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National Health & Medical Research Council
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Attn: Rebecca Hughes
Research Scientist, NHMRC, NICS

Dear Ms Hughes

Thank you for your letter of 29 June 2011, with regards to the NHMRC having been commissioned by DoHA to develop Clinical Practice Guidelines for the treatment and management of Borderline Personality Disorder (BPD).

The Mental Health Coordinating Council wishes to reiterate its view expressed in a number of submissions to Government including a letter to Minister Nicola Roxon concerning Recommendation 25 in the Community Affairs Committee Report on Mental Health in Australia in December 2009, stating our concern with regards to the diagnosis of BPD and the development of specialist services from which the initiative for specific clinical guidelines presumably evolved.

MHCC proposes that the diagnosis of BPD be reconsidered in the light of long established research evidence supporting that assessment, treatment and care be offered within the theoretical perspective and practice framework of trauma informed care and practice (TICP) for people presenting with a complex range of symptoms and behaviours, rather than viewing the person through the narrow focus of a BPD diagnosis and channelling them through specialist services.

Judith Herman's ground-breaking seminal work on the understanding and treatment of trauma has been widely influential, advocates the alternative diagnosis of Complex PTSD (CPTSD) to describe the symptoms of long term trauma, particularly applicable to adult survivors of childhood sexual abuse most commonly diagnosed with BPD. This evidence is questioning the diagnosis and application is clearly analysed in her book: *Trauma and Recovery: From Domestic Abuse to Political Terror (*(Herman, J. Pandora: 1998).

Louis Cozolino (2005) Professor of Psychology and expert on the neuroscience of psychotherapy, also suggests that BPD may be one variant of complex Post Traumatic Stress Disorder (PTSD), citing widespread evidence of early abuse, trauma and the presence of dissociative symptoms. (*The Impact of Trauma on the Brain*. 2005. Psychotherapy in Australia. Vol 11: 3, 31).

The diagnosis of a BPD has been historically stigmatising and controversial because it implies that the individual's personality is flawed, and that there is little hope of recovery. The features of BPD include emotional instability, intense unstable interpersonal relationships, a need for relatedness and a fear of rejection. As a result, people with BPD often evoke intense emotions in those around them. Pejorative terms to describe persons with a

diagnosis of BPD such as 'difficult; treatment resistant; manipulative; demanding; narcissistic and attention seeking' are often used, and this may become a self-fulfilling prophecy as negative responses trigger further self-destructive behaviour.

Whilst we appreciate that the Clinical Practice Guidelines (as stated in the two page descriptor) will acknowledge that the diagnosis is often a "misdiagnosed and misunderstood condition that can result in negative therapeutic and social experiences", the development of clinical guidelines specifically for people with a diagnosis of BPD will not necessarily encourage trauma informed responses from health care providers., The term BPD is in and of itself traumatising to those people so labelled.

Australia's mental health system has, generally speaking, a poor record in recognising the relationship between trauma and the development of mental health problems. There is a lack of policy focus as to how this knowledge can be incorporated into service delivery.

There may be several reasons for this including:

- a mental health system based on a 'diagnose and treat' approach to mental health care that fails to acknowledge the possible underlying causes of the presenting problems;
- differing perspectives on the scientific validation of the lived experience of people presenting with trauma related symptoms;
- an often ineffective medicalised response for people impacted by trauma;
- clinical assessment focused on what constitutes a diagnosis in terms of a set of characteristics or symptoms, the real issue of what happened to effect the person so profoundly is often relegated to 'interest value' only.

This makes little sense given that recognition and integration of experienced trauma is fundamental to the recovery process.

Trauma-informed programs and services internationally represent the 'new generation' of transformed mental health and allied human services organisations and programs which serve people with histories of violence and trauma.

When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services. Trauma-informed organisations, programs, and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience (that traditional service delivery approaches may exacerbate), so that these services and programs can be more supportive, effective and avoid re-traumatisation.

MHCC vigorously advocates a trauma informed approach to care and practice which moves away from prioritising the search for and treatment of a diagnosis to recognition of the person's traumatic life experience, which may have resulted in an individual's contact with mental health services through adoption of extreme coping strategies.

In order to promote this approach MHCC held a landmark national conference in Sydney on 23-24 June 2011. Over 240 people attended on both days. The conference was targeted at consumers, carers and people who work in mental health and human services sectors including public, private and community managed agencies such as drug and alcohol, primary and allied health, counselling, refugee and therapeutic support services, sexual assault and child protection, disability, Indigenous, culturally, linguistically and ethnically diverse organisations as well as law, justice, education and research. Not only did attendees reflect this diversity, but people attended from every state in Australia.

The conference is part of a broader initiative towards a national agenda for trauma informed care and practice (TICP), which the Mental Health Coordinating Council (MHCC) and its collaborating partners, ASCA (Adults Surviving Child Abuse), ECAV (Education Centre against Violence) and (PMHCCN) Private Mental Health Consumer Carer Network Australia (PMHCCN) are spearheading.

The vision behind the conference was to increase awareness and knowledge about TICP across both the government and non-government sectors in all health and community services. Speakers included high profile mental health consumer advocates - Debra Wells and Merinda Epstein, as well as eminent psychiatrists - Dr Richard Benjamin, Consultant Psychiatrist, Professor Beverly Raphael AM, Professor Louise Newman AM and Professor Warwick Middleton, plus an impressive array of national and international presenters with extensive experience in the field. The conference was opened by a video from the Hon Mark Butler MP, Federal Minister for Mental Health and Ageing. Kathleen Guarino, Senior Program Associate, Clinical Design at the National Center on Family Homelessness, Massachusetts USA presented via webcast.. Kathleen has been a driving force behind the National Center for Trauma-Informed Care (NCTIC), which is funded by the Substance Abuse Mental Health Services Administration (SAMHSA).

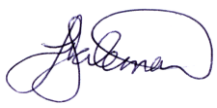
Since 2005 NCTIC has been facilitating interest in, and the implementation of, trauma-informed care in publicly-funded systems and programs. The Center offers consultation and technical assistance, education and outreach and resources to a broad range of service systems, including mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education. SAMHSA is committed to improving public health responses to consumers and NCTIC was inspired by several ground-breaking SAMHSA initiatives to better understand and address the needs of people with trauma histories who receive mental health services.

MHCC and collaborating partners report that responses from the conference and the widespread interest in the sector are clear evidence of the ground swell movement to push for the progression of a trauma informed mental health reform agenda nationally. We can only urge the NHMRC to consider the growing body of professionals and service providers who are opposed to establishment of specialist services and clinical guidelines for people with a diagnosis of BPD and advocate instead for an Australian Centre for Trauma-Informed Care.

Moreover, most importantly we stress the views of consumer advocates with a BPD diagnosis who so succinctly expressed their position in a number of presentations at our conference - that the diagnosis of BPD itself cut to the very core of their sense of self, and that what was needed was a service system that responded within a trauma informed perspective in order to achieve recovery.

MHCC thanks you for your interest and expresses its willingness to provide any further information and be consulted in the future in relation to this initiative.

Yours sincerely,



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