

Editorial

Personality disorders - who cares?

I received a phone call last week from a police sergeant. A young patient had recently suicided and, unfortunately, hadn't been found for some time so her body was a mess.

For over a decade, I've provided medical services for homeless young people. I have found that there is a huge problem with the psychiatric care, or lack of it, of the socially marginalised. It's not easy to arrange specialist medical or surgical care of the poor, smelly or irritable – but arranging psychiatric care is virtually impossible. The irony is that homeless people in Australia in the 21st century don't only often have psychiatric morbidity. They are usually indigent *because* of it.

The young woman who killed herself was a difficult patient. Our final consultation ended when she strode out threatening to do something that would shock me. We both knew what she meant. This seemed to be precipitated by my refusal to prescribe benzodiazepines for insomnia. Luckily for my own stress levels, this episode took place several months before her eventual suicide. The clinic's nurse practitioner was less fortunate, having very recently experienced a similar interaction over a different issue.

The clinical notes make interesting retrospective reading. I saw her 19 times over a two year period. Her diagnosis was usually listed as anxiety/depression. I knew the label of borderline personality disorder would be more accurate but I use it cautiously due to its stigma. Besides, in practice, a diagnosis of borderline personality disorder is often merely a hand-washing exercise by the therapist.

Recent research appears to confirm that a limbic system abnormality underlies this personality disorder. That is, this is a neurological dysfunction, and not a defect of the soul or free will.

The woman's clinical notes include several letters – pleas almost – to psychiat-

In recent years, the Doctors Reform Society has received a useful trickle of money from Copyright Agency Limited payments. The cash comes from use of *New Doctor* articles.

The penny recently dropped that over the last thirty years the DRS has received a total of zero dollars from this journal's, at times, enlightened editorials. The editorials may have been a blackspot in publication databases due to their lack of titles and contents-listed authors. Avarice, rather than editorial megalomania, has led to a decision to correct this.

This issue's lead article concerns the activities of certain major US health care corporations. Even the edited small-legal-target form that has been published is eye-opening. As usual, the issue includes considerable further material relevant to Australia's health system, both present and future.

New Doctor hasn't published an article focussing on mental health for many years, possibly not since a 1998 psychoanalysis of One Nation supporters (William Bor, "The Hanson Factor" 69:9). A phone call last week prompted this page's brief excursion into the area. Hope you find it of interest. AG

ric services to accept this woman as a patient. This is a road I have been down on many occasions with many patients. One of my first actions was to refer her to the local community mental health service. She returned reporting that she'd been told she didn't have a mental illness and they were not interested in following her up. No correspondence indicating otherwise was received.

The notes from our final consultation indicate that she had just been assessed at a public hospital psychiatric unit and told she "didn't need a psychiatrist". The peculiar thing is that a person without psychiatric training would probably recognise that she was screwed-up and in need of urgent care. What are we teaching our

young doctors?

Refusal to provide care seems endemic in mental health services. One wonders just who most psychiatrists are happy to treat. Certainly not the mentally ill if they resort to violence or drug use – prison seems regarded as the institution of choice for them. In a rural area, the local psychiatrist once refused my referral of an actively suicidal patient with major depression. His rationale was that she was drinking and he didn't see drinkers. Had he considered whether a psychotic depressive could live in a rural Aboriginal community *without* drinking? I doubt it.

It is very frustrating to work in primary health care, recognise that a patient suffers a serious life-threatening disorder, and then be unable to arrange specialist review of them. To rub salt in the wounds, experts pop up in the media saying that GPs need to improve their assessments of suicide risk in order to hasten referral to specialist services.

There are ongoing debates about the treatment of personality disorders. Yet, even if one holds doubts about prognosis, it seems peculiar for a specialty to refuse to care for untreatable patients within their sphere. Physicians and surgeons will usually agree to follow up incurable patients offering whatever support they can. Yet few psychiatrists – despite self-important declarations about undertreatment of suicidal youth – have any genuine interest in providing care for people with personality disorders who are neither cashed up nor personable. Psychiatrists lost epileptics to neurologists long ago and may eventually lose psychotics. It will be a nice twist if, a generation from now, personality disorders are all that psychiatrists have left to treat.

Lots of young people deliberately kill themselves. A dozen or more of the statistics have been my patients. Isn't it time the community cut the crap about "the tragedy of youth suicide" and ensured a service actually gets provided for people that desperately need it?

Andrew Gunn
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