NATIONAL MENTAL HEALTH CONSUMER & CARER FORUM

ADVOCACY BRIEF

October 2013

Borderline Personality Disorder

Background:

Borderline Personality Disorder (BPD) is a mental illness that makes it difficult for people to feel safe in their relationships with other people, to have healthy thoughts and beliefs about themselves, and to control their extreme emotions and impulses. People living with a diagnosis of BPD may experience extreme distress in their work, family and social life, and may harm themselves.

It is estimated between 1-4 % of Australians have a diagnosis of BPD of whom 3.5% are in the 24- 25 year old age group. [i] "At least one-quarter of all mental health presentations to emergency departments or inpatient mental health units are people with a personality disorder".[ii] Of those using psychiatric services, the estimation is 23% for outpatient contact and up to 43% of inpatient populations.[iii]

Most persons living with BPD experience very intense extreme emotions and a sense of distrust, confusion, isolation and constant distress. Co-occurring disorders are common in people with BPD (other mental illnesses, drug and alcohol misuse).

Self-harm is a common coping mechanism when the person is unwell and cannot cope with their extreme emotions. Many individuals living with a diagnosis of BPD have also experienced significant trauma in their lives. Some living with a diagnosis of BPD may also experience ongoing psychosocial disability.[iv]

The majority of consumers living with a diagnosis of BPD and their family and friends [carers] encounter constant social and medical discrimination; blamed for their BPD and often labelled as attention seeking and as troublemakers. The stigma, shame and judgement because of self-harming and the BPD diagnosis, result in lack of access to treatment.[v] This situation is largely due to negative health staff attitudes and poor training, because recently there have been developed many effective evidence-based therapies which should be made available for this condition now recognised as a mental illness.[vi]

For many years, BPD was considered to be untreatable and recovery not possible; finally this view is decreasing and there are now many options of treatment and care to assist recovery for a person living with a diagnosis of BPD.

Key Points

- Lack of suitable and appropriate services in the community for people living with a diagnosis of BPD often results in attendance at emergency departments or admissions to secure inpatient units.
- All health and mental health professionals working with people who have a diagnosis of BPD should be respectful, caring, compassionate, consistent and reliable.
- People living with BPD require experienced health professionals who can work within a trauma informed framework that enables a safe, quality and stable therapeutic relationship.
- Carers are a very important part in an individual's recovery and need support, training and information.

- Access to peer support provides genuine contribution to the consumer's recovery.

Recommendations

Recognition needs to be made that those living with a diagnosis of BPD have a mental illness which includes extreme emotions and intense feelings associated with the illness. Treatment should never be denied and respect should be given to the needs of the individual.

Emergency Department health care providers should attend to self-inflicted wounds professionally, ethically, clinically and with compassion and empathy, and refer the person for psychological support.

All health professionals working with a person with a diagnosis of BPD or their family, should be trained in trauma informed care, and have the knowledge and skills to provide a supportive, safe, stable and therapeutic relationship.

Carers play an important part in an individual's recovery. Carers must have access to support, training and reliable information on BPD, and their contributions acknowledged and respected by all health care providers. Peer support should be available to consumers and carers.

Consumers need to be empowered to identify their own treatment goals and recovery plans. The majority of an individual's treatment should occur in a community based setting. Inpatient stays should be short-term when there is a crisis, and not used as a standard treatment option, public and accessible community treatment designed to deliver effective treatments should be available for persons living with a diagnosis of BPD.

Nominated NMHCCF contacts:

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[i] National Health and Medical Research Council; Clinical Practice Guideline for the Management of Borderline Personality Disorder, Melbourne: National Health and Medical Research Council; 2012 www.nhmrc.gov.au/guidelines/publications/mh25

[ii] Grenyer, Brin FS, Improved prognosis for borderline personality disorder: Medical Journal of Australia, doi:10.5694/mja13.10470, MJA 198 (9) 20 May 2013 Project Air Strategy for Personality Disorders www.ihmri.uow.edu.au/projectairstrategy/index.html

[iii] National Health and Medical Research Council; Clinical Practice Guideline for the Management of Borderline Personality Disorder (2012)

[iv] NMHCCF Position Paper:2011, Unravelling Psychosocial Disability www.nmhccf.org.au/Publications-info

[v] NMHCCF Advocacy Brief: 2010, Stigma, Discrimination and Mental Illness in Australia www.nmhccf.org.au/Publications-info

vi Leichsenring F, Leibing E, Kruse J, et al. Borderline personality disorder. Lancet 2011; 377: 74-84.