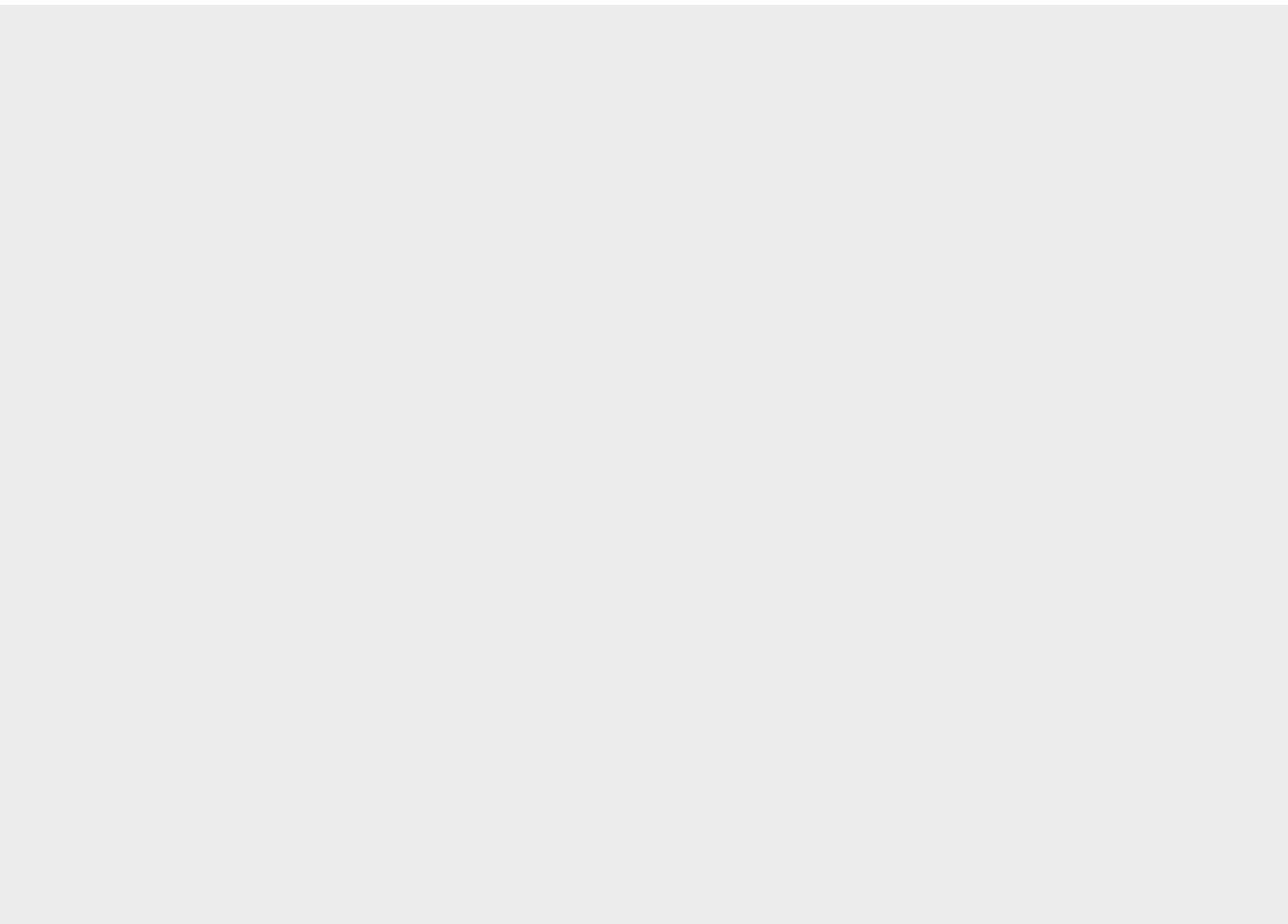# SA Mental Health Commission

South Australian Action Plan for People Living with Borderline Personality Disorder 2017–2020

Foreword

Borderline Personality Disorder (BPD) is a significant mental health issue across Australia. People living with BPD often struggle to find acceptance, respect and compassion within the mental health system and the general community.

This is the first South Australian *Action Plan for People Living with Borderline Personality Disorder*. This Action Plan demonstrates a joint commitment across a range of government departments, agencies and non-government organisations to work in partnership to improve the overall health and wellbeing of people living with Borderline Personality Disorder.

The South Australian *Action Plan for People Living with Borderline Personality Disorder 2017-2020* aims to support the system to meet the *National Health and Medical Research Council Clinical Practice Guideline for the Management of Borderline Personality Disorder 2012* and the principles and objectives within the *National Mental Health Plan*.

I commend the many participants who engaged in the consultation process - particularly people living with (and recovered from) BPD and their loved ones - for their advice and their dedication to minimising the health and social impacts for all people living with BPD in South Australia.

Hon Leesa Vlahos MP
Minister for Mental Health and Substance Abuse

The South Australian Mental Health Commission (SAMHC) was pleased to be invited by the Minister to develop, as a priority, the first *South Australian Action Plan for People Living with Borderline Personality Disorder 2017-2020*.
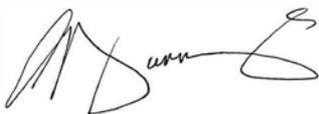
The plan fits well with the ethos of the SA Mental Health Commission to be guided by the wisdom and experience of people with a lived experience of mental ill health, in this case Borderline Personality Disorder, the people who will be most affected by this plan.

Key to the development of this plan was extensive consultation with stakeholders. This was guided by a Steering Group which was very ably Chaired by Karyn O'Keefe, Lived Experience Consultant/Educator.

This Action Plan builds on the 2014 publication *Borderline Personality Disorder: An overview of current delivery of Borderline Personality Disorder services in the public sector across South Australia and a proposed way forward*, developed by the SA Mental Health Clinical Network.

Thank you to everyone who participated in the development of this Action Plan.

The imperative now is for it to be implemented and its effectiveness measured.

Chris Burns CSC
South Australian Mental Health Commissioner

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1. Overview

> *"Everybody struggles with their emotions. People living with BPD experience emotions with much more intensity and have extreme difficulties with regulating those emotions"*
>
> **-** *Person in recovery from BPD*

1.1   Purpose of this Action Plan

This is South Australia's first *Action Plan for People Living with Borderline Personality Disorder* and describes a collaborative approach to reducing the impact of living with BPD as a health priority.

The responsibility for early identification, referral, assessment, treatment and support for people living with BPD in South Australia is shared across the community from the primary health care system, the public and private mental health systems, hospitals, correctional services, forensic services, schools and other government and non-government agencies.

Long-term collaborations and partnerships are, therefore, the foundation to building an effective statewide approach to support people living with BPD. The specific strategies in the Action Plan reflect the integration, teamwork and goodwill needed to construct a system that is responsive to people living with BPD.

Much activity under this plan is expected to be funded within existing resources as many of the actions can build on existing relationships or existing work activities to create new capacity. However, some activities require find new funding streams to implement new strategies which meet performance indicators and / or output measures.

This Action Plan is a statewide document that:

> commits to local strategies and actions required to progress elements of the National Mental Health Plan and National Health and Medical Research Council Clinical Practice Guideline for the Management of Borderline Personality Disorder 2012 (referred to hereafter as 'NHMRC Guideline')[1]

> identifies current relationships and proposes new relationships and joint activities that need to be developed in order to achieve its objectives

> defines local performance indicators, output measures and the lines of governance required to implement and monitor the effectiveness of the actions.

1.2   Priority action areas

The priorities outlined in this Action Plan are:

Action area 1: Community information and education

Action area 2: Workforce development

Action area 3: Earlier identification and referral

Action area 4: Access, treatment, care and support

Action area 5: Governance and partnerships

1.3   Primary target groups

This Action Plan is for all people living with BPD. Within this, primary target groups are:

> people living with BPD who present to Emergency Departments
> young people living with BPD (or at high risk of developing BPD)
> people living with severe and complex BPD
> people living with BPD who receive support from non-government mental health services
> people living with BPD in rural and remote communities
> people living with BPD who are currently long-stay inpatients
> people living with BPD who are in prison
> people living with BPD who are homeless or at risk of homelessness
> parents living with BPD who have children, particularly infants
> family/friends/loved ones who provide support to people living with BPD.

Within these target groups, populations of interests are:
> women and girls
> Aboriginal people, particularly in rural and remote locations
> people from culturally and linguistically diverse groups
> people with particularly complex presentations e.g. multiple diagnoses, comorbidities or disability.

This Action Plan also considers the workforces (including volunteers) providing mental health, drug and alcohol services, custodial services or other services that support people with lived experience of BPD including:
> government staff including SA Health
> non-government organisation staff
> lived experience workers
> private hospitals and health services, including psychiatrists, psychologists and GPs in private practice.

1.4   Policy framework

While there is no single, national plan or strategy related to improving mental health status of people living with BPD, this Action Plan draws primarily from earlier reviews and policy documents including:

> SA Health Borderline Personality Disorder: An overview of current delivery of Borderline Personality Disorder services in the public sector across South Australia and a proposed way forward (June 2014)
> The Framework for recovery-oriented rehabilitation in mental health care (2012)[2]
> National Health and Medical Research Council Clinical Practice Guideline for the Management of Borderline Personality Disorder (2012)[3]
> The Australian Parliament Senate Standing Committee on Community Affairs Report, Towards recovery: mental health services in Australia (2008)[4]
> Strong Foundations & Clear Pathways: Women Offender Framework and Action Plan 2014-2019[5]
> Caring with Kindness: The Nursing & Midwifery Professional Practice Framework[6]
> The Fourth National Mental Health Plan.[7]

The NHMRC Guideline includes recommendations and practice points developed by the BPD Guideline Development Committee, a multidisciplinary committee of people with a background in clinical services, research and lived experience. These recommendations have informed the development of the detailed strategies and actions in Section 5.

This Action Plan aims to build capacity to support the long-term agenda for change recommended by the 2008 Australian Parliament Senate Standing Committee on Community Affairs report that included the development of jointly funded:

> designated BPD outpatient care to provide assessment, therapy, teaching, research and clinical supervision
> training programs for mental health services and community-based organisations in the effective care of people living with BPD
> programs targeting adolescents and young adults, aiming to improve recognition of BPD
> programs targeting providers of primary health care and mental health care, aiming to improve attitudes and behaviours toward people living with BPD.

1.5 Goal, objectives and key indicators

Goal

To assist people living with BPD in SA to achieve recovery, improve quality of life and minimise the personal and social impacts living with of BPD in South Australia.

Objectives

To ensure that all people living with BPD receive the earliest possible, most appropriate treatment and supports to assist in building a contributing life, and are not excluded from mental health services and other supports.

To ensure that effective and appropriate support for carers, including young carers, of people living with BPD in SA are established to minimise the impact on families and friends.

Key indicators

For SA, this Action Plan aims to:

> reduce BPD-related Emergency Department crisis presentations
> reduce BPD-related unplanned public hospital admissions
> reduce excessive length of hospital stay for people with severe and complex BPD
> reduce the use of restraint for people with BPD
> reduce BPD-related substance use disorder
> reduce the number of attempts by people living with BPD to end their own life
> reduce the number of people living with BPD who take their own life.

1.6 Partnership approach

A partnership approach across services will be an essential driver to the success of this Action Plan, and collaboration between agencies and workforces will be required.

Potential partners (and workforces) in SA that will be important to the implementation of this plan include:

> people living with BPD
> families and others providing support to people living with BPD
> SA Health and the Local Health Networks
> Drug and Alcohol Services SA
> Adelaide Primary Health Network
> Country SA Primary Health Network
> Department for Correctional Services
> Department for Communities and Social Inclusion
> Department for Education & Child Development
> The Mental Health Coalition of SA and other non-government organisations
> SAPOL
> SA Ambulance Services
> General practitioners and other primary health settings such as migrant health

- Universities and TAFE Colleges
- The SA Mental Health Commission.

2.   Background to BPD

> *"Borderline Personality Disorder is a very treatable mental illness, most people can achieve recovery."* – *Dr Paul Cammell, Consultant Psychiatrist, Flinders Medical Centre*

2.1   What is Borderline Personality Disorder?

BPD is a significant mental illness. The NHRMC Guideline states that:

'*BPD is a common mental illness...associated with severe and persistent impairment of psychosocial function, high risk for self-harm and suicide, a poor prognosis for co-existing mental health illness, and heavy use of healthcare resources. International data show that the suicide rate among people with BPD is higher than that of the general population. Estimated suicide rates among people with BPD range from 3% to 10%.*'[8]

BPD is a mental illness that can make 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 emotions and impulses. People living with BPD may experience distress in their work, family and social life, and may harm themselves.

The development of BPD is thought to involve a combination of biological factors (such as genetics) and experiences that happen to a person while growing up (such as trauma early in life). Over 80% of people living with BPD report a history of trauma, with many also having diagnosis of post-traumatic stress disorder. For most people living with BPD, symptoms begin to emerge during adolescence or as a young adult. Left untreated BPD has a significant impact on the life of the individual and their loved ones.

People living with BPD have historically met with widespread misunderstanding and blatant stigma. However, evidenced-based treatments have emerged over the past two decades bringing hope to those diagnosed with the disorder and their loved ones.[9]

People living with BPD are at increased risk of suicide and self-harm and frequently have contact with a number of agencies and service providers including hospitals and health services, Drug and Alcohol Services SA, SA Ambulance Services, SAPOL, prison services, general practitioners, NGO community services and housing services.

New approaches to psychotherapy have demonstrated that people living with BPD can achieve recovery with low relapse rates.

2.2   Psychotherapies

Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist, counsellor or other mental health provider. Psychotherapy is also known as talk therapy, counselling or psychosocial therapy.

During psychotherapy, the person learns about their condition, moods, feelings, thoughts and behaviours, and develops life-long skills to assist them in recovery. There are many types of psychotherapy, each with its own approach.

There is a wide range of psychological therapies in use to treat BPD, the primary types being:

> Dialectical Behaviour Therapy (DBT)
> Schema-Based Therapy (SBT)
> Cognitive Behaviour Therapy (CBT)

- Mentalisation Based Therapy (MBT)
- Transference Focused Psychotherapy (TFP)
- Acceptance and Commitment Therapy (ACT)
- Interpersonal Group Therapy (IGP)
- Systems Training for Emotional Predictability and Problem Solving (STEPPS)
- Manualised Cognitive Therapy (MCT)[10]

An overarching model called Good Psychiatric Management (GPM) has also been shown to be effective.[11]

2.3   Rationale

The rationale for developing this Action Plan is the high cost to society (individual, family and community) of failing to treat people living with BPD when there are now a range of effective psychotherapies with low relapse rates.

Diagnosis of BPD can be carried out by a psychiatrist or psychologist and while relatively resource intensive (up to 4-5 hours in a correctional setting) accurate diagnosis facilitates an individual being offered appropriate therapy.

While these psychotherapies are highly cost effective, typically in the initial phases of treatment they need to be offered quite intensively and for periods of up to 6-18 months. Depending on the needs of the individual, this may be a mix of group therapy and 1:1 psychotherapy. Some people will need to return to repeat group and/or 1:1 psychotherapy. Some people require additional supports such as psychosocial support to help them engage and continue with psychotherapy. Psychosocial support also helps the person living with BPD to practice and integrate what they learn within a safe and supportive relationship.

For SA Health, one of the drivers for this Action Plan is that significant numbers of people living with BPD seek help from Emergency Departments as well as mental health and drug and alcohol services.

There is difficulty in providing an appropriate treatment response through the state mental health system, which is not geared or resourced to provide the intensive psychotherapies needed to assist the recovery of people living with BPD, or the supports required to help them achieve success.

The lack of access to extended Commonwealth funded psychological services in the primary care sector is also a significant financial barrier for people looking to access treatment in the community as the Medicare Benefits Schedule does not currently provide sufficient sessions that most people would require to recover from BPD[i]. This makes it difficult for the state to provide a stepped response that integrates tertiary, intermediate and primary care early in the course of illness, and accessible in the community.

In some cases, the interplay of these service limitations, combined with staff attitudes towards people living with BPD have resulted in a highly stigmatised response from health services.

Collaborative action is now needed to develop a coherent, state-wide response, working across agencies to identify people living with BPD early in their course of illness, and preventing the need for repeated admissions to Emergency Departments through better access to evidence-based psychological therapies and other supports when needed.

That said, the moment of presentation to an Emergency Department is a key opportunity to engage with individuals who are seeking help and can play a vital role in 'case-finding' and engaging people living with BPD into longer-term evidence-based therapies that will assist in recovery.

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[i] At the time of writing MBS funding was targeted towards high prevalence, less complex illness - up to 10 individual and 10 group sessions with a psychologist once a year (with another 6 under special circumstances). BPD patients typically require weekly sessions of group and/or individual therapy for at least a year.

2.4   BPD statistics

Population prevalence

> The epidemiology of BPD at the population level has been studied mainly in the United States, showing rates varying between 0.5 % [12] and 1.4 % [13,14,15,16,17]

> Two studies have found higher rates of 2.7 % [18] and 5.9 % [19] respectively.

> The NHMRC Guideline suggests Australia has a population prevalence of 1-4%.

> Based on a population prevalence estimate 1-4 %, in South Australia we would expect approximately 17,000 – 68,000 South Australians to be living with BPD. [20]

Health service usage

> The NHMRC Guideline highlights international research on prevalence of BPD among people using psychiatric services which has been estimated at up to 23% for outpatient populations, and up to 43% for inpatient populations.

> Across Australia, 90% of admissions to hospital with a principal diagnosis of BPD are female. [ii]

> In South Australia, half are under the age of 30 and two thirds are under the age of 35. [21]

> In South Australia, at Helen Mayo House (which admits women with severe mental illness and their infants) 50% of women self-identify with the criteria of BPD and 25% have this diagnosis clinically. [22]

> While no reliable data currently exists on repeat admissions, advice from clinicians is that further targeting individuals with a previous hospital admission, would have even greater impact.

> In Australia, compared to other personality disorders, living with BPD is more strongly associated with having more than one mental illness, greater disability and lost days of total and partial role functioning. It is also strongly associated with having sought mental health consultations from GPs, psychiatrists and psychologists. [23]

Community mental health contacts

> Across Australia, 89% of all contacts with community mental health care services with a principal diagnosis of BPD were for women.

> Across Australia, women aged 20-24 years accounted for more of the community mental health care contacts than any other group. [24]

> Of these contacts, more than half were for those aged up to 34 and more than two-thirds for those aged up to 39. [25]

2.5   Mothers and their children

As highlighted above, the epidemiology of BPD shows high prevalence in the age groups from adolescence into the mid-30's which corresponds with the peak child-bearing ages for women.

International research suggests children born to mothers with BPD are considered high risk for poor psychosocial outcomes [26,27] which may include BPD symptoms, internalising (including depression) and externalising problems, insecure attachment patterns, and emotional dysregulation. Findings suggest that vulnerability from mother to offspring may in part be transmitted via the impact of maternal mental health on parenting style. [28]

Therefore, a key time for providing therapeutic support to women with BPD is the time of presentation to health services during the antenatal period.

[ii] *The much higher proportion of females accessing services compared to males in Australia suggests further research is needed regarding prevalence in males and access to services.*

Women with BPD are often better motivated at these times to undertake intense therapies (mothers do things for their infants they might never have done just for themselves) which is also protective for their infant.

Mothers with BPD are also at higher risk of postnatal depression, as they are more vulnerable to severe emotional dysregulation in the post-natal period.

2.6   Prisoners

While no research has been undertaken in SA on prevalence in the prisoner population, a recent survey in WA estimated that nearly a quarter of women (23%) and 15.8% of men fulfilled criteria for borderline personality disorder.

This was not dissimilar to a New Zealand study which indicated 20.3% of women and 25.7% of men fulfilling the criteria for borderline personality disorder.[29]

At 30 June 2016, there were 191 adult female prisoners in South Australia, almost all in Adelaide Women's Prison, and 2,752 adult male prisoners.[30, iii]

If the WA prevalence data is used to estimate total numbers for SA it could be expected that 44 female and 435 male prisoners could be living with BPD.[iv]

While female prisoners have a higher prevalence of BPD than male prisoners, given the total numbers of 44 female and 435 male, both genders of prisoners should be targeted for treatment. [31,32,33,34]

People living with BPD experiencing co-morbidities appear to be much more likely to come into contact with the criminal justice system, particularly when combined with:

> substance use disorder
> low cognitive functioning
> antisocial personality disorder.

The challenge in supporting people living with BPD in prison is that prisons were never designed to be therapeutic environments and can exacerbate symptoms in people with trauma-related mental health issues.

Internationally, some correctional facilities have recently augmented staff training on trauma, including programs on techniques to respond effectively to trauma symptoms, the trauma-recovery approach, and trauma-specific interventions. During training, staff learn ways to minimize triggers, stabilize offenders, reduce critical incidents, deescalate situations, and avoid measures that may repeat aspects of past abuse (e.g. restraint and seclusion).

The value of employing a 'trauma-informed correctional care' approach for people living with BPD cannot be underestimated as the physical environment and many of the routines for managing behaviour in a correctional setting are particularly counterproductive for people living with BPD and exacerbate their illness. [35]

This was highlighted recently in the Ombudsman SA Final Report 2013[36] which suggested that the traumatic effect of the prison environment, including the use of restraints had a detrimental impact on the prisoners' mental health triggering a cycle of self-harm.

Therefore, people living with BPD could benefit from diversionary, early release or resettlement programs particularly when evidence-based therapies are offered within these programs.

[iii] *Not included: police lock-ups; police prisons; cells in court complexes; immigration detention centres; home detention programs; military prisons; mental health facilities; juvenile facilities, including those under the authority of adult corrective services.*

[iv] *Anecdotal and clinical experience in SA suggests that the prevalence of BPD in the Adelaide Women's Prison may be as high as 30-40%*

2.7   Young people

While historically BPD has gone unrecognised in children and adolescents as formal diagnosis was not usually applied to people until after 18 years of age, recent research shows that the diagnosis can still reliably be made under 18 years of age, both as sub-syndromal and full-threshold BPD.[37]

However, due to the lack of research on treatment modalities, there is still insufficient evidence to say exactly which style of therapy is the most effective for people under 18 years of age.

That said, early treatment with psychological therapies in young people exhibiting severe difficulties with emotional regulation, or who present sub-syndromal should be considered given the:

> lifetime costs of BPD when left untreated
> the hospital admissions for BPD occurring under 18 years of age
> suicides in people with BPD under 18 years of age
> the opportunity to provide support prior to life difficulties becoming more entrenched
> the essential role that good mental health plays in healthy adolescent development.

2.8   Culturally and linguistically diverse communities

The National Health Mental Health Commissioners National Review of Mental Health Programs and Services (2014) states that

'*People who have an experience of immigration to Australia or how have fled traumatic home circumstances as refugees have specific mental health experiences and needs which must be accounted for if support is to be effective…They can also face problems of seclusion and restraint in the mental health system because of issues such as language barriers and culturally different approaches to health and wellbeing.*'[38]

Factors that can impact upon treatment outcomes include:

> therapist knowledge and skills in successfully forming and maintaining relationships with people who have a culture different from their own
> therapy materials and methods require contextualisation and modification
> the use of interpreters adding to feelings of shame, and risk of breaches of privacy particularly in small communities
> varying cultural rules and the impact on the meaning of words or behaviour.

Therefore in the implementation phase of strategies and actions within this Action Plan, consideration needs to be given to the modifications and workforce development required to equip staff delivering treatment services and supports to effectively communicate cross culturally.[39,40]

2.9   Guideline based care

The NHMRC Guideline provides advice for developing treatment approaches including:

> people living with BPD should be provided with structured psychological therapies that are specifically designed for BPD
> psychological therapy should be conducted by one or more health professionals who are adequately trained and supervised
> adolescents aged 14-18 years old with BPD or symptoms of BPD that are significantly affecting their lives should be offered structured psychological therapies
> where available people under 25 should have services provided in a youth-oriented service

- doctors should not choose medicines as a person's main treatment because medicines can only make small improvements in some of the symptoms of BPD, but do not improve BPD itself[v]
- admissions to hospital should not be used as standard treatment, and should generally only be used as short stays to deal with a crisis when someone is at risk of suicide or serious self-harm
- hospital stays should be short, aimed at specific, mutually agreed goals
- generally, health professionals should not arrange long-term stays.
- treatment should begin in Emergency Departments while a person's medical needs are being dealt with
- self-inflicted injuries should be dealt with professionally and compassionately
- where available, health professionals should consider referring people with severe and/or enduring BPD to a specialist service
- treating a person for BPD is a legitimate use of health services
- BPD should never be used as a reason to refuse health care to a person
- Families, partners and carers can play an important part in supporting a person's recovery.

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[v] *While medications are not the main treatment for BPD, people with a diagnosis of BPD are often prescribed medications, either for symptoms of BPD and/or for other mental health diagnoses. Pharmacologic treatment should be part of a documented management plan and reviewed regularly for therapeutic and adverse effects to ensure safe, appropriate and effective medication management throughout the patient journey (SA Health Chief Pharmacist).*

2.10   Building trauma informed systems

What is trauma?

Trauma is a perceived or real threat to a person's life, body or sense of self and may arise from a single incident or repeated adverse events that can interfere with a person's ability to cope or to integrate the experience. Trauma can:

> accumulate across a life span
> arise from interpersonal abuse and or neglect
> occur in childhood or adulthood
> be caused by a 'single event incident'
> lead to long-term consequences such as, suicidality, substance abuse, and addictions, self-harming behaviours, dissociation and re-enactments of past abusive relationships
> be trans- generational and effect whole communities.[41]

Trauma informed care and practice

The concept of 'trauma informed care and practice' (TICP) has emerged in recognition of the fact that trauma is a wide-spread, harmful and costly public health problem – but that with appropriate supports and interventions people can overcome traumatic experiences.

TICP is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

> *'For many people with BPD, their goals for treatment involve managing their emotions, finding purpose in life, and building better relationships. Many people with BPD have experienced significant trauma, either in the past or in their daily lives, so they need health care that makes them feel safe while they recover.'* (NHMRC Guideline)

While over 80% of people living with BPD report a history of trauma, some cannot identify this as a variable in their diagnosis. However, it is worth noting that what might appear to be non-traumatic for one person, may in fact be traumatic for another. For example, some children are severely traumatised by early invasive medical procedures that may not readily appear in a person's trauma history.

The concept of TICP should not be mistaken for focussing heavily on individual trauma within therapy, but is about ensuring we develop welcoming, kind and compassionate services which seek to understand people's experiences, to see the human in distress.

2.11   Stigma, discrimination and access

Access to services is not just about delivering services in a range of geographic locations. Access can also be a general concept that describes the fit between the person living with BPD and the health care system.

Stigma is defined as a mark of disgrace that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotyped group. Negative attitudes create prejudice which leads to negative actions and discrimination. [42]

While stigma is common with all mental illnesses, workforce attitudes combined with significant systemic barriers to treatment means people living with BPD experience additional discrimination when trying to access services.

In many settings (including mental health and correctional settings) people living with BPD and their families report having their symptoms dismissed as attention-seeking or bad behaviour. Misguided actions and stigmatised attitudes of service providers have resulted in a culture of 'no service'.

A recent survey of 153 people with a diagnosis of BPD about their experiences when attempting to receive support for managing their illness found that:[43]

> people living with BPD experience significant challenges and discrimination when attempting to get their needs met within both public and private health services, including general practice
> seeking help from hospital emergency departments during crises was particularly challenging
> people in rural areas had more difficulty accessing services
> community supports were perceived as inadequate to meet their needs
> better training for health professionals was required.

Given the stigma many people experience living with BPD once diagnosed, some people will choose not to identify with their diagnosis, or to be associated with mainstream mental health treatment services. Therefore further consideration of how to connect with these people living with BPD could be valuable in the design of future services or programs.

2.12   Partners, families and support people

The right enduring relationships with significant others can assist with recovery. For example, in supportive family/household settings, significant others can greatly assist in providing validating environments, working collaboratively with the person living with BPD to support treatment.

The NHMRC Guideline states that:

> '*Health professionals should be aware that families, partners and carers may feel blamed for the persons BPD, and should show sensitivity and a non-judgemental attitude. It is helpful to remind family, partners and carers that not all people with BPD have a history of abuse or neglect, and that the condition is partly due to genetic and biological factors…[but that]…to discuss the role of trauma in a specific case, these discussions should only take place with the consent of the person with BPD...manage these discussions in a manner that minimises guilt and blame.'*

Living with BPD can be challenging for the individual, and where strong emotions and impulses affect relationships, partners, families and support people can strengthen their own coping strategies and ability to support their loved one through accessing education, support, information, therapy and or therapeutic skills training for themselves. [44]

3.   Health and social costs

According to the Australian National Survey of Mental Health and Well-Being, 4.8% of the Australian fulltime workforce has a personality disorder, with a personality disorder being predictive of work impairment.[45] Lost work productivity due to mental disorders, such as personality disorders and substance-related disorders, contributes an economic loss of AUD$2.7 billion each year.

Research was completed in 2001 by the NSW Centre for Health Economics Research and Evaluation into the net cost to a health service after one year of treating 30 patients with an intensive psychotherapy program. [46]

In the 12 month period prior to the study the direct health services costs of the group totalled $756,789 ($25,526 per patient).

After implementing a $130,050 program of psychotherapy ($3,435 per patient) there was a reduction in direct health service usage costs over 12 months from $756,789 to $89,230 ($2,974 per patient).

This represents an annual direct cost savings of $546,509 (72%) including psychotherapy, or $676,559 (88%) net of psychotherapy costs. [vi]

Cost savings were higher in those patients who were high users of hospital services.

Of these direct health service savings, 95% came from reduction in usage of inpatient services.

Given that most people experience low relapse rates, most of these savings are likely to be recurrent.

This analysis did not consider all the broader costs including housing, correctional services, family services and other supports, or lost productivity to the state.

The high societal costs of personality disorders suggest the importance of prioritising the development and implementation of effective personality disorder treatments and supports, particularly for those presenting frequently to hospital or mental health services.

Treating and supporting people living with BPD will:

> Optimise opportunities for recovery, and reduce the frequency of relapse
> Reduce the current and future cost of health care and other services
> Reduce the wider societal costs of supporting people living with BPD.

[vi] *the net costs of psychotherapy were defined as the costs of health care for twelve months after psychotherapy was completed plus the cost of the psychotherapy less the cost of conventional care*

4. Implementation and evaluation

4.1 Implementation

Over-arching monitoring of the *South Australian Action Plan for People Living with BPD 2017-2020* will be provided by SA Health Executive.

Groups established that will be key to the implementation and monitoring of this Action Plan include:

> an SA BPD Model of Care Reference Group (BPD-MOC)

> an SA Action Plan for People Living with Borderline Personality Disorder Implementation and Monitoring Group (SABPD-IMG).

These two groups are expected to be ongoing for the life of the Action Plan.

The Model of Care Reference Group will include representation from the NGO sector and people with lived experience.

A number of smaller workgroups may also need to be established to assist with the day-to-day operational implementation of key elements of this Action Plan with a focus on specific target groups such as:

> mothers

> prisoners

> young people

> Aboriginal people (via the Aboriginal Mental Health Reference Group)

> CALD populations (or specific cultural groups)

These smaller groups may be either time-limited or on-going. The Implementation Group will consist of a cross-section of organisations including NGOs and people with lived experience, and will be established to facilitate partnerships, and oversee and provide local reports on the implementation of the specific actions.

4.2 Progress reporting

Periodic progress reports will be prepared each year. Responsibility for coordination of progress reporting will rest with the Mental Health Strategy Division of SA Health.

Progress reports will be prepared with the assistance of the SA BPD Implementation and Monitoring Group and may include information or data provided by other partners to the Action Plan.

Progress reports may contribute to the final evaluation of the Action Plan.

4.3 Evaluation

Given this is the state's first Action Plan for People Living with Borderline Personality Disorder, applying principles of program evaluation to the Action Plan will ensure the system is accountable, achieves the stated objectives and has laid the foundation for continuous improvement.

Program evaluation will assist SA Health and SA Mental Health Commission to:

> assess the continued relevance and priority of objectives in the light of current circumstances, including government policy changes (appropriateness)

> test whether the outcomes achieve stated objectives (effectiveness); and

> ascertain whether there are better ways of achieving these objectives (efficiency).

The evaluation framework for this Action Plan will define of appropriateness, effectiveness and efficiency as:

> appropriateness - the continued relevance and priority of objectives in the light of current circumstances such as government policy context, including the suitability of program design in response to identified needs

> effectiveness - whether outcomes have achieved stated objectives, and to what extent outputs have contributed to outcomes

> efficiency - whether there are better ways of achieving these objectives, including consideration of expenditure and cost per output, project governance arrangements, and implementation processes.

5. Detailed strategies and actions

The priority action areas of the South Australian Action Plan for People Living with Borderline Personality Disorder 2017 - 2020 are:

Action area 1: Community information and education

Action area 2: Workforce development

Action area 3: Earlier identification and referral

Action area 4: Access, treatment, care and support

Action area 5: Governance and partnerships

The following tables detail the strategies, actions, output measures, and major partners to the specific actions.

In these tables, the major partners involved in each action have been identified, however many activities will require wider collaboration with other individuals or organisations.

People living with, or recovered from BPD and carers will be involved in the co-design of strategies and actions.

Specific consideration in the co-design of each strategy will need to be given to ensure reach to/inclusion of Aboriginal people and culturally and linguistically diverse communities.

Action area 1: Community information and education

Strategy	Action	Output measures[vii]	Major partners[viii]
1.1 Undertake work to reduce stigma related to living with BPD	Undertake targeted health promotion activities aimed at reducing stigma and discrimination for people living with BPD (including supporting national BPD week)	Projects completed	SA Health Primary Health Networks NGOs
1.2 Develop an internal and external Communication Strategy for SA Health including web presence, social media and targeted anti-stigma campaign	Develop Communication Strategy including: > Branding > Web presence > Social media use > Internal communication > Anti-stigma campaign > Awareness raising	Defined in Communication Strategy Monitoring of each action/project as it unfolds	SA Health
1.3 Provide publicly available information to assist people to live with and recover from BPD	Develop and maintain a single portal, Borderline Personality Disorder website to assist people living with BPD, carers and service providers to access current, consistent information, referrals and resources specific to South Australia Partners to this action plan to routinely provide updated information to be made available on the website including: > Public mental health services > Private providers > Non-government organisations.	Website established	Private Mental Health Consumer Carer Network (Australia) Limited [ix]

[vii] *Where relevant will aim to capture demographics with output measures - age, gender, aboriginality, country of birth, postcode, co-morbidity*

[viii] *To include people with lived experience.*

[ix] *Janne McMahon, Chair and CEO of the Private Mental Health Consumer Carer Network (Australia) Limited and Justyna Rosa, Acting Program Manager, Life Without Barriers have advised that they applied in May for and have received funding to develop an SA BPD website funded by SA Health.*

Strategy	Action	Output measures[vii]	Major partners[viii]
1.4 Ensure carers have access to health information and resources (including recovery-focussed skills-based programs with support of a mental health worker) and are involved in the co-design.	Promote recovery-focussed support groups and good quality information resources for people living with BPD (with facilitating support from a mental health worker) Promote the use of existing and related programs and resources for people living with BPD such as parenting programs and resources.	Periodic review of information and access to information and support groups	SA Health NGOs
1.5 Ensure carers have access to health information and resources (including recovery-focussed skills-based programs with support of a mental health worker) and are involved in the co-design.	Promote recovery-focussed support groups providing good quality health information and resources for people supporting others living with BPD (with facilitating support from a mental health worker) Promote the use of existing and related programs and resources for people supporting others with BPD such as parenting programs and resources.	Periodic review of information and access to information and support groups	SA Health NGOs
1.6 Build awareness and skills in young people and their friends/families/support people to identify emerging BPD symptoms (that may be related to trauma) adopt supportive behaviours and find appropriate treatment pathways	Engage and resource schools and youth services in contact with young people to be able to raise the awareness of young people and their friends/families/support people on : > Emerging BPD symptoms (that may be related to trauma) > Supporting others with emerging BPD symptoms > Treatment and hope for recovery	No. of people receiving awareness training Training effectiveness analysis	SA Health Department for Education and Child Development Universities (i.e. student wellbeing programs) Primary Health Networks
	Engage and resource aboriginal workers to be able to raise the awareness of young Aboriginal people and their friends/families/support people on: > Emerging BPD symptoms (that may be related to trauma) > Supporting others with emerging BPD symptoms > Treatment and hope for recovery	No. of people receiving awareness training. Training effectiveness analysis	SA Health Primary Health Networks

Strategy	Action	Output measures[vii]	Major partners[viii]
	Engage with and resource CALD leaders to be able to raise the awareness of young CALD people and their friends/families/support people on: > Emerging BPD symptoms (that may be related to trauma) > Supporting others with emerging BPD symptoms > Treatment and hope for recovery	No. of people receiving awareness training Training effectiveness analysis	SA Health CALD partners Primary Health Networks
1.7 Develop appropriate processes and resources to support young people receiving a BPD diagnosis (both clinical and peer-based resources) that communicate hope for recovery, and living well. Involve young people in co-design.	Develop targeted resources appropriate for young people based on groups most likely to be exhibiting any of the symptoms including: > LGBTIQ young people > CALD young people > Aboriginal young people.	Targeted resources developed in partnership with young people from specific groups Available on the net with evidence of use	SA Health Primary Health Networks

Action area 2: Workforce development

Strategy	Action	Output measures[x]	Major partners
2.1 Undertake work to reduce stigma related to living with BPD	Ensure workforce development programs are co-designed and co-delivered with people living with or recovered from BPD and focus on reducing stigma and building a compassionate and constructive system response to for people experiencing BPD symptoms.	Programs have input from people with lived experience Period reports from people with lived experience indicating level of stigma	SA Health Primary Health Networks NGOs
2.2 Build awareness and skills in the wider workforces related to identifying BPD like symptoms (often in the context of trauma) adopting supportive behaviours, avoiding exacerbating behaviours and finding appropriate diagnostic and treatment pathways	Specialised training programs for staff to raise awareness of BPD (often in the context of trauma) and to equip them with skills to de-escalate situations and provide a positive environment for people living with BPD: > General Practitioners > Drug and Alcohol Services staff > Pharmacists > Correctional officers > Police Officers > Ambulance Officers > Family services workers > School support staff > Community service workers > Housing providers > Homeless sector service providers > Family and relationship counsellors > Disability Services > Aboriginal health workers > CALD health workers > Interpreters.	No. of people receiving awareness training Training effectiveness analysis	SA Health Department for Correctional Services SAPOL Department for Education and Child Development Department for Communities and Social Inclusion Primary Health Networks Universities and TAFE NGOs

[x] *Demographics required with output measures include - age, gender, aboriginality, country of birth, postcode, co-morbidity*

Strategy	Action	Output measures[x]	Major partners
	Programs to include people with lived experience as educators, and focus on building empathy and understanding.		
2.3 Train the health and social care workforce to effectively work together to case-find, make appropriate referrals and/or deliver treatments or enhance other health and social care responses to people living with BPD (including caring for people in emergency departments, and for people transferring between child and adult services)	Training and education be offered across the sector in both public and private settings: > Counsellors > Psychologists > Midwives > Mental Health Practitioners (Nurse/OT/Social Workers) > Lived experience workers > Drug and Alcohol Services treatment staff > Aboriginal health practitioners > Psychiatrists > Pharmacists > Emergency Department staff > General nursing and medical staff > SA Prison Health staff > NGO mental health support/peer support/homelessness staff Consider skills related to cross cultural communication including effectively using interpreters.	Curriculum relating to supporting people with emerging BPD symptoms or living with BPD embedded into vocational, tertiary courses and CPD training Enhanced access based on experience of people living with BPD and carers	SA Health (including SA Drug and Alcohol Services) Primary Health Networks Universities and TAFE NGOs
2.4 Develop an expanded list of providers prepared to be published as a BPD expert or with BPD clinical interest	Publish a web-list of health professionals with advanced training to deliver evidence-based therapies so people living with symptoms of BPD and their support people can find them: > General Practitioners > Psychiatrists > Psychologists and counsellors > Drug and alcohol treatment providers > Specialist Care Coordinators (NGO)	SA Health web list published and routinely updated. List to include professionals skilled in specific therapies to support people living with BPD Enhanced access based on	SA Health Primary Health Networks Universities and TAFE NGOs

Strategy	Action	Output measures[x]	Major partners
	> Interpreters Consider skills related to cross cultural communication including effectively using interpreters.	experience of people living with BPD and carers	
2.5 Undertake projects to reduce stigma related to living with BPD	Undertake targeted health promotion and/or research activities aimed at reducing stigma and discrimination for people living with BPD.	Projects completed.	SA Health Primary Health Networks Universities and TAFE NGOs

Action area 3: Earlier identification and referral

Strategy	Action	Output measures	Major partners
3.1 Build capacity of GPs, health, education and social care workers to identify young people and adults who would benefit from clinical assessment [xi,xii]	Adopt a common, validated BPD screening tool to use with young people Adopt a common, validated BPD screening tool to use with adults	No. of people screened No. of people referred for assessment	SA Health, DECD and all partners
3.2 Build capacity of Aboriginal health practitioners and workers to identify young people and adults who would benefit from clinical assessment	Adopt a common, validated BPD screening tool to use with young people from Aboriginal backgrounds Adopt a common, validated BPD screening tool to use with adults from Aboriginal backgrounds	No. of people screened No. of people referred for assessment	SA Health and all partners
3.3 Build capacity of CALD health workers to identify young people and adults who would benefit from clinical assessment	Adopt a common, validated BPD screening tool to use with young people from CALD backgrounds Adopt a common, validated BPD screening tool to use with adults from CALD backgrounds	No. of people screened No. of people referred for assessment	SA Health, DECD and all partners
3.4 Build capacity of Drug and Alcohol Services staff to identify people who would benefit from specialist assessment	Adopt a common, validated BPD screening tool relevant for us in the drug and alcohol setting	No. of people screened No. of people referred for assessment	DASSA

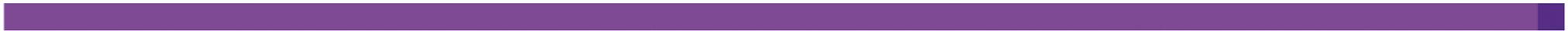[xi] * A BPD diagnosis is not generally applied to pre-pubescent children

[xii] See NHMRC Guideline R4 for clinical triggers for assessment.

Action area 4: Access, treatment, care and support

Strategy	Action	Output measures	Major partners
4.1 Increase access to evidence-based treatments – both crisis strategies and longer term strategies (including structured, one to one, flexible psychological therapies and groups) for people living with BPD symptoms in a range of settings offering choice (including services targeting young people and parents, Aboriginal people and CALD communities)	Develop a business case for a *South Australian Personality Disorder Hub* to support LHNs and other partners to this Action Plan to implement the NHMRC Guideline ensuring better access to services for people living with BPD through: > developing a suite of SA guidelines, manuals and clinical tools > evidence-based, recovery focussed workforce development > providing advice on local approaches to care planning, service re-design and management of crisis presentations to ED across the state > clinical training, workforce development and scholarships > specialised advice, liaison/secondary consultation > the establishment of targeted, individual, intensive assessment and treatment program for the most severe and complex cases > Provide program coordination for this Action Plan.	Business case supported, SA guidelines developed and implemented (including ED guidelines) Enhanced access based on experience of people living with BPD and carers	SA Mental Health Commission / SA Health
	Department for Correctional Services and SA Health work together to develop a model of care for people living with BPD in prison	Model developed	Department for Correctional Services/SA Health
	Child and Adolescent Mental Health Services (CAHMS) to investigate models for earlier intervention for young people presenting with self-harm	Model identified	CAHMHS/SA Health
	Helen Mayo House to develop business case to carry on with Mother – infant DBT program (currently research funded until 2017)	Business case supported and service continued	WCHN/SA Health
	Drug and alcohol treatment services to increase skills to treat and support people living with BPD and prevent the development of severe substance use disorders	Training completed	DASSA

Strategy	Action	Output measures	Major partners
	Ensure programs provide longer treatments and additional treatment sessions for people living with BPD in primary care (e.g. Primary Mental Health Services and Better Access)	Initiatives expanded to provide effective treatment for BPD	SA Health Primary Health Networks
	Ensure people living with BPD with complex needs do not remain in hospital for longer than clinically necessary due to lack of community/psychosocial supports including supported housing	People living with BPD in hospital with complex needs provided with timely supports for discharge, housing and individualised support, organised prior to discharge.	SA Health Primary Health Networks Housing SA Other partners

Action area 5: Governance and partnerships

Strategy	Action	Output measures	Major partners
5.1 Establish an on-going BPD Model of Care Reference Group to develop, monitor and continuously improve a *SA Guidelines for the Treatment of Personality Disorders* and an *SA Model of Care for People Living with BPD*, with a focus on clinical pathways and shared care arrangements for treatment and community supports for people living with BPD	Develop a model of care which gives consideration given to guideline based care and using the learnings from earlier SA health recommendations (2014 report) and other jurisdictions including: > the episodic nature of people's needs > comorbidities not excluding people > enhancing teamwork > engagement at Emergency Departments (and people with frequent presentations) > creating a stepped system (including NGOs) and the wider supports needed to support individual recovery > access to lived experience consultants > creating common documentation > defining hubs and spokes in the tertiary system > a model for prisoners > considering people with disabilities, homeless and at risk of homelessness > considering people with language barriers	SA Model of Care developed	SA Health (including SA Drug and Alcohol Services) and other partners
5.2 Establish a set of clinical indicators for the monitoring of BPD therapy	Develop site-based clinical performance measures that also include higher order indicators related to recovery and living a contributing life.	Incorporation into corporate performance monitoring systems	SA Health and all other partners
5.3 Continuously improve clinical practice for treating people living with BPD	(See 2.3 establishing a BPD Model of Care Reference Group) Enhance data collection systems to monitor this Action Plan including evidence of recovery and living a contributing life.	Model of Care maintained and continuously improving Key indicators reported on	SA Health and all other partners
5.4 Jointly monitor this Action Plan through cross-departmental/cross-agency governance process and third	Monitoring to be conducted by: 1) Action Plan for People Living with BPD Implementation and Monitoring Group; and	A jointly prepared SA Action Plan for People Living with BPD Monitoring Report	SA Health and all other partners

Strategy	Action	Output measures	Major partners
party Program Evaluation	2) Government departmental executive committees	Evaluation Report prepared for the Implementation and Monitoring Group	
5.5 Participate in the strengthening of national reporting and improving understanding of burden of illness and recovery	Improve reporting when required which may relate to incidence and BPD related mortality and achieving recovery and a contributing life.	Annual provision of data Annual provision of linked data reporting mortality of cases	SA Health SA Primary Health Networks
	Mandate reporting of people with BPD who are current clients of public and private mental health services who die by suicide, and ensure any learnings translated into practice.	Number of deaths reported	Office of Chief Psychiatrist
5.6 Develop evidence-based responses and evaluate the impact of programs; and improve understanding through research and promote balance in research.	Evaluate the Action Plan for People Living with BPD and publish key learnings.	Program evaluation conducted	SA Health SA Primary Health Networks Universities and TAFE
	Work with universities to develop a research agenda for BPD in South Australia.	State research agenda includes BPD	

Appendix: Project Steering Group

Members who participated either face to face meetings, or by correspondence:

Name	Position/Organisation
Karyn O'Keefe	Lived Experience Advisor/Educator (Chairperson)
Dr Paul Cammell	Consultant Psychiatrist, Flinders Medical Centre, Southern Adelaide Local Health Network
Janne McMahon	Network Chair and CEO Private Mental Health Consumer Carer Network (Australia)
Matthew Halpin	Coordinator Lived Experience Workforce, CALHN
Geoff Harris	Executive Director, Mental Health Coalition of SA
Karen Bailey	Parent, Sanctuary Support Group Representative
Dr Michael Findlay	Medical Unit Head, SA Prison Health Service, Central Adelaide Local Health Network
Luke Williams	Manager, High Dependency Unit, Department for Correctional Services
Dr Narain Nambiar	Clinical Director, Forensic Mental Health Service, Central Adelaide Local Health Network
Emma Williams (sharing representation with Janet Muirhead)	Team Leader, MOSAIC Counselling Services, Relationships Australia (SA)
Dr Ann Sved Williams	Psychiatrist, Helen Mayo House, Women's and Children's Health Network
Liz Prowse	Director, Strategic Mental Health Operations, Child and Adolescent Mental Health Services, Women's and Children's Health Network
Jill Davidson	Chief Executive, SHineSA
Sarah Murray	Executive Manager, Innovation and Design, Adelaide Primary Health Network
Tania Mansur	Assistant Manager, Child, Youth and Severe Mental Illness, Country SA Primary Health Network
Ann-Marie Hayes	Executive Director, Statewide Services and Child Development, Department for Education and Child Development
Pauline McIntee	Director, Child and Family Health, Department for Education and Child Development
Janet Muirhead	Practice Manager, Counselling Services, Relationships Australia (SA)
Dr Chis Wurm	GP Psychotherapist, Addiction Specialist, University of Adelaide/Central Adelaide Local Health Network
Justyna Rosa	Program Manager, Partners in Recovery Life Without Barriers
Tracey Hutt	Principal Project Officer, SA Mental Health Commission
Ian James	Principal Aboriginal Health Advisor , Office of the Chief Psychiatrist, SA Health

A/Prof Michael Baigent	Senior Psychiatrist and Addiction Medicine Specialist, Drug and Alcohol Services SA, SA Health
Margaret Hartstone	Psychologist in private practice
Joanne Peak	Clinical Services Coordinator, Adelaide Women's Prison and Pre Release Centre, SA Prison Health Service
Superintendent Robert Gray	Portfolios, Commissioner's Support Branch, SAPOL
Rob Elliot	Manager, Patient Transport Services, SA Ambulance Services
Ruth McPhail	Manager of Operations, Country Mental Health SA Local Health Network
Helen Schenscher	Northern Adelaide Local Health Network, Project Lead Borderline Personality Disorder Guideline Implementation Working Group
Clare Bookless	Psychologist, private practice
Jane Ellis	Consumer Consultant, Office of Chief Psychiatrist, SA Health
Liz Hodgman	Parent, Sanctuary Support Group
Judy Burke	Parent, Sanctuary Support Group
Bob Burke	Parent, Sanctuary Support Group
Dr Aaron Groves	Chief Psychiatrist, Office of Chief Psychiatrist, SA Health
Dr Tarun Bastiampillai	Executive Director, Mental Health Strategy, SA Health (Project Sponsor)
Emma Willoughby	Consumer Consultant, Office of Chief Psychiatrist, SA Health
Nicole Moulding	Associate Professor Nicole Moulding, UniSA
Dr Mark Lourghead	Lecturer, Lived Experience UniSA
Dr Gizelle Dias	Clinical Lead, Northern Health Network
Charmaine Gallagher	Social Worker, Western Community Mental Health, Central Adelaide Local Health Network

Acronyms

AUD	Australian dollars
BPD	Borderline Personality Disorder
CALD	culturally and linguistically diverse
DBT	dialectical behaviour therapy
GP	general practitioner
NGO	non-government organisation
NHMRC	National Health and Medical Research Council
PTSD	Post-traumatic stress disorder

Definitions

Aboriginal	In the context of this report, the term Aboriginal is used to mean Aboriginal and Torres Strait Islander.
Consumer	Person living with, or recovered from BPD
Carer	Person with lived experience of caring for a person living with BPD

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