agencies delivering prevention and promotion programs and initiatives
- MHC
- mental health professionals from a range of disciplines including:
  - peer workers
  - allied health
  - nursing, medical
  - psychology
  - psychiatry
- individuals and agencies working in regions across the state including:
  - rural and remote and metropolitan districts / regions (particularly relevant for cross-sectoral working groups)
- individuals and agencies working with different age cohorts (relevant for cross-age cohort working groups), including:
  - infant children and adolescents
  - youth
  - adults
  - older adults
- the sponsoring organisation.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN EAG for final approval. In order to keep the Steering Groups at workable sizes, applicants were selected on the basis of their ability and willingness to represent the concerns of multiple cohorts.

A list of the Inaugural Steering Group for the Personality Disorders Mental Health Sub Network is available in Appendix C.

Personality Disorders Mental Health Sub Network Open Meeting

Stakeholders for Personality Disorders mental health services in Western Australia met for the inaugural open meeting of the Personality Disorders Mental Health Sub Network at the Bendat Community Centre on 30 August 2016.

A total of 53 people attended the Open Meeting including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations.

- 70 people registered to attend the Open Meeting.
- 53 people attended the Open Meeting (76 per cent of those that registered).
- 40 organisations were recorded as having representatives at the meeting.

Open meeting process

The energy and good will demonstrated throughout the establishment of the Personality Disorders Mental Health Sub Network continued to develop momentum throughout the Open Meeting.

The Open Meeting program is available in Appendix A.

Following the acknowledgement to country given by Mental Health Co-lead Alison Xamon, the Open Meeting heard overviews from Dr Helen McGowan, regarding the Mental Health Network; Mr Tim Marney regarding the *Western Australian Mental Health, Alcohol and Other Drug*

Services Plan 2015-2025 and Ms Alicia Wilson regarding the personality disorders mental health sector.

Panellists recommended by the Personality Disorders Mental Health Sub Network Implementation group then shared snapshots of key issues and perspectives in the personality disorders mental health sector.

Following a networking break the meeting resumed with a workshop session facilitated by an external provider.

The outcomes of the panel discussion and workshop session as captured by the facilitator are themed and summarised below.

Panel discussion

The Panel consisted of representation from the following perspectives:

- Carer — Ms Helen Farrell
- Clinical Psychologist Coordinator — Ms Teresa Stevenson
- Consultant Psychiatrist — Dr Pauline Cole
- Mental Health Manager — Ms Melinda Brooker
- Clinical Psychologist — Ms Sandra McMillan

The following points were captured by the facilitator during the panel session:

- Working in the sector has been quite challenging as a peer support worker and facilitator. The amount of people lost or in pain is incomprehensible, no is listening to the voices.
- I have experienced discrimination and stigma but not sure if it's about a lack of knowledge or a lack of empathy.
- 'Personality Disorder' - what a poor name; I'm a person with a degree and two lovely children.
- The language we use, that sets up an 'us' and 'them' situation, is destructive:
  - hopefully the Sub Network can focus on building a new language
  - it's not a one size fits all, we're all different and we need a system that allows people to write their own narratives.
- Personality disorders is a huge area with so much mess behind us and we need to remember there are *people* in need who need us to wipe the slate clean and start communicating as services:
  - what makes it even more challenging is that we're at a huge crossroads with NDIS and services chasing funding.
- The statistics are damning but I'm happy that we're here today to do something about it:
  - the field of mental health is currently relying on goodwill to deliver its program.
- What have we done about rolling out the National Health and Medical Research Council (NHMRC) guidelines in WA?
  - I would like to see more advocacy and resourcing from our Minister around these guidelines.
- Mental health reform needs to be about treatment and not cost containment to address the conflict between clinical policy / governance and practice.
  - Need acknowledgement that borderline personality disorder (BPD) treatment is a legitimate use of healthcare services and funding.
- BPD is a public mental health crisis and everybody needs to acknowledge and address this.
- General Practitioners (GPs) understand that we need more dialectical behaviour therapy (DBT) and training is the key, as we've been trained to label, pigeonhole and diagnose.
- We're chipping away at this with WAPHA with money to spend and people committing their time, which is positive.
- DBT skills in schools would be wonderful, as it is currently happening in the United States.

- Stigma still exists in the community but also in clinical settings:
  - a lack of training and ongoing education is a major contributing factor
  - understanding trauma pathways can encourage a more empathic stance and treatment for clients.
- Non-government organisations (NGOs) working with clients post discharge are holding a significant amount of clinical risk without the necessary clinical support:
  - needs some real effort put into collaborative pathways for people at an episodic level, to ensure smooth transitions in times of crisis.
- DBT should be recognised as gold standard but the current funding system doesn't recognise this with NGOs struggling to maintain services focused on real gaps in the system.
- Early information and intervention before people meet criteria for diagnosis or before crises is absolutely key:
  - challenging if people are still living in those challenging family environments or they're young and haven't had the negative consequences yet.
- Under 18s don't have the options that adults have so they're at the mercy of Department for Child Protection and Family Support (DCPFS) or other people paid to make choices for them.
- The positive message is that cooperating and getting support for people early really sets them on the right path for the future:
  - we need to cooperate and connect services better.

Workshop outcomes

Participants were asked to consider the panel presentations and take into account their own knowledge and experience of the sector to answer the following questions:

  - What do you see as key issues, challenges and gaps in service delivery that are still to be resolved in the personality disorder mental health space?
  - For this issue, what potential solutions would you propose?

Responses were shared in real time via GroupMap - allowing cross pollination of ideas from all participants. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The following points were captured during the workshop session by the facilitator, summarised and themed:

A need for increased training and education on personality disorders across the workforce:

- A need for training and education for the workforce, particularly in NGOs who are holding considerable responsibility in the community.
- Education for Emergency Department (ED) clinicians, mental health and general to address the stigma.
- Need better education and training for clinicians on personality disorders and treatment options.
- Include training in curricula at post graduate level to target particular disciplines' needs for knowledge regarding personality disorders presentations for medicine, psychology, and other students.
- Increase awareness of current clinicians and services that treat individuals with personality disorders.
- Lack of education training and support for GPs.
- Need for a specialist mental nursing training as current generalist approach leaves nurses ill equipped to manage mental health presentations, especially complex presentations.
- Training and support for clinicians and carers to break down stigma, have a better understanding of the disorder and spectrum of presentations within co-morbid conditions, understanding the biosocial model underpinning the condition.
- Changing entrenched, out dated clinical perspectives.
- Increased understanding of illness through training.
- Training all staff – not just clinical, emphasis on interpersonal.
- Target graduate clinicians to change culture of work practice.
- Some staff not understanding that managing unhelpful behaviours is not helped by a punishing, punitive stance, patients have already had a lot of that in their lives.

Lack of cooperation and collaboration within the sector, including acute, inpatient, community, outpatient, NGO and private services:

- Lack a comprehensive, coordinated strategy through a peak body or Centre of Excellence for treatment of people with personality disorders in WA. To establish evidence based training, evaluation, coordinated service development and implementation and ongoing support for clinical services in maintaining services (to enable top-down and bottom-up service development).
- Lack of consistency in approach to inpatient treatment.
- Lack of cooperation and collaboration within health, including acute, inpatient, community, outpatient, NGO and private services.
- Require a closer working relationship between community services and acute care services (working together rather than parallel).
- Gaps in provision for youth and early intervention for personality difficulties.
- Lack of cooperation and collaboration between in-patient / acute settings and community mental health settings.
- Timely transitional care between hospital and community.
- More effective communication between services.
- There is no coherent treatment pathway for clients with antisocial personality disorder in the Health Department.
- Fragmented care approach.
- Absence of Care Coordination.
- Lack of collaboration.
- Consistency of services.
- Gap after clinical care finishes.
- One client, one record to follow them around, rather than multiple records that services don't share with each other.

- Gaps in coherent therapeutic integration of individual treatment and family / carer support.
- Cacophony not a Symphony at the moment – flip this around!!

Need for more early intervention, assessment and diagnosis through education of health professionals and the public, and adequate funding:

- Early intervention assessment and early diagnosis through education of health professionals and public is lacking.
- Early recognition and response of children at risk.
- Emphasis on early intervention is needed.
- Identify at-risk families and teach effective parenting (circle of security) strategies to primary attachment figures.
- Lack of prevention approaches to personality disorders.
- Lack of resources available for personality disorders presentations and prioritised for crisis care rather than treatment, prevention and case management.
- Early identification of personality traits and accurate information for consumers and carers.
- The need for evidence based intervention (DBT) available – access. Higher demand than.
- Acknowledging the need for early intervention –is there adequate funding / who is being resourced?

Inequitable access to services caused by restrictive criteria and postcode limitations:

- Long waiting lists for existing programs AND the person must have a case manager with public mental health service to be picked up – willingness of public mental health services to provide case management is variable.
- Increased access to specific step-down and crisis intervention services is needed (e.g.: Hampton Rd).
- Stop the post code lottery by making sure that the contracting from the MHC is specific enough to give priority to evidence based treatments for this high risk group.
- Inequitable access to effective comprehensive (crisis, community, individual and group) psychological treatment for specific groups - full-time workers, shift workers, geographical areas (no program at some area services), males, parents with preschool children, culturally and linguistically diverse (CALD) and Aboriginal, incarcerated / forensic system.
- People who fall outside diagnostic criteria for BPD often do not get treatment for personality disorders issues.
- Lack access to evidence based treatments.
- Long wait for government services and may not get picked up when they are eventually seen.
- No DBT services at all in certain postcodes – inequality of service access.
- Post code lottery for treatment.

Need for a specialist personality disorders service in WA:

- WA is one of the only states in Australia that doesn't have a specialist personality disorders service despite it being recommended by the NHMRC.
- Confusion about whether personality disorders are core business of mental health services is leading to people not being able to access mental health services and programs.
- No disorder specific emergency / crisis interventions.
- No specialist personality disorder service to provide a program of education to government and non-government services and clinicians.
- Governance of mental health services under general health means that there is little value placed on non-procedural interventions; solution is endorsed care pathways and service specifications which are precise and part of commissioning.

Need for specific targeted services (e.g. Perinatal and Parenting):

- Lack of specific, targeted services for pregnant women and mothers with BPD – emerging evidence of poor outcomes (obstetric, psychosocial, mental health, child development) for this group.
- Lack of DBT services for men.
- No disorder specific step-up / step-down services.
- Specific needs of adolescents with emerging personality disorders – at risk of unplanned pregnancy, single parenthood.
- Lack of Perinatal and Parenting Services.

Certain personality disorders (e.g. Emotionally Unstable Personality Disorder) or treatments (e.g. Transference-Focused Psychotherapy) not given as much recognition as other conditions and treatments:

- DBT prioritised over other supportive relationships and therapies (Transference-Focused Psychotherapy {TFP}, etc.) that keep patients regulated and safe.
- Addressing all personality disorders not just Emotionally Unstable Personality Disorder (EUPD).
- Other personality disorders (not EUPD) don't get as much recognition.
- Better recognition of people with cluster of symptoms re EUPD.
- Over valuing of DBT in the context poor maintenance of skills at follow up and increasing evidence of other evidence based interventions, such as mentally based treatment (MBT).

Need for more effective data collection and research on the cost of treatment and to inform clear evidence based, best practice guidelines:

- More effective data collection and research committed to this area.
- Lack of evidence of the cost of personality disorder treatment (ED visits, admissions, community mental health input, NGO input) to justify the cost of providing treatment options for people with personality disorders.
- General Health services (EDs) not being costed with mental health.
- Research into alternative therapies so that a range of therapies can be offered, solution – use emerging data over next 18 months to educate and change services.
- Lack of clear evidence based, best practice guidelines.
- Difficulty getting a primary diagnosis impacting on support required.

Lack of adequate supervision for clinicians and staff:

- Lack of adequate supervision for clinicians that equips them to deal with challenging consumers with personality disorders; to prevent burnout and poor practice or re-traumatising of consumers.
- Ongoing supervision for staff and for supervisors is required.

Other issues:

- New funding models Activity Based Funding (ABF) attach funding to assessment or short term intervention. Lack of funding for long term support. Public mental health services focusing upon acute care so not providing longer term support and intervention for personality disorder treatment.
- Accommodation services should be supportive in providing accommodation rather than waiting until crisis happens.
- Lack of responsive, ongoing, long term support for people for a personality disorder who have not recovered yet.
- Lack of a flagging protocol / model that alerts community care team and inpatient teams.
- Need for crisis support.
- Absence of resources.
- Lean workforce and cost control impacting of continuity of care.
- ED need a special mental health section to focus on mental health presentations.
- No dedicated mental health areas for mental health assessments.

- Poor governance related to changeover.
- More administration support to free up clinical time.
- More peer support workers in clinical settings needed.
- Personality disorders not seen as a legitimate reason for admission to hospital.
- Need a list of private practitioners with the skills and availability to work with personality disorders.
- Need for map of available services.
- Cultural shift required in psychiatry to not avoid Axis II Diagnosis - effective treatments for personality disorders do exist outside of the medical model.
- Wide array of evidence-based psychotherapy resources currently exist and are available at service level but not mandated to utilise if it does not fit with endorsed suites of services.
- Competence between treatment modalities.
- 80 - 20 rule of BPD of patients Diagnosed at 20 years old don't meet criteria post middle age – if can keep patients alive beyond 40s, fewer interventions required for those left with life-long diagnosis.
- Re-name the diagnosis to reduce stigma.
- Dual Stigma.
- Removing diagnosis of personality disorder if now recovered and no longer meets criteria.
- Social supports and network.
- Can we learn from cross cultural epidemiology factors re presentation (absence of personality disorders in some cultures).
- Poor representation of private sector at forums such as this.
- If working with personality disorders, need to screen for complex trauma; if positive for complex trauma, need to screen for dissociation when working with personality disorder presentations.
- Decimation.

Issues rated highly by participants

Participants were invited to identify the issues they believed were important by using the 'like' indicator in GroupMap. The points below are the issues and gaps identified by the wider group of participants as highly important.

- A need for training and education for the workforce, particularly in NGOs who are holding considerable responsibility in the community.
- Lack of adequate supervision for clinicians that equips them to deal with challenging consumers with personality disorders; to prevent burnout and poor practice or re-traumatising of consumers.
- Lack of consistency in approach to inpatient treatment.
- Lack a comprehensive, coordinated strategy through a peak body or Centre of Excellence for treatment of people with PD in WA.
- To establish evidence based training, evaluation, coordinated service development and implementation and ongoing support for clinical services in maintaining services (to enable top-down and bottom-up service development).

The detailed participant responses are available in Appendix B.

Next steps

The information collected from the Open Meeting workshop will be used to guide the Personality Disorders Mental Health Sub Network Steering Group in the development of their work plan and inform the MHC to support the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (*Plan). The Personality Disorders Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health to advise on the planning of health services.

In addition to working on identified projects, the Steering Group will work to foster engagement and communication in the Personality Disorders mental health sector.

Developments, issues for broader discussion and achievements will be reported back to the broader Personality Disorders Mental Health Sub Network membership via the Health Networks.

Appendix A: Open Meeting program

Department of **Health**

Mental Health Commission

GOVERNMENT OF WESTERN AUSTRALIA

Personality Disorders Mental Health Sub Network

Inaugural Open Meeting

9:30am Tuesday 30 August 2016

The Bendat Parent and Community Centre, 36 Dodd St, Wembley

Time	Program	
9:00am	Registration	
9:30am	Introduction Acknowledgement of Country	Ms Alison Xamon
9:35am	Mental Health-The Big Picture	Mr Tim Marney
9:45am	Overview of Mental Health Network	Dr Helen McGowan
9:55am	Overview of Personality Disorders Mental Health Sub Network	Ms Alicia Wilson
10:05am	Panel discussion – identifying issues and possible solutions in the personality disorders mental health sector	Ms Helen Farrell - Lived Experience and Peer Worker Ms Teresa Stevenson - Clinical Psychologist Coordinator Dr Pauline Cole – Consultant Psychiatrist Ms Melinda Brooker - Mental Health Manager, Clinical, 360 Health + Community Ms Sandra McMillan - Clinical Psychologist, Youth Unit, Fiona Stanley Hospital
10:25am	Networking break	All
10:50am	Reflect and build on themes	Mr Will Bessen
11:45am	Joining the Personality Disorders Mental Health Sub Network and Steering Committee	Ms Alison Xamon
11:55am	Concluding remarks and acknowledgements	Mr Mark Pestell
12:00pm	**Close and Networking**	

Registrants of this event will have the opportunity to find out how they can actively participate in the Personality Disorders Mental Health Sub Network and help shape its priorities.

Appendix B: Detailed participant input

The table below captures the individual issues and respective solutions raised by participants in the workshop session using the iPad technology.

The 'likes' indicator was used as a method to ensure the feedback component of the session was targeted to key areas within the available time frame and is also displayed.

Issue	Proposed solutions	Likes
• A need for training and education for the workforce, particularly in NGOs who are holding considerable responsibility in the community.	• Quality training and quality assurance processes needed.	9
• Lack of adequate supervision for clinicians that equips them to deal with challenging consumers with personality disorders; to prevent burnout and poor practice or re-traumatising of consumers.	• A belief exists that personality disorder treatment requires a specific approach so you're not able to work well with someone if not trained in that approach. • Staff understanding that trauma informed care will be therapeutic, would be a start. • Inappropriate case allocations in the context of a lean workforce given the current fiscal climate in health.	9
• Lack of consistency in approach to inpatient treatment.	• An agreed model of inpatient care across each hospital. • A standardised approach would be helpful. • Differences between services can be dramatic. • Agreed recognition for brief crisis admissions.	9
• Lack a comprehensive, coordinated strategy through a peak body or Centre of Excellence for treatment of people with personality disorders in WA. • To establish evidence based training, evaluation, coordinated service development and implementation and ongoing support for clinical services in maintaining services (to enable top-down and bottom-up service development).		9
• Require a closer working relationship between community services and acute care services (working together rather than parallel).		8
• Education for ED clinicians, mental health and general to address the stigma.		8

Issue	Proposed solutions	Likes
• Gaps in provision for youth and early intervention for personality difficulties.		8
• Lack of cooperation and collaboration within health, including acute, inpatient, community, outpatient, NGO and private services.	• Map available services across sectors; regularly update (6 – 12 monthly) and make available online.	8
• Lack of cooperation and collaboration between in-patient / acute settings and community mental health settings.	• And even the private and NGO sectors. Often experiences by consumers with BPD are re-traumatising and abandoning.	8
• Long waiting lists for existing programs AND the person must have a case manager with public mental health service to be picked up – willingness of public mental health services to provide case management is variable.	• MHC to provide expectations and guidance to public mental health services to provide case management to ensure people can access programs. • Education of public mental health to recognise personality disorder care as core business.	8
• New funding models (ABF) attach funding to assessment or short term intervention. Lack of funding for long term support. Public mental health services focusing upon acute care so not providing longer term support and intervention for personality disorder treatment.	• This is a significant issue, with lack of permission by management to provide the required therapeutic services for these consumers in any continuous and meaningful manner. Often necessitates early discharge of patients with minimal ongoing support or graduated discharge planning from community services.	8
• Need better education and training for clinicians on personality disorders and treatment options.	• Education for GPs. • Education for clinicians on evidence based treatments. • Have this education occurring during university courses, diplomas etc. (the earlier the better). • Consumers can provide examples of lived experiences.	7
• Cultural shift required in psychiatry to not avoid Axis II Diagnosis - effective treatments for personality disorders do exist outside of the medical model.		7
• Early intervention assessment and early diagnosis through education of health professionals and public is lacking.		7

Issue	Proposed solutions	Likes
• Early recognition and response of children at risk.	• Trauma informed educational facilities.	7
• Include training in curricula at post graduate level to target particular disciplines' needs for knowledge regarding personality disorder presentations for medicine, psychology, and other students.		7
• Increased access to specific step-down and crisis intervention services is needed (e.g.: Hampton Rd).		7
• Lack of DBT services for men.		7
• Lack of education training and support for general practitioners.		7
• More effective communication between services.	• DCPFS run ‘signs and safety meetings’ that identify a risk and a way forward rather than risk paralysing the treatment. • Power and control to consumer by drawing up more specific consent forms allows specific information to be given to specific department or people. • Prisons Department have something along these lines.	7
• One client, one record to follow them around, rather than multiple records that services don't share with each other.	• Mindfulness of privacy. • Individual consumers having a care plan / record they hold and take with them to educate services.	7
• Stop the post code lottery by making sure that the contracting from the MHC is specific enough to give priority to evidence based treatments for this high risk group.		7
• WA is one of the only states in Australia that doesn't have a specialist personality disorder service despite it being recommended by the NHMRC.		7
• Absence of resources.		6
• Accommodation services should be supportive in providing accommodation rather than waiting until crisis happens.		6

Issue	Proposed solutions	Likes
• Acknowledging the need for early intervention –is there adequate funding / who is being resourced?		6
• Confusion about whether personality disorders are core business of mental health services is leading to people not being able to access mental health services and programs.	• Clearer identification of Personality Disorder is core business for community mental health services. • If community mental health Services aren't picking up patients then need to put more support into NGO services. • Specific training for community services to allow for treatment there.	6
• Emphasis on early intervention is needed.	• School education is imperative!!! • Resource this area effectively and save money long term. School psychologists to be adequately funded.	6
• Gap after clinical care finishes.	• Post clinical care, there needs to be consumer peer led groups funded appropriately.	6
• Identify at-risk families and teach effective parenting (circle of security) strategies to primary attachment figures.		6
• Lack of prevention approaches to personality disorders.	• Joined up services that include DC, Police, mental health, schools, early intervention programs etc. working together. • Also working with families.	6
• Lack of resources available for personality disorders presentations and prioritised for crisis care rather than treatment, prevention and case management.	• Case management and treatment.	6
• Need a list of private practitioners with the skills and availability to work with personality disorders.		6
• Need for a specialist mental nursing training as current generalist approach leaves nurses ill equipped to manage mental health presentations, especially complex presentations.		6
• Need for map of available services.		6

Issue	Proposed solutions	Likes
• Ongoing supervision for staff and for supervisors is required.		6
• Personality disorders not seen as a legitimate reason for admission to hospital.		6
• There is no coherent treatment pathway for clients with antisocial personality disorder in the Health Department.	• There are treatment paradigms such as Schema Therapy and MBT that could be used efficiently.	6
• Training and support for clinicians and carers to breakdown stigma, have a better understanding of the disorder and spectrum of presentations within, co-morbid conditions, understanding the biosocial model underpinning the condition.	• Training in trauma-informed care practices.	6
• DBT prioritised over other supportive relationships and therapies (TFP, etc.) that keep patients regulated and safe.	• As long as evidence based treatments.	5
• Inequitable access to effective comprehensive (crisis, community, individual and group) psychological treatment for specific groups • Full-time workers, shift workers, geographical areas (no program at some area services), males, parents with preschool children, CALD and Aboriginal, Incarcerated / forensic system.		5
• More administration support to free up clinical time.	• Clinical time can be freed up this way. Explore electronic mediums to free up staff time. • Admin staff full time equivalent to be increased to allow clinicians to dedicate more time to clinical work.	5
• More effective data collection and research committed to this area.	• To guide sector development – clear objectives outlined. Data needs to be meaningful and purposeful with mindfulness to privacy (Mental Health Act). • Tertiary institutions need to be funded to conduct effective research.	5
• More peer support workers in clinical settings needed.		5

Issue	Proposed solutions	Likes
• No disorder specific step-up / step-down services.		5
• People who fall outside diagnostic criteria for BPD often do not get treatment for personality disorder issues.	• We should move to a more generic PD classification system as per Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) and then allocate better generic treatment paradigms.	5
• Timely transitional care between hospital and community.	• Pilot - mentalising support for EUPD. • Cost difficulties for private, long waits for public.	5
• 80 - 20 rule of BPD of patients Diagnosed at 20 years old don't meet criteria post middle age – if can keep patients alive beyond 40s, fewer interventions required for those left with life-long diagnosis.		4
• Lack access to evidence based treatments.	• What would count as 'evidence-based treatment'? • Alternatives to DBT too. • The efficacy of DBT in comparison to other comparable treatment approaches needs further exploration; currently at best but a well-marketed treatment approach with similar outcomes and efficacy than many others, and with substantial well-documented shortfalls. Blind adherence to the DBT hype risks repeating the now-established fallacy of cognitive behaviour therapy as The Only 'evidence-based treatment'.	4
• Changing entrenched, out dated clinical perspectives.		4
• Difficulty getting a primary diagnosis impacting on support required.	• Access to clinical skills allowing better diagnosis and accessing training.	4

Issue	Proposed solutions	Likes
• Early identification of personality traits and accurate information for consumers and carers.	• DBT groups in schools. • Education campaign on personality disorders – National Education Alliance for Borderline Personality Disorder Australia is starting this process – watch for information during Mental Health week and (hopefully!) upcoming Catalyst episode. • More awareness of specialty services. Information for schools, carers, GPs etc. • Fact sheets for family members and individuals on personality disorders.	4
• Fragmented care approach.		4
• Gaps in coherent therapeutic integration of individual treatment and family / carer support.		4
• Increase awareness of current clinicians and services that treat individuals with personality disorders.	• Set up a website with current information on private practitioners willing to work with personality disorders, government treatment services and NGO treatment options. • Resources must be constantly updated. • Information for family members and carers.	4
• Lack of evidence of the cost of personality disorder treatment (ED visits, admissions, community mental health input, NGO input) to justify the cost of providing treatment options for people with personality disorders • General Health services (EDs) not being costed with mental health.	• Have a comprehensive costing study to identify costs of ongoing support vs cost of treatment.	4
• Lack of responsive, ongoing, long term support for people for a personality disorder who have not recovered yet.		4
• Lack of Perinatal and Parenting Services.	• Specialist services for BPD within the antenatal periods, early postnatal period – to develop bonding and attachment to infant. • Additional Specialist Support Training Services.	4
• Lean workforce and cost control impacting of continuity of care.		4

Issue	Proposed solutions	Likes
• Long wait for Government services and may not get picked up when they are eventually seen.		4
• No DBT services at all in certain postcodes – inequality of service access.	• Develop a specialist DBT Statewide service which is not post code specific. • Have a consultation team that provides guidance to clinicians and people in the field.	4
• No disorder specific emergency / crisis interventions.		4
• No specialist personality disorder service to provide a program of education to government and non-government services and clinicians.	• Specialist service could provide top tier clinical services, consistent education program for clinicians, supervision for clinicians on complex cases, hub of peer support model, training of peer workers.	4
• Other personality disorders (not EUPD) don't get as much recognition.	• Personality disorders sub network to raise awareness of all different personality disorders. • Best practice and evidence based guidelines for all personality disorder diagnoses. • Definite need for this!	4
• Re-name the diagnosis to reduce stigma.		4
• Some staff not understanding that managing unhelpful behaviours is not helped by a punishing, punitive stance, patients have already had a lot of that in their lives.	• Ongoing support for support workers / clinicians.	4
• Specific needs of adolescents with emerging personality disorder – at risk of unplanned pregnancy, single parenthood.		4
• Training all staff – not just clinical, emphasis on interpersonal.		4
• Absence of Care Coordination.		3
• Addressing all personality disorders not just EUPD.		3

Issue	Proposed solutions	Likes
• Better recognition of people with cluster is symptoms re EUPD.	• Project Air Strategy NSW. • Education of EDs. • GP education. • Interpersonal skill building of clinician – not just intellectual understanding. • Misdiagnosis. • Should be more generic personality disorder Diagnosis as per DSM-V.	3
• Can we learn from cross cultural epidemiology factors re presentation (absence of personality disorders in some cultures).		3
• Increased understanding of illness through training.		3
• Lack of a flagging protocol / model that alerts community care team and inpatient teams.	• Be aware of stigma.	3
• Lack of collaboration.		3
• Lack of specific, targeted services for pregnant women and mothers with BPD – emerging evidence of poor outcomes (obstetric, psychosocial, mental health, child development) for this group.		3
• Need for crisis support.		3
• Poor representation of private sector at forums such as this.		3
• Post code lottery for treatment.		3
• Research into alternative therapies so that a range of therapies can be offered, solution – use emerging data over next 18 months to educate and change services.		3
• Target graduate clinicians to change culture of work practice.		3
• The need for evidence based intervention (DBT) available – access. Higher demand than available.		3

Issue	Proposed solutions	Likes
• Wide array of evidence-based psychotherapy resources currently exist and are available at service level but not mandated to utilise if it does not fit with endorsed suites of services.		3
• Cacophony not a Symphony at the moment – flip this around!!	• Policy created that is evidence driven. • Need a conductor taking a stand – leadership from top-down.	2
• ED need a special mental health section to focus on mental health presentations.	• Need more Mental Health Observation Areas (MHOAs) like Sir Charles Gairdner Hospital have implemented. • Should have them?	2
• If working with personality disorders, need to screen for complex trauma; if positive for complex trauma, need to screen for dissociation when working with personality disorder presentations.		2
• Removing diagnosis of personality disorders if now recovered and no longer meets criteria.		2
• Consistency of services.	• Attempts to fix consistency of service could be part of problem – e.g.: recent attempts at No Wrong Door service provision eradicated effective treatments to meet one-size-fits-all agenda.	1
• Governance of mental health services under general health means that there is little value placed on non-procedural interventions.	• Solution is endorsed care pathways and service specifications which are precise and part of commissioning.	1
• Lack of clear evidence based, best practice guidelines.	• Developed and endorsed pathways for personality disorders that are recognised and accepted and implemented within mental health services and NGO sector.	1
• No dedicated mental health areas for mental health assessments.		1
• Over valuing of DBT in the context poor maintenance of skills at follow up and increasing evidence of other evidence based interventions, such as MBT.		1

Issue	Proposed solutions	Likes
• Poor governance related to staff changeover.		1
• Social supports and network.		1
• Competence between treatment modalities.		0
• Decimation.	• Service providers to better understand (i.e. be educated) aetiology of personality disorders.	0
• Dual Stigma.		0
• Poor governance related to changeover.		0

Appendix C: Inaugural Personality Disorders Mental Health Sub Network Steering Group

At the conclusion of the Personality Disorders Mental Health Sub Network Open Meeting, expressions of interest in joining the Steering Group of the Sub Network were called for. The Sub Network Implementation Group chose the following representatives to form the inaugural Personality Disorders Mental Health Sub Network Steering Group:

- Sian Jeffery
- Sandra McMillan
- Elizabeth Webb
- Alicia Wilson
- Matt Ruggiero
- Melinda Brooker
- Judith Packington
- Giulia Pace
- Tanya Devadason
- Ajay Velayudhan
- Catherine Holland
- Jane Forrest
- Chelsea Ganfield
- Kelly Clark

Appendix D: Acronyms

Acronym	Definition
ABF	Activity Based Funding
BPD	Borderline Personality Disorder
CALD	Culturally And Linguistically Diverse
CPFS	Department for Child Protection and Family Services
DBT	Dialectical Behavior Therapy
DSM-V	Diagnostic and Statistical Manual of Mental Disorders V
EAG	Executive Advisory Group
ED	Emergency Department
EUPD	Emotionally Unstable Personality Disorder
GP	General Practitioner
MBT	Mentally Based Treatment
MHC	Mental Health Commission
MHN	Mental Health Network
NGO	Non-government Organisation
NHMRC	National Health and Medical Research Council
TFP	Transference-Focused Psychotherapy
WAPHA	Western Australian Primary Health Alliance

This document can be made available in alternative formats on request for a person with a disability.