SANE AUSTRALIA

Understanding the experiences of healthcare professionals regarding personality disorder

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Table of contents

Key terminology

Carer	A family member, friend or other person who supports someone living with a mental illness
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th edition
Healthcare professional	A general practitioner, psychiatrist, psychologist, nurse, paramedic, occupational therapist, social worker, counsellor, or other clinician
ICD-10/11	International Classification of Diseases, 10th or 11th edition
Lived experience	Current or former experience of mental illness
Personality disorder	A condition characterised by pervasive and persistent patterns of thoughts, emotions and behaviour that significantly deviate from cultural expectations and cause clinically significant distress or impairment (American Psychiatric Organization, 2013). The following specific types of personality disorder are identified in DSM-5: Paranoid personality disorder (PPD) Schizoid personality disorder (SPD) Schizotypal personality disorder (SZPD) Antisocial personality disorder (ASPD; ICD-10 dissocial personality disorder) Borderline personality disorder (BPD; ICD-10 emotionally unstable personality disorder) Histrionic personality disorder (HPD) Narcissistic personality disorder (NPD) Avoidant personality disorder (AVPD; ICD-10 anxious-avoidant personality disorder) Dependent personality disorder (DPD) Obsessive-compulsive personality disorder (OCPD; ICD-10 anankastic personality disorder)
Specialist service	A service providing support tailored to personality disorder, or providing a treatment which has demonstrated efficacy specifically for personality disorder

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Executive summary

Around 6.5% of Australians are believed to be living with personality disorder, which involves pervasive and persistent patterns of thoughts, emotions, and behaviour that lead to impairment and distress. Personality disorder is a highly stigmatised mental illness, and many people living with this condition have reported challenges accessing the care they need. In 2018, SANE Australia completed a research project in order to better understand the experiences of Australians living with personality disorder, as well as the experiences of their carers, families, and support persons. The present study complements that original work and was developed in order to understand an alternative perspective – that of healthcare professionals.

This mixed methods study aimed to understand healthcare professionals' experiences working with people living with personality disorder, including their attitudes, experiences of training, confidence, challenges, and perceived treatment gaps. This study involved an online survey of 146 healthcare professionals, and in-depth interviews with nine healthcare professionals. Participants were mostly psychologists, mental health nurses, and social workers. Most participants reported experiences related to treating people living with borderline personality disorder (BPD). Discussion of other personality disorders was less frequent.

Nearly all participants reported first undergoing training in this area during their tertiary studies, most commonly during their postgraduate studies (30.6%). Several participants commented that they were not adequately trained in treatment for personality disorder during their studies, and many had sought additional specialist training or learned on the job. Participants commented on the need for more affordable and accessible training options.

Participants described various treatment pathways, including assessment, diagnosis, risk management, treatment, and maintaining recovery. Less than 50% of participants reported that they consistently provide diagnoses to adults they have determined to be living with personality disorder, although for some this was not their responsibility. This figure was even smaller for adolescents living with personality disorder, with some participants being unwilling or unsure if this was appropriate. Many participants discussed the importance of providing evidence-based treatments; working collaboratively with people living with personality disorder; and being patient, compassionate, and empathetic. Most participants stated that Medicare, the National Disability Insurance Scheme, and public hospitals were not meeting the needs of this population, and discussed the challenges of providing adequate support within the current Australian mental health system.

Most participants reported positive attitudes towards people living with personality disorder. However, 94% agreed that they had witnessed colleagues or other healthcare professionals being stigmatising towards people living with personality disorder. Several discussed factors that might contribute to this stigma, including a lack of education about personality disorder, focusing on and sharing negative experiences with this population, and burnout. In a statistical analysis, there was no relationship between degree of stigmatising attitudes and gender, age, or years of experience working as a healthcare professional. However, those with less stigmatising attitudes were more likely to work collaboratively with people living with personality disorder when making decisions about their own treatment.

Four themes were identified in the thematic analysis:

- ‘The ‘thriving clinician’ described the kind of healthcare professional who is typically drawn to working with people living with personality disorder.
- ‘Expertise’ spoke to the importance of ongoing education and training.
- ‘Cultural shift’ highlighted how the shift in culture surrounding personality disorder awareness and advocacy has pushed the discourse into a more positive space.
- A ‘patchwork approach’ articulated how, because of sporadic funding, clinicians often had to ‘work the system’ and to fulfil multiple roles (sometimes outside of their skillset) in order to deliver the support required.

The results of this study highlight the need for an increase in education and training opportunities in order to upskill healthcare professionals in the treatment of people living with personality disorder. The results also underscore the importance of redesigning the Australian mental health system to enable healthcare professionals to provide more intensive, flexible, and long-term support, tailored to individual needs.

Introduction

Personality disorder involves pervasive and persistent patterns of thoughts, emotions, and behaviour that significantly deviate from cultural expectations (American Psychiatric Association, 2013). Personality disorder leads to clinically significant distress and impairment across many aspects of life: this may include difficulty changing behaviour or adapting to different situations, sustaining work, and forming positive relationships with others. Personality disorder is argued to be, at its core, a disturbance in one's sense of self and interpersonal functioning (American Psychiatric Association, 2013). In Australia, it is estimated that 6.8% of men and 6.5% of women meet diagnostic criteria for at least one personality disorder, with overall prevalence ranging from 0.5% for histrionic personality disorder, and up to 3.1% for obsessive compulsive personality disorder (Jackson & Burgess, 2000). However, as this national prevalence data is more than twenty years old, its relevance to Australia's current population is uncertain, but is similar to international estimates (Lamont & Brunero, 2009).

Ten personality disorder diagnoses are recognised by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), which is the dominant classification system within the Australian mental heath sector. These include 'Cluster A' disorders (paranoid, schizoid, and schizotypal personality disorders), 'Cluster B' disorders (antisocial, borderline, histrionic, and narcissistic personality disorders), and 'Cluster C' disorders (avoidant, dependent, and obsessive-compulsive personality disorders). The International Classification of Diseases, 10th edition, provides similar categories with some name variances (Table 1). The recently released International Classification of Diseases, 11th edition (World Health Organization, 2018) utilises a restructured classification system. The individual personality disorder diagnoses have been replaced by a single diagnosis: *personality disorder*. ICD-11 has introduced degrees of severity ranging from *mild* to *severe,* based on a person's level of dysfunction in interpersonal relationships and everyday life. *Domain traits* have also been included to personalise diagnoses, and a 'borderline' specifier is available.

Of particular interest to researchers and healthcare professionals is borderline personality disorder (BPD), which is characterised by difficulty regulating emotions and impulses, unstable interpersonal relationships, and unstable self-image (National Health and Medical Research Council, 2012). BPD is conceptualised as a particularly severe form of personality disorder (Grenyer, 2017; Sharp et al., 2015). Approximately 1% of Australian adults live with BPD (Jackson & Burgess 2000). People with BPD experience high levels of distress and may engage in self-harming behaviour as a way to manage their distress. The suicide rate for people living with BPD is up to 45 times that of the general population (Chesney, Goodwin, & Fazel, 2014).

Table 1. Personality disorders, as identified by DSM-5 and ICD-10

DSM-5 Cluster	Personality disorder	Brief description
A	Paranoid personality disorder (PPD)	A pattern of distrust and suspicion such that others' motives are interpreted as malevolent.
	Schizoid personality disorder (SPD)	A pattern of detachment from social relationships and a restricted range of emotional expression.
	Schizotypal personality disorder (SZPD)	A pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.
B	Antisocial personality disorder (ASPD; ICD-10 dissocial personality disorder)	A pattern of disregard for, and violation of, the rights of others.
	Borderline personality disorder (BPD; ICD-10 emotionally unstable personality disorder – borderline or impulsive type)	A pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity.
	Histrionic personality disorder (HPD)	A pattern of excessive emotionality and attention seeking.
	Narcissistic personality disorder (NPD)	A pattern of grandiosity, need for admiration, and lack of empathy.
C	Avoidant personality disorder (AVPD; ICD-10 anxious-avoidant personality disorder)	A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
	Dependent personality disorder (DPD)	A pattern of submissive and clinging behaviour related to an excessive need to be taken care of.
	Obsessive compulsive personality disorder (OCPD; ICD-10 anankastic personality disorder)	A pattern of preoccupation with orderliness, perfectionism, and control.

Many healthcare professionals develop stigmatising attitudes towards people living with personality disorder (National Health and Medical Research Council, 2012). The reasons for this stigma are complex: for example, interpersonal conflict between a healthcare professional and a person living with BPD may lead a clinician to develop and apply negative stereotypes to others with BPD; anecdotes and assumptions may be shared among services; and a lack of training and understanding of recovery prospects may lead to confusion and feelings of incompetence among clinicians (Treloar, 2009; Veysey, 2014). Furthermore, there is little discussion of personality disorder in the general public, with most mental health educational campaigns focusing on less complex (but more common) mental illnesses.

In 2018, SANE published a ‘Spotlight Report’ for the National Mental Health Commission on the topic of personality disorder (Carrotte & Blanchard, 2018). This report included a literature review and an environmental scan to explore key evidence-based approaches to treatment, and the availability of such services in Australia. The report also involved a qualitative study of Australians living with personality disorder and their carers to examine their experiences with evidence-based approaches to prevention, early intervention, treatment and support for recovery, and relapse prevention. This work highlighted the need to increase awareness and understanding of the experiences of people living with personality disorder in Australia. Many people living with personality disorder and carers reported experiencing stigma from healthcare professionals and believing the level of support provided was inadequate. However, the Spotlight Report did not explore the experiences of healthcare professionals working with people living with personality disorder. Hence, the aim of this study was to expand on the findings of the Spotlight Report for healthcare professionals working in this field.

The Australian context

Australians living with personality disorder and their carers access mental health services via various pathways. There are specialist personality disorder services that operate in Victoria and New South Wales. People living with personality disorder may access treatment in the public system, which is generally free but may involve long waiting lists, or in the private system, which requires fee for service.

Some government initiatives partially or completely fund treatment, including the Medicare Benefits Schedule (MBS) Better Access initiative which provides rebates for up to 10 sessions with a psychologist per calendar year. People living with personality disorder may also access psychological support through community-based services, which are funded through primary health networks. Other initiatives, such as the National Disability Insurance Scheme (NDIS), may provide funding depending on individual circumstances.

Treatment guidelines provide recommendations on best-practice approaches for people living with personality disorder in Australia. The *NHMRC Clinical Practice Guideline for the Management of Borderline Personality Disorder* include building strong relationships between clinicians and their clients, providing access to sufficiently intense psychotherapy, utilising community-based treatment services, and avoiding inpatient services where possible (National Health and Medical Research Council, 2012). The *Project Air Treatment Guidelines for Personality Disorders* notes that the duration of psychotherapy will depend on individual needs, but the expected duration of treatment is a minimum of one year (Project Air Strategy for Personality Disorders, 2015, p. 40). Both sets of guidelines endorse the involvement of carers, families, and other support persons in a meaningful way throughout treatment.

There are various evidence-based psychological treatments for personality disorder. The highest quality and most consistent evidence is for BPD, and recommends treatments including: dialectical behaviour therapy (DBT), mentalisation based therapy (MBT), transference focussed therapy, schema therapy, systems training for emotional predictability and problem solving

(STEPPS), and cognitive analytic therapy (CAT; Carrotte & Blanchard, 2018). Various healthcare professionals and clinical services provide these therapies throughout Australia. However, most are located in capital cities. In previous research, many people living with personality disorder noted their belief that there are not enough specialist services available, and that treatment is generally very expensive or involves a long waiting list (Carrotte & Blanchard, 2018).

Attitudes towards personality disorder

All known research into stigma and personality disorder has centred on BPD. A literature review of relevant BPD studies (Ross & Goldner, 2009) found that BPD is one of the most stigmatised mental illnesses. For example, the authors identified that mental health nurses tend to perceive people living with BPD as being ‘bad’, whilst people accessing mental health services with other diagnoses tend to be perceived as ‘ill’.

In the Australian context, qualitative research has explored the attitudes of healthcare professionals towards BPD (Treloar, 2009). In this study, participating healthcare professionals indicated that the symptoms of BPD could generate a negative personal response in clinicians, including perceptions of personal inadequacy, which may then increase anxiety. Some people with BPD present to mental health services repeatedly, demonstrate slow therapeutic progress, and have symptoms such as poor interpersonal skills that may impact relationships with healthcare professionals. All these factors contribute to healthcare professionals’ responses and attitudes. Participants reported their belief that the mental health system did not adequately support people living with BPD, as well as a lack of training and resources available. Further qualitative research has identified a need for more training and education, regular clinical supervision, clearer guidelines and protocols, and attitudinal change (Fanaian, Lewis, & Grenyer, 2013).

A recent publication by Day et al. (2018) tentatively suggests that the stigma towards BPD is reducing. In this study, mental health staff at a public health service in Australia completed survey measures in 2000 and 2015. Based on quantitative measures, the 2015 sample demonstrated more positive attitudes towards people living with BPD and self-harm compared to the 2000 sample. Qualitatively, participants used more positive language when discussing their experiences. The authors posited that this was due to the development, promulgation, and implementation of more evidence-based treatments, leading to a more positive prognosis for BPD.

In the past five years, there has been an increase in national advocacy efforts by organisations such as the Australian BPD Foundation and BPD Awareness Week, an expansion in research, treatment and outreach services by organisations such as Oxygen Youth Health, Project Air Strategy for Personality Disorders, and Spectrum. This has been accompanied by revisions of major personality disorder treatments such as dialectical behaviour therapy (Linehan, 2014), and an increase in media discussion and more positive representations of BPD (for example, SANE Australia, n.d.). A new study is needed to reflect these changes, given that the majority of studies into healthcare professionals and personality disorder were published more than five years ago. Furthermore, previous research that has taken place has tended to focus on just one group of healthcare professionals – mental health nurses (Day et al., 2018; Ross & Goldner, 2009). The current study aims to fill these research gaps in order to understand the current perspectives of healthcare professionals regarding personality disorder, and to update and expand on prior research.

Objective

This mixed methods study involved a convenience sample of healthcare professionals who have experience supporting or treating people living with various personality disorders in Australia. The study explored their attitudes, experiences of training, confidence in supporting people living with personality disorder, challenges, and perceived treatment gaps.

The aim of this study was to ask Australian healthcare professionals who support or treat people living with personality disorder the following questions:

1. What training do healthcare professionals typically receive in the field of personality disorder?
2. What types of treatment and support services are provided or recommended?
3. What are the challenges of treating people living with personality disorder?
4. What changes would healthcare professionals like to see with regards to service provision and access, training, guidelines, et cetera.?
5. What are the attitudes of healthcare professionals towards people living with personality disorder?
6. Are healthcare professionals aware of relevant personality disorder treatment guidelines, and are these recommendations being followed?

It was hypothesised that:

1. Healthcare professionals received minimal training as part of their university studies with more intensive training accessed via professional development.
2. Among those who provide psychotherapy, there will be significant variation in treatment approaches. DBT and CBT will be the most common approaches.
3. Key challenges will relate to education, service availability, and countertransference.
4. Healthcare professionals will recommend an increase in funding and service availability, and earlier/more comprehensive education.

5. Personal attitudes will be mostly positive but participants will identify stigma witnessed throughout their careers. Participants with more experience will have less stigmatising attitudes.
6. Familiarity with treatment guidelines and adherence to recommendations will vary.

Methodology

This project involved a mixed methods approach, with:

a) a quantitative online survey of healthcare professionals

b) up to 12 in-depth interviews with healthcare professionals.

The project was reviewed and approved by an independent Human Research Ethics Committee, Bellberry Limited (Protocol Identifying Number 2018-07-594)

Participants

- Participants were required to meet the following inclusion criteria:
- aged 18 years or older
- experience working as a healthcare professional – for example, a general practitioner, psychiatrist, psychologist, nurse, paramedic, occupational therapist, social worker, counsellor, or other clinician
- experience working with people with a diagnosis of personality disorder at least occasionally through their practice (either currently or in the past)
- able to speak and understand English
- willing and able to give informed consent.

Additionally, participants who were interested in participating in an in-depth interview were required to attend a 30-60 minute interview with a SANE researcher (face-to-face or via phone/Skype). Twelve interviews were proposed – this number was selected as being sufficient to add context and depth to the exploratory quantitative responses, and achievable within the study timeframe.

In this report, ‘participants’ refers to all healthcare professionals who participated in the study, whereas ‘respondents’ is used when referring to a subsection of the participant group (for example, those who provided optional open-ended responses).

To simplify text within the survey, the word ‘consumer’ was used throughout. This was introduced to participants with the following statement:

> *Consumers are people who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, and have accessed services and/or received treatment. This includes people who describe themselves as a ‘peer’, ‘survivor’ and ‘expert by experience’. In this survey, the word ‘consumer’ means a person living with personality disorder.*

Recruitment

Advertising occurred via SANE's social media, an email newsletter notice, and by contacting relevant organisations and professional networks. Every participant who completed the online survey was asked if they were also interested in participating in an interview. If interested, they were asked to provide an email address, which was linked to data for the interested participants. The researchers considered all expressions of interest as they arrived. Potential participants were chosen to represent a diversity of experiences. For example, the researchers considered the demographic details, type of healthcare professional, length of time working in the field, and level of training. Once the researchers selected participants, these participants were contacted via email and asked to participate in an interview. If a participant did not respond to either phone call or email within a week, another participant was selected in their place. This process continued until the recruitment period ended.

Measures and materials

Survey: The survey was conducted via the online survey platform SurveyMonkey. Questions were asked about participant demographics, including: age, gender, language(s) spoken, and occupation. Questions were developed to explore participants' experience working with people living with personality disorder and were aligned with the study objectives described above. The questionnaire was initially developed by the researchers based on the findings of SANE's Spotlight Report, mentioned above (Carrotte & Blanchard, 2018). This questionnaire was designed to see if clinicians' experiences, opinions and practices aligned with those reported by people living with personality disorder, as well as their carers, families, and support persons.

The survey questions also assessed whether the treatment practices participating healthcare professionals employ are in line with best practice recommendations (National Health and Medical Research Council, 2012; Project Air Strategy for Personality Disorders, 2015; see Table 2). These documents provide guidelines for assessment, diagnosis, and treatment based on clinical consensus and research. Representatives from the National Mental Health Commission also reviewed the questionnaire and provided feedback.

Table 2. Best practice recommendations assessed in the present study

Guideline	Source
When assessing for personality disorder, conduct a semi-structured interview and consider the use of screening questionnaires or other instruments.	NHMRC p.10; Project Air, p.18
Once a diagnosis of personality disorder is established, it should be disclosed and explained to adults.	NHMRC, p.9; Project Air, p.19
Once a diagnosis of BPD is established, it should be disclosed and explained to people aged 12-18. Consider diagnosis of other personality disorders in young people.	NHMRC, p.9; Project Air, P. 29
Where planning structured psychological therapies for personality disorder, the therapist should adapt the frequency of sessions to the person’s needs and circumstances.	NHMRC, p.10; Project Air, p.39
Psychotherapy is the treatment of choice for personality disorder, with an expected duration of treatment of at least one year with weekly sessions.	Project Air, p.40
People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals.	NHMRC, p.6
Healthcare professionals should refer a person with BPD to a specialised BPD service or other services as indicated.	NHMRC, p.6
Healthcare professionals should undertake continuing professional development to maintain and enhance their skills.	NHMRC, p.6
Medication should not be used as a primary therapy for personality disorder.	NHMRC, p.6; Project Air, P. 27
Healthcare professionals should refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available.	NHMRC, p.7
Distinguish between ‘chronic’ and ‘acute’ risk, and consider brief hospital admission in response to ‘acute’ risk.	Project Air, p.9; NHMRC p.129
When planning treatment for people living with personality disorder, with consent, involve their family in care (including development of crisis plans).	NHMRC, p.12, p.16; Project Air p. 30
Healthcare professionals should inform people living with personality disorder about the range of treatment options that are available and, if more than one suitable option is available, offer the person a choice.	NHMRC, p.10; Project Air, P.19

Two continuous scales were included in the survey. Firstly, the Shared Decision Making Questionnaire was included (SDM-Q-Doc, physician version; Scholl, Kriston, Dirmaier, Buchholz, & Härter, 2012). This nine-item scale assesses how healthcare professionals explore decisions with their patients, and is a widely used scale for assessing collaborative decision-making in consultations. Higher scores represent a greater degree of shared decision-making. This scale was adapted to present-tense rather than past-tense to capture more general experiences as the original scale was designed to refer to a specific consultation. The scale has demonstrated adequate validity and internal consistency (Doherr, Christalle, Kriston, Härter, & Scholl, 2017; Scholl et al., 2012).

Secondly, the Opening Minds Stigma Scale for Health Care Providers (OMS-HC) was used to explore healthcare professionals' attitudes towards personality disorder (Modgill, Patten, Knaak, Kassam, & Szeto, 2014). This 15-item scale explores stigma in relation to mental illness across three dimensions: attitude, disclosure/help-seeking, and social distance. Higher scores represent a greater degree of stigma. The scale has demonstrated adequate validity and internal consistency (Modgill et al., 2014). Based on methods used in past research on BPD stigma, the questions were modified to refer to 'personality disorder' instead of 'mental illness' (Knaak, Szeto, Fitch, Modgill, & Patten, 2015).

In-depth interviews: Researchers used a discussion guide and audio recorder (via a mobile phone application) for interviews. Participants were provided with a digital participant information and consent form in order to obtain informed consent. This form contained information about the project, requirements of participation, risks and benefits to participants, information regarding privacy and confidentiality, and contact details of the Principal and Associate Investigators.

Procedure

Online survey: Participants accessed the online survey via a SurveyMonkey link. The landing page of the survey presented the participant information and consent form. The first page of the survey asked for participants' demographic details and their occupation. The remainder of the survey involved the questions and scales described above. At the end of the survey, participants were asked to enter their email address if they would like to enter a lucky prize draw to win one of three $100 Giftpay vouchers. These email addresses were stored separately to survey responses to maintain anonymity.

In-depth interviews: At a mutually agreed date and time, participants attended an interview with a researcher. Prior to the interview, the researcher sent a digital information and consent form to the participant. Participants were asked to return a signed form to the researchers via email prior to the interview, and to keep a copy on their computer for their personal records. When the phone call began, the interviewer revisited the purpose of the interview and other key points outlined in the consent form with the participant. After any queries were resolved, the interviewer turned on the recording equipment and began the interview, using a discussion guide. At the end of the interview, each participant was thanked for their time and was emailed a $100 Giftpay voucher. The recording was turned off and the audio file was transferred immediately to a private folder on

SANE Australia's online storage system. Audio files were sent to a secure external contractor for transcription.

Data Analysis

Survey: Quantitative data were exported from SurveyMonkey to SPSS. Descriptive statistics were analysed, including percentages of participants who work in particular healthcare professions and their experience working with people living with personality disorders. Simple inferential statistics were run exploring the relationships between healthcare professional type, demographics, amount of training, stigma, shared decision-making, and other variables.

Interviews: Data were analysed according to standard qualitative procedures, with immersion in the data, followed by open coding, axial coding, and selective coding (Miles, Huberman, & Saldana, 2013). The qualitative data analysis software NVIVO was used to conduct this analysis. To reduce the risk of bias, two researchers thematically coded a subset of data (two interviews) independently to develop a thematic framework. These analyses were compared, and then one researcher (EC) analysed the remainder of the transcripts based on emerging themes.

Symbols used in presentation of results

“ Content next to blue quotation marks involves a direct quote from a participant via in-depth interview.

✏ Content next to a blue pencil is a written response obtained through the online survey.

Terms used in presentation of results

Mean: The value obtained by dividing the sum of several quantities by their number; an average.

Median: A value lying at the midpoint of a distribution, such that there is an equal probability of falling above or below it.

Mode: The most frequently occurring value.

Standard deviation (SD): A measure of variation or dispersion within a distribution.

Results

Online survey

This survey was open to the potential participants between 6 September 2018 and 18 October 2018. In total, 275 participants responded to the survey. Thirty-three participants were removed prior to analysis as they did not complete any questions after viewing the consent form and selecting ‘yes’. Three participants were excluded as they indicated that they had never worked with someone living with personality disorder. Of the remaining participants, 95 were excluded as they completed less than 50% of the survey and did not complete the SDM-Q-Doc and OMS-HC scales at the end of the survey. The final sample of 146 participants was examined using pairwise analysis to preserve as much data as possible (for each question, all participants with valid data were included via pairwise deletion).

The mean age of participants was 43.6 years (SD = 11.9 years) and the mean number of years working as a healthcare professional was 16.2 years (SD = 11.0 years). Most participants (90.4%) worked with people living with personality disorder in their current role and 9.6% in a former role only. Demographic details are presented in Table 3.

Table 3. Participant demographics (*n* = 146)

Variable	Category	*n*	%
Gender	Female	126	86.3%
	Male	19	13%
	Trans female	1	0.7%
	Trans male	0	0%
	Non-binary	0	0%
Aboriginal or Torres Strait Islander identity	Neither	139	95.2%
	Aboriginal	7	4.8%
	Torres Strait Islander	0	0%
First language	English	140	95.9%
	Other	6	4.1%
Profession	Psychologist or provisional psychologist	55	37.7%
	Social worker	31	21.2%
	Mental health nurse	30	20.5%
	Other	19	13%
	Counsellor	10	6.8%
	Occupational therapist	9	6.2%
	Registered nurse	9	6.2%
	Psychiatrist	3	2.1%
	General practitioner (GP)	1	0.7%
	Paramedic	0	0%
Location of workplace*	Major city	90	68.2%
	Inner regional	24	18.2%
	Outer regional	22	16.7%
	Remote	10	7.6%
	Very remote	1	0.8%

**Asked only for participants with current experience with personality disorders; percentages created according this sample size (n = 132)*

BPD was the most common personality disorder seen by participants in their practice. Overall, 142 of 146 participants (97.3%) reported that they had worked with a person living with BPD at least once in their life. The median selected option for this personality disorder was ‘weekly’ contact, but 47.9% reported ‘every day or nearly every day’. Less commonly seen personality disorders were ASPD, NPD, AVPD, DPD, and OCPD, with the median selected option being ‘monthly’ contact. The least commonly seen personality disorders were PPD, SPD, SZPD, and HPD, with median selected response being ‘less than monthly’. See Figure 1 for distribution of responses.

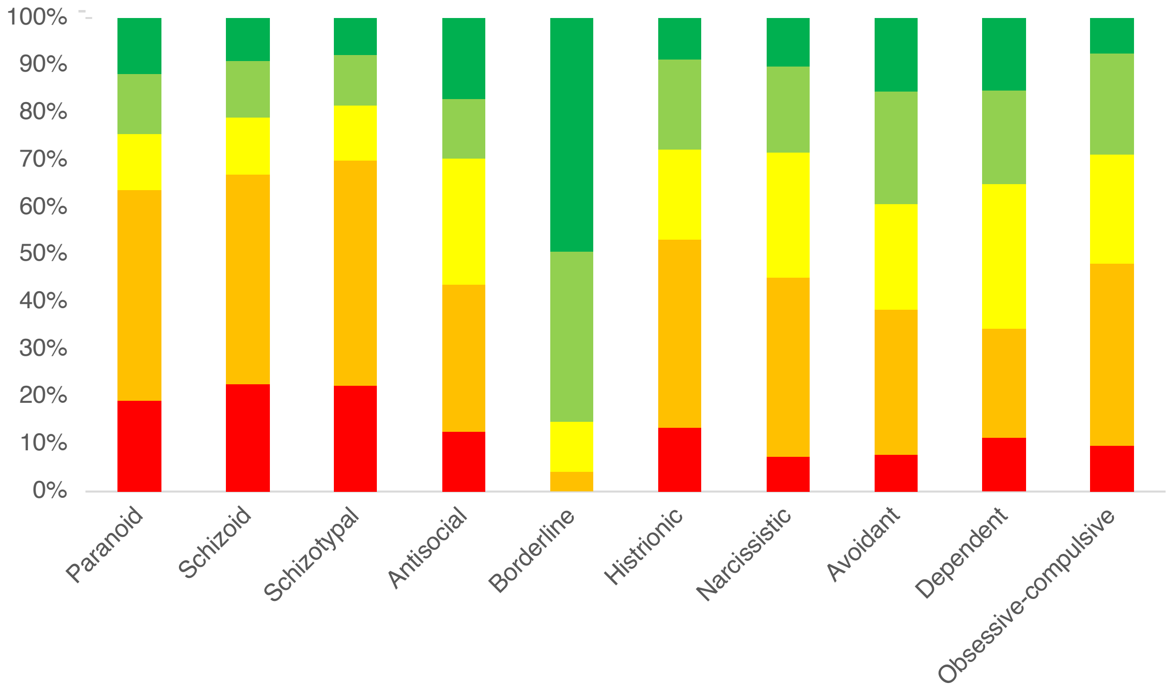

Figure 1. Distribution of responses for how often healthcare professionals worked directly with people living with various personality disorders

Most participants reported working in either a hospital setting or private psychological practice. The types of treatment provided were most commonly emergency or crisis support, case management, and counselling/psychotherapy (Table 4). Participants were able to select multiple responses to these questions.

Table 4. Participants' organisation type and type of support provided (*n* = 146)

Variable	Category	*n*	%
Type of service or organisation	General medical practice	4	2.7%
	Private psychological practice	32	21.9%
	Publicly-funded, community-based practice	14	9.6%
	Specialist personality disorder service	7	4.8%
	Public hospital, inpatient or outpatient services	49	33.6%
	Private hospital, inpatient or outpatient services	8	5.5%
	Public hospital, emergency department	9	6.2%
	Private hospital, emergency department	1	0.1%
	Ambulance services	0	0.0%
	Crisis assessment and treatment team (CATT)	10	6.8%
	Charity/not-for-profit	17	11.6%
	Forensic setting/service	9	6.2%
	Drug or alcohol treatment service	6	4.1%
	Residential service	10	6.8%
	Research organisation	0	0.0%
	Helpline, online or other phone/digital service	4	2.7%
	School or other educational institution	5	3.4%
	Other	23	15.8%
Type of support provided	General medical support/treatment	33	22.6%
	Medication management/prescribing	23	15.8%
	Counselling/psychotherapy	119	81.5%
	Outreach services	49	33.6%
	Emergency or crisis support	79	54.1%
	Case management	72	49.3%
	Other	54	37.0%

Training

Participants were asked, 'As part of your training in mental health treatment, at what stage did you first learn about treatments for personality disorder?' Nearly all participants reported first experiencing training regarding personality during their tertiary studies, most commonly postgraduate studies (30.6%; Table 5).

Table 5. Training experience (*n* = 144)

Where/when first trained	*n*	%
Undergraduate studies	38	26.4%
Postgraduate studies	44	30.6%
Professional development	16	11.1%
TAFE	4	2.8%
Student placement	0	0.0%
On the job	9	6.3%
Other	3	2.0%

Participants were asked to comment on their experience of training in an open text box. Most participants reported that although they learned about personality disorder at university, this training was generally minimal, even for those who completed studies more recently. Some participants reported that although the topic was first introduced at university, the bulk of their training was either on the job or via student placement. Many reported accessing additional specialist training. This was often described as self-directed and self-funded rather than requested and funded by an employer. Among those who commented on treatment quality, many stated that their early training was insufficient in scope and often very minimal. Most who attended specialist training reported that this was high quality and valuable. A minority of participants reported that specialist training contained inaccurate or stigmatising messages.

> *Inadequate training in postgraduate social work program. Inadequate training provided by my NGO* [non-government organisation] *employer. I have done my own PD* [professional development] *and education out of necessity and interest.*
>
> Written comment - Female, 37, social worker.

Therapeutic approach and decisions

Participants were asked to comment on their typical approach to five components of treatment – *assessment, diagnosis, treatment, risk management,* and *maintenance of recovery* – via four optional open-text boxes. These data are incorporated with quantitative data within this section.

For respondents who commented on *assessment,* most reported conducting a clinical interview incorporating some formal screening tools. Some participants were only involved in intake services, while others did not conduct an assessment themselves, if this was another clinician's responsibility (for example, a psychiatrist). Participants discussed using a mental status examination, exploring symptoms and presenting problems, exploring the person's history (including symptom development, treatment history, relationships, social factors, and trauma), a risk assessment, and identifying the person's treatment goals. Depending on the setting, sometimes a physical assessment was also conducted. Some participants stated that they involved carers and families, or other healthcare professionals as part of the assessment. Others mentioned creating a formulation using various approaches such as the Five Ps (presenting problems, precipitating factors, predisposing factors, perpetuating factors, protective factors), or a formulation based on a particular type of therapy such as MBT or schema therapy.

Among those who used standardised measures, a wide variety were reported, including semi-structured diagnostic tools (for example, Structured Clinical Interview for DSM-5). Various scales also measured:

- General psychological distress (for example, Kessler Psychological Distress Scale, Depression Anxiety Stress Scale)
- Measures of cognitive impairment (for example, Mini-Mental State Examination)
- Personality disorder symptoms (for example, Personality Assessment Inventory, Minnesota Multiphasic Personality Inventory, Borderline Personality Questionnaire)
- Trauma and stress (for example, Post-Traumatic Stress Disorder Checklist for DSM-5)
- Alcohol and drug use (for example, Alcohol Use Disorders Identification Test)
- Schemas (for example, Young Schema Questionnaire, Schema Mode Inventory)
- Child-parent relationships and attachment (for example, Adult Attachment Interview, Working Model of the Child Interview, Circle of Security Interview)
- Emotion regulation and coping (for example, Coping Scale for Adults, Difficulty in Emotion Regulation Scale)
- Specific symptoms of other mental illnesses (for example, Eating Disorder Examination, Generalised Anxiety Disorder scale).

Fewer participants reported on *diagnosis*. Several reported that it is not within their role to provide a diagnosis and this is someone else’s responsibility (such as a psychiatrist or GP). Some reported determining a provisional diagnosis before consulting with another team member (often a psychiatrist) to confirm the diagnosis. Some reported using diagnostic criteria to aid their formulation and opinion, but not communicating a diagnosis. Others reported that people with personality disorder received this diagnosis prior to arriving at their service, typically if this was a specialist service. For those who did diagnose, most reported confirming that they meet diagnostic criteria (via the DSM-5 or ICD 10/11) and communicating this with the person. Some reported providing psychoeducation and discussing their formulation.

> *I don't usually give a 'diagnosis', I just talk about emotion dysregulation or the DBT treatment.*
>
> Written comment – Female, 29, clinical psychologist

In quantitative data, many participants reported that they ‘always’ or ‘almost always’ assess, disclose and explain personality disorder diagnoses for adults (48.2% reporting ‘always/almost always’). However, this proportion was much smaller for those working with older adolescents aged 15-17 (19.9% always/almost always) and younger adolescents aged 12-14 (8.9% always/almost always). In the written response, below, a psychologist expands on why she is unwilling to diagnose personality disorder in adolescents, although her rationale does not align with the NHMRC clinical guidelines.

> *I would be very cautious re diagnosing personality disorder in young people <15, even those <18. I don't believe you can diagnose a PD* [personality disorder] *when the personality is still forming.*
>
> Written comment – Female, 30, psychologist

For those providing *treatment*, responses were more varied depending on the participant’s role, type of organisation, and level of experience. Participants reported using a variety of treatment approaches including: medication, education, crisis assessment and treatment, case management, and counselling. Others reported referring or linking to other services.

For those who used counselling or psychotherapy, approaches differed significantly. The choice of therapy was related to various factors such as the scope of the service, previous training, anticipated length of consumer contact with a service, formulation, and individual goals. Common components of therapy included emotion regulation, distress tolerance, behavioural analysis, and trauma-informed practice. For some services, the treatment was specific to another mental illness, such as eating disorder treatment through an eating disorder service. Any participant who reported providing counselling or psychotherapy via a quantitative response was asked to select the type of therapy provided (Table 6). Most participants reported using a mix of approaches, supportive counselling, DBT, and/or CBT. The least common approaches were MBT and psychodynamic therapy.

Table 6. Therapeutic approach utilised when working with people living with personality disorder

Therapeutic approach	'Ever used' this therapy		'Mainly use' this therapy	
	n	%	*n*	%
Supportive	47	39.5%	61	51.3%
Eclectic/mix	29	24.4%	65	54.6%
Cognitive behaviour therapy (CBT)	50	42.0%	44	37.0%
Dialectical behaviour therapy (DBT)	24	20.2%	59	49.6%
Psychodynamic therapy	27	22.7%	15	12.6%
Mentalisation-based therapy (MBT)	22	18.5%	8	6.7%
Schema therapy	30	25.2%	19	16.0%
Acceptance and commitment therapy (ACT)	46	38.7%	35	29.4%
Narrative therapy	37	31.1%	20	16.8%
Trauma therapy	46	38.7%	33	27.7%
Motivational interviewing	49	41.2%	35	29.4%

Presented for the 83.8% of the sample who have provided counselling/psychotherapy, *n* = 119

Participants who reported using DBT (*n* = 81) were asked follow up questions. Among this group, 36.4% were involved with a comprehensive or full DBT program, 57.1% provided individual therapy only, and 6.5% were involved in group therapy only. Those delivering group therapy were asked further questions. According to respondents (*n* = 33), there was an average of 29.0 (*SD* = 15.8) sessions provided, however these ranged between 3 and 50 sessions.

Participants completed the SDM-Q-Doc to assess shared decision-making in treatment (a histogram is presented in Figure 2). Scores ranged 23-54, with a mean score of 44.4 (*SD* = 6.3). The median score was 45. Scores trended positively, indicating a reasonably high level of shared decision-making during treatment. At the time of writing, no categories or cut-off scores are available for this scale so we cannot report responses in categories (for example, 'high' versus 'low' shared decision-making).

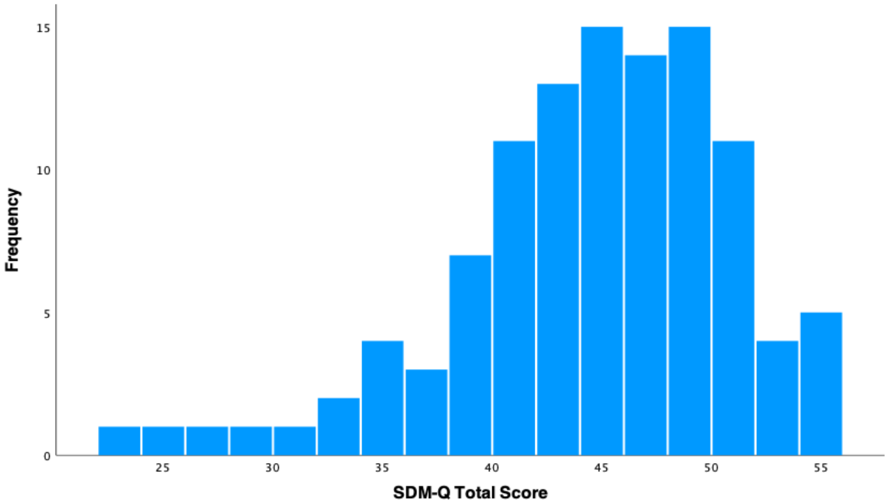

Figure 2. SDM-Q total score

Table 7. Respondents' treatment behaviours on Likert scale from Never – Always/ Nearly Always

Question	*n*	Median response	Mode response
If I believe an adult consumer has personality disorder, I assess, disclose, and explain the diagnosis to them	141	Sometimes	Always/nearly always
If I believe an older adolescent (age 15-17) has personality disorder, I assess, disclose and explain the diagnosis to them	142	Never	Never
If I believe a younger adolescent (age 12-14) has personality disorder, I assess, disclose and explain the diagnosis to them	141	Never	Never
I adapt treatment frequency to the consumer's needs and circumstances	142	Always/nearly always	Always/nearly always
I prescribe medication as a first-line treatment for personality disorder[1]	142	Never	Never
I refer consumers to specialist services if I cannot provide appropriate support	143	Always/nearly always	Always/nearly always

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[1] *Note*: Only around 3% of participants were GPs or psychiatrists, and therefore able to prescribe medication. Hence, this results of this question must be interpreted with caution.

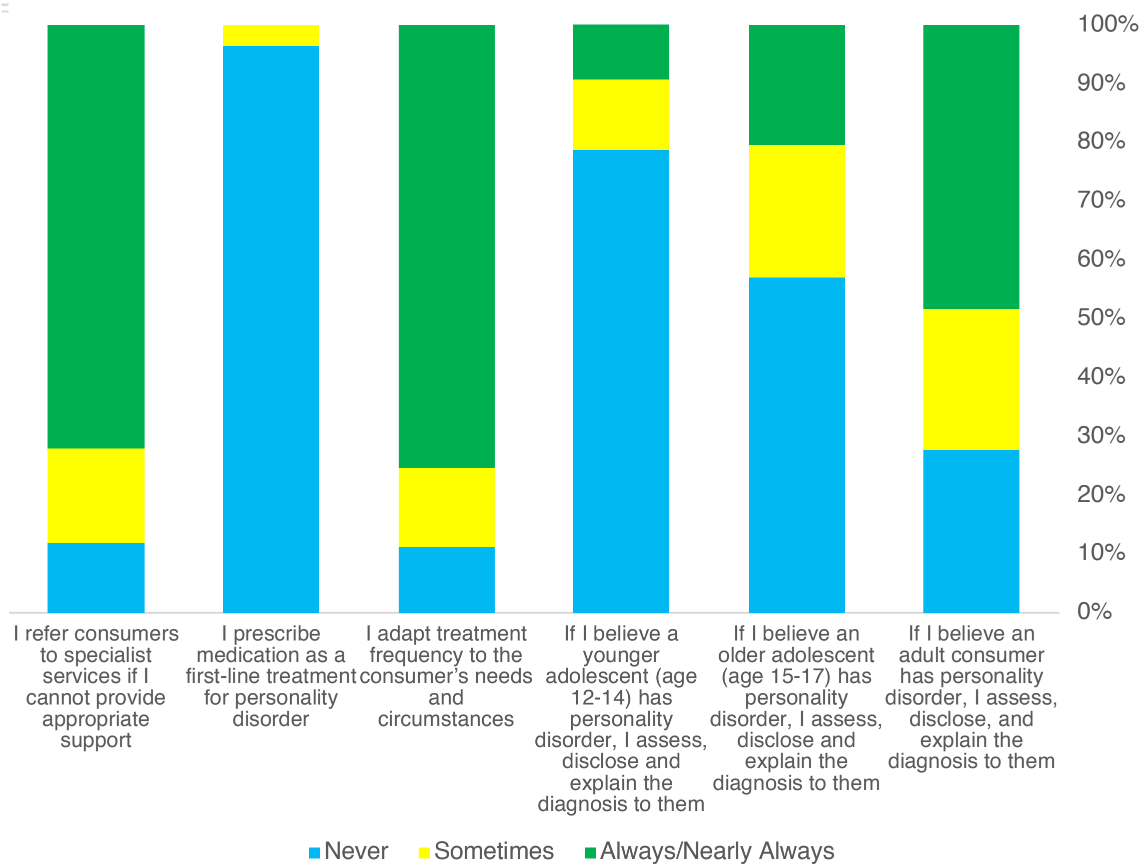

Figure 3. Respondents’ treatment behaviours on Likert scale from Never – Always/ Nearly Always

Participants were asked about the degree to which they involved carers, families and other support persons in treatment (Tables 8-10). Carer involvement was consistent for adolescents with personality disorder, but slightly less consistent for adults with personality disorder. As only the first question assessed intent/consent to involve carers, it is possible that those healthcare professionals who do not regularly involve carers may not have consent to do so.

Table 8. Carer involvement for adults, among participants who work with adults

Question	Total number of respondents	Median response	Mode response
I discuss with consumers if and how they want carers involved in treatment	129	Always or nearly always	Always or nearly always
I inform carers about the consumers' diagnosis	121	Sometimes	Sometimes
I consider the views of carers when it comes to planning treatment	126	Sometimes	Sometimes
I provide carers with information or educational material	131	Always or nearly always	Always or nearly always
I refer carers for their own professional support	134	Always or nearly always	Always or nearly always
I involve carers in treatment processes	130	Sometimes	Sometimes
I inform carers about consumers' risk	129	Always or nearly always	Always or nearly always

Table 9. Carer involvement for older adolescents (15-17), among participants who work with older adolescents

Question	Total number of respondents	Median response	Mode response
I discuss with adolescents if and how they want carers involved in treatment	72	Always or nearly always	Always or nearly always
I inform carers about the adolescent's diagnosis	69	Always or nearly always	Always or nearly always
I consider the views of carers when it comes to planning treatment	72	Always or nearly always	Always or nearly always
I provide carers with information or educational material	75	Always or nearly always	Always or nearly always
I refer carers for their own professional support	75	Always or nearly always	Always or nearly always
I involve carers in treatment processes	69	Always or nearly always	Always or nearly always
I inform carers about adolescents' risk	71	Always or nearly always	Always or nearly always

Table 10. Carer involvement for younger adolescents (12-14), among participants who work with younger adolescents

Question	Total number of respondents	Median response	Mode response
I discuss with adolescents if and how they want carers involved in treatment	39	Always or nearly always	Always or nearly always
I inform carers about the adolescent's diagnosis	37	Always or nearly always	Always or nearly always
I consider the views of carers when it comes to planning treatment	39	Always or nearly always	Always or nearly always
I provide carers with information or educational material	41	Always or nearly always	Always or nearly always
I refer carers for their own professional support	40	Always or nearly always	Always or nearly always
I involve carers in treatment processes	39	Always or nearly always	Always or nearly always
I inform carers about adolescents' risk	40	Always or nearly always	Always or nearly always

For some participants, risk management was an ongoing and formal process, whereas for others it was more brief or informal. Participants reported assessing for both risk to self and risk to others, depending on individual circumstances. Some used structured tools or guidelines to assist risk assessment. Several reported developing safety plans collaboratively with the person living with personality disorder. Participants involved in a DBT program reported using various techniques including crisis survival skills and phone coaching. Some participants reported engaging with emergency services if risk is acute. Some participants emphasised the importance of keeping clear records of risk management and related decisions.

To maintain recovery, participants reported using a variety of approaches such as promoting healthy coping skills and independence, relapse prevention techniques, acknowledging change and growth over time, and using positive reinforcement. Some provided treatment for an extended period of time, but others were required to discharge consumers after meeting a certain target (e.g., finishing a course of treatment or no longer being classified as 'severe'). Some participants who delivered psychotherapy reported decreasing the frequency of sessions over time, or having 'booster' sessions occasionally. Others transitioned consumers to less intensive services.

Awareness of best practice guidelines

Participants were asked to rate how familiar they were with two documents that provide guidelines for treatment of personality disorder on a sliding scale from 0-100. An image of the cover of each set of guidelines was presented. On average, participants were moderately familiar with treatment guidelines, with respondents being less familiar with the *Project Air Treatment Guidelines for Personality Disorders* compared to the *NHMRC Clinical Practice Guideline for the Management of Borderline Personality Disorder* (Table 11).

Table 11. Familiarity with best practice guidelines (scored 0-100)

Guideline	Mean familiarity rating	*SD*
NHMRC Clinical Practice Guideline for the Management of Borderline Personality Disorder	43.7	34.7
Project Air Treatment Guidelines for Personality Disorders	33.9	33.4

Perceptions of mental health system

Participants were asked whether or not they perceived that particular named services and initiatives were meeting the needs of people living with personality disorder. Results are presented in Table 12.

Participants' free text comments expressed a widely held perception that services are underfunded and insufficiently available across Australia. Some participants noted that the services are meeting the needs of some people living with personality disorder, but not the majority. The final column of Table 12 summarises some key points raised by participants via the open text box.

> *There is nowhere near enough funding for these consumers to receive adequate support; most people I know cannot afford a full DBT group program which would be the ideal treatment, it is so expensive. So most people I see tend to just see me for 10 sessions sporadically which is not enough.*
>
> Written comment – Female, 29, clinical psychologist

Table 12. Perception that services and initiatives are meeting the needs of consumers on Likert scale from 'strongly disagree' (1) to 'strongly agree' (5)

Services or initiative	Total number of respondents	Median rating	Mode rating	Themes raised in participant comments
Medicare funding	127	Disagree	Strongly Disagree	Better Access program only provides 10 sessions in a calendar year; this is insufficient for many living with PD who have complex needs.
Public hospital services	133	Disagree	Strongly Disagree	Underfunded, can promote dependence, may discharge too early, consumers have reported negative experiences (for example, being traumatised, stigma and discrimination).
Private hospital services	108	Neither agree nor disagree	Disagree	Expensive, dependent on private health insurance, treatment quality inconsistent.
Primary Health Networks (PHNs)	104	Disagree	Disagree	Operate under a medical model, underfunded.
Emergency or crisis support services	132	Disagree	Disagree	Similar to 'public hospital services' comments above.
Specialist personality disorder services	107	Agree	Agree	Not available in every state, deliver high quality training and treatment if accessible, demand on services very high.
Youth mental health services	105	Neither agree not disagree	Agree	Youth services often underfunded, designed for more mild/moderate mental illness, high demand, youth-friendly.
Dedicated DBT programs	119	Agree	Agree	High quality support; limited availability, can be expensive to access or have long waitlists, not always adhering to standard DBT model.
National Disability Insurance Scheme (NDIS)	101	Strongly Disagree	Strongly Disagree	Difficult to access for people living with personality disorder, rollout incomplete, provides limited services where available.

Attitudes

Participants completed the OMS-HC Total Score; a histogram is presented in Figure 4. The mean score was 44.9 (*SD* = 9.4) and the median score was 43. Scores ranged from 25-77. Results trended towards the middle and lower scores, indicating less stigmatising attitudes. Similar to the SDM-9, at the time of writing, no categories or cut-off scores are available for this scale so we cannot report responses in categories (for example, ‘high’ versus ‘low’ levels of stigmatising attitudes).

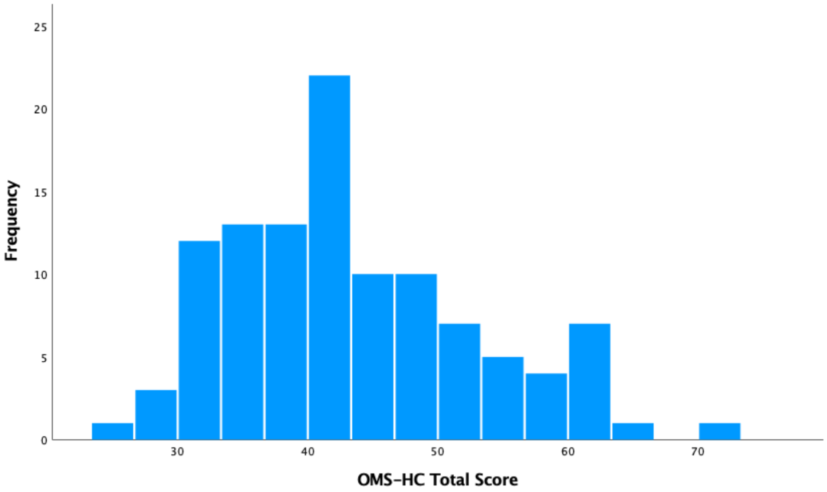

Figure 4. OMS-HC total score distribution

Participants were asked ‘Have you ever noticed colleagues or other health professionals being stigmatising towards personality disorder? For example, calling consumers “attention-seeking” or other negative labels, spreading myths or reinforcing stereotypes that you are aware of’. Among the 138 respondents, 94% answered ‘yes’ and 5.9% answered ‘no’. Participants were invited to comment on their responses in an open text box.

Several respondents provided examples of stigma they had witnessed, including labelling (for example, ‘manipulative’), not taking suicide risk seriously, misunderstanding recovery prospects, and failure to treat people living with personality disorder using person-centric care and incorporating individual goals. Others commented their belief that their colleagues in general are accepting, positive, and hopeful, and noted that they are witnessing stigma less frequently or not at all. Participants attributed stigma to a lack of appropriate education, countertransference, and burnout, expressed through the use of dark humour as way of coping with workplace stress.

> *Unfortunately in the hospital system I have seen a lot of stigma, and labelling, as well as assumptions made about a person with personality disorder. This is especially the case with clients with BPD. (e.g. 'she's so borderline'; 'she's a frequent flyer in the hospital').*
>
> Written comment – Female, 27, clinical psychologist

Participants were asked to list three qualities they believed were integral to working with people living with personality disorder. A word cloud is presented in Figure 5, with larger text representing more common words. The three most common qualities listed were patience, compassion, and empathy.

Figure 5. Word cloud of qualities participants identified as being integral to working with people living with personality disorder

Participants were asked four final open-text questions. Firstly, participants were asked what they enjoy about the work. A minority of participants used this open text box to comment that they do not enjoy the work. Several participants stated they enjoyed the challenge and creativity of the work, finding it meaningful and rewarding to see consumers' quality of life improve. Some commented on building meaningful relationships and admiring the tenacity, courage, insight, and empathy of people living with personality disorder.

> *The treatment is complex/clinically challenging. The individuals I treat are amazing, warm, empathic, funny and interesting.*
>
> Written comment – Female, 45, social worker.

Secondly, participants were asked what they have learned from working with people living with personality disorder. Participants reported that they have developed their therapeutic skills – becoming more patient, setting more boundaries, and making fewer assumptions about consumers. Several participants commented on developing a more thorough understanding of trauma throughout the lifespan, and how resilient people can be. Some participants described an improved ability to recognise their own burnout, triggers, and limitations, and practicing the skills they teach in treatment such as mindfulness and emotion regulation.

Thirdly, participants were asked what they find challenging about the work. Participants most frequently commented on the lack of resources and funding, and interpersonal challenges. Interpersonal challenges included experiencing verbal and physical aggression, idealisation and devaluation, and blaming. Participants indicated that interpersonal difficulties, slow progress, and risk management could trigger strong emotional reactions in themselves including guilt, frustration, stress, anxiety, and self-doubt. Several reported experiencing burnout and vicarious traumatisation. Others reported experiencing challenges within organisations, including poor communication and a high caseload.

> *It is time consuming and emotionally draining. Regular supervision with experienced, skilled professionals is essential to avoid burnout however it is rarely available.*
>
> Written comment – Female, 37, social worker.

Finally, participants were asked to comment on what they felt they needed to support or improve their work with this population. Many participants commented on a desire for more accessible and affordable training in personality disorder treatment. Others reported a desire for more referral options, particularly community-based, long-term, and affordable psychotherapy. Several commented on a desire for improved access to specialist personality disorder services and treatments. Others commented on the need for a cultural and systematic shift that focusses on better understanding personality disorder and providing adequate support – in particular, a boost to the number of Medicare-funded sessions for access to private psychology.

> *I am forced to deliver limited treatment because those seeking help do not have the capacity to fund their recovery fully and do not have their needs recognised in a practical way by Medicare, NDIS, etc.*
>
> Written comment – Male, 33, clinical psychologist.

Multiple regression

A multiple regression analysis was used to test if the certain participant response categories significantly predicted OMS-HC (stigma) and SDM-Q-Doc (shared decision-making) total scores. These tests were conducted in two separate models using the same predictor variables in each model including:

- Gender (male vs female).
- Aboriginal or Torres Strait Islander identity (ATSI vs Not ATSI).
- Service provided (provides Counselling/psychotherapy vs other service).
- Profession (counselling vs other; MHN vs other; psychologist vs other).
- Location (major city vs other region).
- Frequency of contact (works with patients with PDs weekly/daily vs monthly/less than monthly/never).
- Workplace (works in hospital vs other organisations).
- OMS-HC total score (continuous).
- SDM-Q-Doc total score (continuous).

Participants who did not identify with these categories could not be included in the analysis. Neither age nor years working as a healthcare professional demonstrated a linear relationship with the dependent variable, and could not be included in the model.

SDM-Q-Doc total

The results of the regression analysis indicated that the 10 variables included in the regression accounted for 18.6% of the variance in shared decision-making scores ($R^2 = .19$, $F\,[10, 97] = 5.56$, $p < .05$). Out of all variables included in the model, OMS-HC score was the only variable that was found to be a significant predictor of SDM-Q-Doc Total ($\beta = -.37$, $p < .001$), with higher OMS-HC scores predicting lower SDM-Q-Doc scores.

Table 13. Standardised and unstandardised regression coefficients predicting SDM-Q-Doc total scores (*n* = 108)

Variable	Unstandardized coefficients		Standardized coefficients		
	B	Std. Error	*β*	*t*	Sig.
Constant	54.40	3.63		15.01	.000
Male	2.14	1.79	0.11	1.20	.235
ATSI	-0.31	3.68	-0.01	-0.08	.934
Provides counselling/psychotherapy	1.47	1.99	0.08	0.74	.463
Profession: counselling	0.30	1.87	0.02	0.16	.874
Profession: MHN	0.37	1.99	0.03	0.19	.854
Profession: psychologist	-2.30	1.93	-0.18	-1.19	.236
Major city	-0.33	1.30	-0.03	-0.25	.802
Work with PDs weekly/daily	1.07	1.20	0.09	0.90	.373
Hospital organisation	-1.82	1.27	-0.14	-1.43	.156
OMS-HC total score	**-0.24**	**0.06**	**-0.37**	**-3.93**	**.000**

OMS-HC total

Results of the regression analysis for OMS-HC Total indicated that the 10 variables accounted for 17.7% of the variance in stigma scores ($R^2 = .18$, $F(10, 97) = 2.09$, $p < .05$). Similarly, out of all variables included in the model, SDM-Q-Doc Total was the only variable that was found to be a significant predictor of OMS Total ($\beta = -.37$, $p < .001$), with higher SDM-Q-Doc scores predicting lower OMS scores.

Table 14. Standardised and unstandardised regression coefficients predicting OMS-HC Total scores (*n* = 108)

Variable	Unstandardized coefficients		Standardized coefficients		
	B	Std. Error	*β*	*t*	Sig.
Constant	66.43	7.48		8.88	.000
Male	3.08	2.73	0.11	1.13	.262
ATSI	-2.81	5.60	-0.05	-0.50	.617
Provides counselling/psychotherapy	3.40	3.02	0.12	1.12	.264
Profession: counselling	1.47	2.85	0.07	0.52	.606
Profession: MHN	-1.57	3.03	-0.07	-0.52	.606
Profession: psychologist	-3.77	2.94	-0.20	-1.28	.202
Major city	0.18	1.98	0.01	0.09	.929
Work with PDs weekly/daily	0.72	1.84	0.04	0.39	.697
Hospital organisation	-1.06	1.96	-0.06	-0.54	.589
SDM-Q-Doc total score	**-0.57**	**0.14**	**-0.37**	**-3.93**	**.000**

In-depth interviews

In total, there were 57 expressions of interest for in-depth interviews and 17 participants were contacted. Nine participated in an in-depth interview, all conducted via phone. Interviews lasted 35-89 minutes. There were six female participants and three male participants, and mean age was 46.9 (*SD* = 10.7, range = 32-61 years). The mean number of years working as a healthcare professional was 21.1 (*SD* = 10.4, range = 6-36 years). Participants included mental health nurses (*n* = 4), a social worker, a GP, a clinical psychologist, a provisional psychologist/occupational therapist/rehabilitation counsellor, and a social worker/counsellor. A summary of participant characteristics is presented in Appendix A.

Four themes were identified in the thematic analysis: *The thriving clinician, Expertise, Cultural shift,* and *A patchwork approach.*

Theme 1 – The thriving clinician

Participants' responses indicated that a certain type of person is drawn to work with people living with personality disorders, and that certain characteristics are necessary to thrive in this space. These traits might be inherent to certain healthcare professionals – as Mona (46, social worker) said: 'It suits my personality style'. For others, the traits developed over time.

Empathy and understanding were key and, for some participants, personal lived experience of mental illness or trauma allowed them to empathise more with people living with personality disorder. Several commented on the necessity of building a long-term, trusting relationship with people living with personality disorder – and needing to have the interpersonal skills to facilitate this. Collaboration was vital, with the intention of empowering people living with personality disorder to develop their own skillset and work towards their goals. Communication was also valued – both with clients and their families, carers and any other members of their treatment team (if applicable). Managing compassion fatigue and burnout was integral.

> *When you work with clients who have really difficult life experience and really difficult experiences with services, it's really rewarding. And you know, you can't save them all, at all! But I kind of get a strong sense of reward from working with them. It's more about doing the right thing than being liked I guess. I am certainly not always liked!*
>
> Rochelle, 33, occupational therapist, provisional psychologist and rehabilitation counsellor

Some participants commented on these qualities explicitly, while others demonstrated these traits through their interviews. Most participants were passionate about their work and spoke respectfully about people living with personality disorder. They described the work as uniquely rewarding. Many had witnessed a significant change in consumers' quality of life over time.

> *They are people who are struggling at the end of the day, and sometimes they just don’t have the resources available that I might have, or have had… If someone falls off a boat and can’t swim, you don’t tell them they have a swimming disorder! And you don’t attack them for not being able to swim! So I like that you are handing these people a stick, because they are out there fighting their battle.*
>
> Marcus, 51, clinical psychologist

Participants spoke in detail about the challenges of the work, including the need to set boundaries, engage in self-care, and not take things personally if experiencing interpersonal difficulties with a person living with personality disorder. Managing risk and sitting with this anxiety was challenging: ‘the constant worry that one of them will end up dead… it’s quite terrifying’ (Rochelle, 33). Some spoke about thriving with the challenges and unpredictable nature of the work. Several commented on the need to be persistent and resilient in the context of challenging experiences and often slow or non-linear recoveries.

> *I can see improvement in millimetres. I don’t need to see country miles!*
>
> Samuel, 54, community forensic mental health nurse

Several participants acknowledged that most people working in the mental health sector, or in certain healthcare settings, will treat people living with personality disorder. However, not every healthcare professional is going to thrive in that setting – or have the training and expertise (the notion of expertise is explored below). Participants suggested that the choice to work with people living with personality disorder is not always clear or informed. Even for people demonstrating some or all of the qualities described above, the wider context around them made it difficult to thrive. This was most evident in participants who had worked in hospitals or other acute care settings, where interactions were short-term, usually crisis-focused, and with little opportunity for developing a therapeutic alliance. In these settings, participants implied that healthcare professionals are more vulnerable to burnout, frustration, resentment, and countertransference. Even those working in one-on-one settings experienced these challenges. However, they tended to identify and recognise this more actively in interviews. In general, these participants were more self-reflective.

> *People with this diagnosis [BPD] have a way of getting under your skin. A way of affecting you, because they are looking for connection and closeness and yet closeness is the lowest form of currency in their economy. So if closeness is trashed, or abandoned, sabotaged actively, quite easily and quickly… so to maintain that unwavering consistency is a real ideal, it's hard to pull off from the clinician chair, but I do strive towards it. But I am not 100% at pulling that off.*
>
> Robert, 58, social worker and counsellor

Theme 2 - Expertise

What does it mean to be an expert in the personality disorder space? Most participants implied that the most critical component of expertise was education. This facilitated the ability to create a formulation and reach a shared understanding, to work in accordance with evidence-based practice, and to strengthen empathy, resilience, and other traits described above.

Many participants noted that when they first started working in this space, they felt unprepared and overwhelmed. This was mostly attributed to a lack of awareness, training, and education about personality disorder. Despite having the best intentions, several commented that they made mistakes or acted in a way that was unhelpful for the person living with personality disorder.

> *No one is prepared for the first time they work with someone who has a very poor self-regulation as a result of a borderline personality disorder. One needs preparation around boundaries and solidarity of boundaries. You don't have a clue what you are going to need, so absolutely I wish I had been trained.*
>
> Robert, 58, social worker and counsellor

Nearly all participants reported engaging in specialist personality disorder training, beyond what was provided in tertiary studies. Others reported that, for better or worse, most of their learning happened on the job. For many, training was self-initiated and participants had to be proactive about seeking out training and education. The quality and comprehensiveness of training varied – two participants reported travelling to the USA to complete training with DBT creator, Professor Marsha Linehan, whereas others relied on outreach or webinars due to living in a rural or remote area. Similar to written responses in the survey, several participants commented on the need for further training for themselves and colleagues, particularly those outside major cities. As such, outreach training was valued within these contexts. Training was described as critical for increasing knowledge and competence, and challenging myths and the stigma around personality disorder.

> *You know, because DBT says that they are doing the best that they can and they can always do better. So what happens is if the system says, 'they aren't doing the best that they can'? The system is now punishing them. Whereas if I come from a position where I believe that this person is doing the best that they can, okay. So as soon as I do that, it stops me from thinking that they are a horrible individual, or a nasty individual, or a waste of space. Whatever they are doing, they are trying their best.*
>
> Marcus, 51, clinical psychologist

Some very experienced participants implied that despite seeking out training and education, they still did not perceive themselves to be fully trained or competent in the area. This was attributed to the challenging and unpredictable nature of the work, including fluctuating levels of engagement and risk, as well as an ever-evolving therapeutic landscape.

> *We never feel that we know enough, so we always have to go and get more training and keep ahead of the ball.*
>
> Marcus, 51, clinical psychologist

The perception of expertise impacted clinicians' decisions whether or not to diagnose and what treatments to offer, although this was also impacted by factors such as treatment availability and the age of the person living with personality disorder. Often these decisions were left to a psychiatrist when there was a psychiatrist as the head of a treatment team.

One participant working in private practice admitted that he did not want to brand himself as an 'expert' in the area, acknowledging that doing so could attract an overwhelming client load relating to personality disorder. This was despite having had significant training, clear empathy, and a solid knowledge base in the area. He reflected on his reluctance, and acknowledged that he is a relatively 'open' professional but the work involved can be very challenging and unappealing.

This theme suggests that regardless of the level of training, working with people living with personality disorder can bring up self-doubt and uncomfortable beliefs, such as the perception that one is incompetent. However, working in this space may not necessarily involve becoming an 'expert'. Instead, 'expertise' is about accessing specialist training, having the desire to continuously learn and update knowledge, the ability to sit with uncertainty, and to cope with challenges as they appear.

Theme 3 – Cultural shift

Participants acknowledged that there has been a cultural shift in personality disorder awareness and advocacy, both within Australia and internationally. This was attributed to increased public discussion, more specialist services and training opportunities, and a shift in how personality disorders are perceived (they were once predominantly viewed as untreatable). The publication of the NHMRC clinical guidelines in 2012 and a shift to newer versions of the DSM and ICD impacted how personality disorders are conceptualised. For some participants, an increase in awareness of trauma-informed practice, and use of these principles, resulted in a shift in how personality disorder is understood and approached within healthcare settings. Some participants reported an increase in understanding, confidence, and enjoyment of the work over time, particularly attributed to this cultural shift. However, the cultural shift was described as slow, with a lot of hard work involved.

> *There are plenty of people in mental health who do have quite negative attitudes towards people with personality disorders, but I think there are an increasingly enlightened group who are trying to spread that enlightenment. But it's just slow going.*
>
> Mona, 46, social worker

Several participants commented on the need for prevention of personality disorder, and early intervention. They spoke of 'bigger picture' ideas, such as prevention of trauma in early childhood, and introducing skills-based interventions in high schools (such as teaching mindfulness and distress tolerance in school).

Most participants acknowledged that although the culture is shifting, there is still a significant amount of stigma regarding personality disorder. This was usually described from a *third-person* perspective, with many participants eager to provide examples of discrimination they had witnessed by others, but less able to demonstrate insight into how their own behaviour may have contributed to stigmatisation. Participants attributed others' stigma to various reasons, including: a lack of training, the challenges of the work (including countertransference), and myths. Few discussed what contributed to their own stigmatising attitudes. One participant noted the following:

> *Sometimes when a patient is going really well it is not something that you think about. And then when they perhaps aren't going that well, that becomes big… the ones that cause you the biggest headaches are probably the ones you remember the most.*
>
> Susanna, 32, general practitioner

Negative experiences are the most memorable. If healthcare professionals have negative experiences in the context of personality disorder, these will be the ones that stick in their mind. Perhaps these are the experiences that they will share with others as they talk about their work with colleagues or friends. Although the broader culture is shifting, if negative stories are the ones that dominate, the stereotypes will continue to thrive. The data suggest that healthcare professionals may unintentionally be contributing towards the stigma through this process.

Theme 4 – A patchwork approach

Despite a shift in cultural awareness and understanding, most participants reported this did not translate to a meaningful shift in service availability. Many reported that they are under-resourced – most significantly in rural and remote areas, but even in capital cities. This was attributed mostly to a lack of funding, the severity of which differed from state to state. Participants acknowledged that many people living with personality disorder were not requiring tertiary care but current community-based funding streams could not scaffold appropriate care.

> *We are in the stepped* [care] *model. I think that there is a lack of understanding within some PHNs as to what that would actually mean. So the referrals we get are severe, but not severe enough to warrant tertiary intervention. So clients that are too severe for, say, headspace or a private practice psychologist to manage, they are the referrals that we take. We can't maintain the number of cases that the PHN thinks we should.*
>
> Rochelle, 33, occupational therapist, provisional psychologist and rehabilitation counsellor

Due to this difficulty, participants found themselves making do with what they had available in their area – a 'patchwork' approach. In some cases this involved being flexible and taking on multiple roles, such as acting more like a therapist than a case manager, or taking on case management responsibilities despite being a therapist. Often these roles blended together.

> *In my training, we were trained to do therapy and I'm being told that is not my role... it's called case management. And you know we talk through stuff and whatever, and I suppose on some level what I do is sort of resembling therapy.*
>
> Belinda, 50, mental health nurse

Often services were stretched, with long waiting lists. This meant that people living with personality disorder often could not access care at the right place and time. In certain areas, some people living with personality disorder struggled with accessing care for their physical health, as well as housing and other social supports.

> *Where we are* [in remote QLD]*, we have nothing. No homeless shelter. No GPs that bulk bill anymore. So our clients just don't go to the doctor and then they just go to the emergency department for everything. So that's a real frustration, I think the government brought that in. So the clients are not going to the GP, and they are not getting their scripts because they cannot afford the $30 that they have to pay. So that is a challenge.*
>
> Barbara, 61, mental health nurse

Others spoke of the need to approach this work holistically, which is not always possible within service and funding limitations, often working with a limited number of services and with a medical model approach.

> *Funding pressures and looking at short term therapy, you know, centring on the individual and the individual not in context… we spend a lot of times talking about what therapy works, but you know, what about people who are homeless? Can we not remember things like Maslow's Hierarchy of Needs? …It's not just about me providing a service, it's around housing, employment, access to education, access to psychosocial care, supporting my clients who are also supporting other family members.*
>
> Rochelle, 33, occupational therapist, provisional psychologist and rehabilitation counsellor

Discussion

This study explored healthcare professionals' attitudes, experiences, and behaviours towards working with people living with personality disorder. It involved an online survey of healthcare professionals and nine subsequent interviews to explore experiences in-depth. Many participants were passionate about their work, and provided thoughtful responses with a great degree of self-reflection. The results of this study were closely aligned with SANE's previous Spotlight Report into personality disorder, which was conducted from the perspective of people living with personality disorder, and carers, families and other support persons (Carrotte & Blanchard, 2018).

Most participants reported receiving minimal training in personality disorder during their university studies. Several commented on there being insufficient early-stage training and – more often in the case of older participants – being taught information they later found to be inaccurate or against evidence-based guidelines. Few participants reported receiving training in personality disorder as a core competency within their studies. Outside of university, many participants reported seeking out additional training, often driven by their own perceived need rather than being a workplace requirement. Training opportunities were limited by geography and cost, and for many this involved 'cherry-picking' the training that seemed most accessible or interesting to them. There was a sense that the extent of training and professional development required in this field is poorly defined, bringing up questions about what it means to be an *expert* in this field, let alone what it means to be *competent* in this field.

Treatment and support services were informed by a number of factors, including training received by participants, understanding of best-practice principles, confidence, and service-related limitations. In general, participants were only moderately aware of Australian personality disorder treatment guidelines, and were more familiar with the NHMRC clinical guidelines (2012) than with the Project Air guidelines (2015). Regardless, many participants reported that their practices adhered to best practice guidelines, including providing evidence-based psychotherapy in the community and involving carers where possible. Most participants reported assessing and disclosing personality disorder diagnoses for adults, which is recommended, but few reported disclosing this diagnosis to adolescents, which goes against recommendations for BPD (National Health and Medical Research Council, 2012). When exploring the reasons for this, it was apparent that participants were wary of the stigma of BPD, concerned about labelling adolescents, and unsure if this would be beneficial when an adolescent's personality is still developing. However, the main reason cited by guidelines for this recommendation is to facilitate early intervention via referral to effective treatment (National Health and Medical Research Council, 2012).

The guidelines both recommend involving carers and families in the care and treatment planning for both adults and adolescents living with personality disorder (National Health and Medical Research Council, 2012; Project Air Strategy for Personality Disorders, 2015). This guideline was consistently followed for adolescents but less consistently for adults living with personality disorder. In interviews, participants emphasised that some people living with personality disorder are unwilling to give consent for carer involvement, or do not have a carer or family member who would be appropriate to involve in treatment. Hence, this may have limited involvement.

Most participants reported using crisis management and psychotherapy, although this was often done with a degree of case management. DBT and CBT were the most common psychotherapy approaches. This is most likely due to the fact that DBT is the most well-known and researched treatment for BPD (Carrotte & Blanchard, 2018). Furthermore, CBT is known, anecdotally, to be a common psychotherapy taught in Australian universities. However, the evidence base is mixed for CBT for treatment of personality disorder and generally not condoned for treatment of BPD (Carrotte & Blanchard, 2018). Several people reported working in specialist DBT services but the nature of these services differed significantly, with the number of group sessions provided ranging from 3-50 sessions. The standard DBT training schedule incorporates modules to be completed over 24 weeks, and then repeated, making a total of 48 weeks of group skills training. Linehan (2014) suggests expanding to three sets of 10-14 week modules as an alternative. The present study indicates that many DBT programs are being run in a non-uniform manner that is not aligned with evidence-based protocols. This is most likely due to factors such as funding and workplace settings. Unfortunately we were not able to assess what was involved for participants who reported using 'DBT-informed' therapy only. However, research indicates that skills use – taught through attending skills training – is a key mechanism of recovery for people living with BPD (Rudge, Feigenbaum, & Fonagy, 2017).

On a positive note, the majority of study participants demonstrated at least some positive attitudes towards people living with personality disorder. Many reported enjoying the work, and discussed people living with personality disorder with empathy and respect. Many participants reported valuing the relationship they could form, and finding it rewarding to contribute to their recovery. This was apparent through both qualitative and quantitative data.

A minority of participants who clearly demonstrated clear negative attitudes towards people living with personality disorder. Even those with more neutral or positive attitudes acknowledged a number of challenges of this work. On a broad scale, these challenges were related to stigma within services and the general community, and service availability and limitations, with most participants believing that the Australian mental health system is not meeting the needs of people living with personality disorder. In particular, participants were critical of the brevity of the Medicare Better Access Scheme, the difficulty of accessing services through NDIS, and the lack of structured and appropriate treatment options available within public hospitals, emergency services, and PHNs. Many participants reported 'making do' with whatever services are available in their area and desired a significant boost in funding and service availability. Participants also reported more personal challenges associated with working with people living with personality disorder, which were broadly aligned with previous research (for example, Ross & Goldner, 2009; Treloar, 2009; Veysey, 2014). This work often entails consumers who are at a high risk of harm to themselves (or others), who can be inconsistent or hostile at times during treatment, leading to anxiety, frustration, and self-doubt for the healthcare professional. This increased the risk of compassion fatigue and burnout. Many participants reported reflecting on their own countertransference reactions whereas others reported witnessing this in others. Some responses implied that healthcare professionals are unintentionally contributing to the stigma of personality disorder by sharing negative but memorable stories with others, which are subsequently overgeneralised, reinforcing stereotypes.

In the quantitative data, the only variable that significantly correlated with degree of stigma was the extent of shared decision-making with consumers. This is despite a number of variables being included in the model including gender, location, and frequency of contact with people living with personality disorder. Neither age nor years working as a healthcare professional showed a linear correlation with the two variables of interest and could be included in the model. This suggests a significant relationship between these two variables, with participants expressing fewer stigmatising attitudes are more likely to include people living with personality disorder in treatment-related decisions. It is possible that additional variables not included in the analysis explain more of the variance in stigma and shared decision-making, such as amount of training, confidence, or personality-related variables. The study did not have a sufficient sample size to identify any small effect sizes via multiple regression (Field, 2018). Future research should explore these variables with a larger sample in order to identify small effects.

Limitations

There are several limitations to the data and findings presented in this report. Participants were recruited from the broader Australian community to complete an online survey about working with people living with personality disorder. It is probable that the results of the subgroup of healthcare workers who self-selected to participate do not represent the views or experiences of the wider healthcare professional workforce. Indeed, healthcare professionals who avoid working with people living with personality disorder and/or hold stigmatising views about this consumer group may be unlikely to participate in such a study. The data were self-reported, cross-sectional, and subject to respondent bias based on personal experience. There was no way to objectively assess whether participants were employing evidence-based approaches in their practice.

Recruitment challenges resulted in the sample being smaller than planned. The survey was targeting a specific healthcare professional population. Few organisations were willing to share the recruitment notices, including organisations representing psychiatrists and paramedics, according for their lack of representation. Hence, there were few psychiatrists and no paramedics. This also limited the participants available for in-depth interviews, with most participants being mental health nurses, psychologists and social workers. Only around half of those contacted agreed to interviews despite their expression of interest. This may be due to healthcare professionals having a busy workload and being unable to volunteer their time for an interview. Interviews also tended to be more biased to those with more experience, with a mean of 10.4 years of experience as a healthcare professional, limiting generalizability (note that there were few expressions of interest from less experienced healthcare professionals, and those who were contacted did not respond to the interview request).

The questions were worded so they would be relevant to all personality disorders. However, there is variability in the symptoms and challenges associated with the different personality disorder diagnoses. Hence, the results of this study may not reflect the needs and challenges associated with all personality disorders. Participants had more experience working with people living with BPD than with other personality disorders; therefore it is likely that they were answering with this diagnosis in mind.

Future quantitative research should also be undertaken to explore the relationships between stigma, shared decision making, and other relevant variables using and with a larger sample size. This may require changes to the recruitment processes, including liaising with relevant organisations prior to participation to confirm they will share recruitment notices, a longer recruitment period, and considering alternative options for reimbursement.

Conclusion

The results of this study suggest that a subset of healthcare professionals working with people living with personality disorder seek training opportunities relevant to personality disorder out of personal interest, find personal satisfaction working with this consumer group, are frustrated by scarce resources, and would like to see substantive improvements in service provision, training, and professional supervision. Most participants commented on the lack of early, comprehensive training, the overall stigma around personality disorder, and the challenges of working within a mental health system that is not designed to provide appropriate support and services to people living with personality disorder. Several participants also indicated negative attitudes towards people living with personality disorder.

Participants identified that nearly all healthcare professionals will work with people living with personality disorder at some point in their career, and all need a minimum level of competency in appropriate personality disorder treatment. Most participants reported that in order to achieve competency, they had to access additional, specialist training, with opportunities limited by funding and region. Clinicians also need to be able to manage compassion fatigue and burnout, through access to adequate training, supervision, and workplaces that set reasonable workloads. Hopefully, the National BPD Training Strategy (delivered through the Australian BPD Foundation and other personality disorder groups) will begin to fill this gap.

However, the results also indicate that large-scale changes are needed within the Australian mental health system, which in its current form is not adequately meeting the needs of people living with personality disorder. Healthcare professionals may have no option except to provide treatment that they understand is not sufficiently intensive, affordable, evidence-based, trauma-informed, or holistic. Participants indicated that their perception of stigma among healthcare professionals has reduced over time but is still very present, limiting healthcare professionals' willingness to work in this area and their ability to be empathetic and provide appropriate treatment.

Further investigation is required to determine how the Australian mental health system can be improved to better meet the needs of people living with personality disorder. It is known that providing evidence-based support for BPD is cost-effective, providing an average saving of

US$2,987.82 (approximately AUD$3,900) per person, per year, despite variation in health-related costs across studies and countries (Meuldijk, McCarthy, Bourke, & Grenyer, 2017). A significant initial investment is required to increase training and service availability to support healthcare professionals, people living with personality disorder, and carers, families, and other support persons, with an investment in training and service availability necessary. This has the potential to enrich and save lives, as well as be cost effective in the long-term.

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Appendix A. Participant demographics (in-depth interviews)

Pseudonym	Age	Gender	ATSI	State	Profession, years working as healthcare professional	Personality disorders most frequently seen	Type of service
Miranda	37	Female	No	QLD, major city	Mental health nurse, 6	PPD, ASPD, BPD, DPD	Public hospital
Mona	46	Female	Aboriginal	QLD, major city	Social worker, 25	BPD	Public mental health service, private DBT service
Barbara	61	Female	No	QLD, remote	Mental health nurse, 30	PPD, BPD, HPD, AVPD	Public hospital, private hospital emergency department, alcohol and drug treatment
Samuel	54	Male	No	TAS, various locations	Community forensic mental health nurse, 36	ASPD, BPD, PPD, DPD, OCPD	Forensic outreach service
Susanna	32	Female	No	TAS, inner regional	General practitioner, 8	BPD, HPD	Medical practice within youth mental health service
Marcus	51	Male	No	WA, inner regional	Clinical psychologist, 25	BPD, AVPD, DPD	Public mental health service, forensic service
Belinda	50	Female	No	NT, remote	Mental heath nurse, 27	BPD, AVPD	Public hospital
Rochelle	33	Female	No	TAS, various locations	Occupational therapist, provisional psychologist and rehabilitation counsellor, 11	BPD, AVPD, DPD	Charity/not-for-profit
Robert	58	Male	No	WA, major city	Social worker and counsellor, 22	BPD, AVPD	Private mental health practice

Appendix B: Brief summary of psychotherapy approaches

Acceptance and commitment therapy (ACT) – involves noticing and accepting thoughts, emotions and other private events, and taking meaningful action aligned with values

Cognitive behaviour therapy (CBT) – focuses on the relationship between thoughts, feelings and behaviours. CBT helps the person to challenge and overcome automatic beliefs, and to use practical strategies to change or modify their behaviour

Dialectical behaviour therapy (DBT) – involves a combination of CBT techniques with skill development relating to mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness

Family therapy – styles of psychotherapy that involve working with families or couples through direct participation in therapy sessions

Integrationist therapy – involves integrating two or more psychotherapeutic approaches, sometimes called an ‘eclectic’ approach

Interpersonal psychotherapy (IPT) – emphasises current interpersonal and social contexts, such as relationship issues

Mentalisation-based therapy (MBT) – involves improving mentalisation, the process by which people implicitly and explicitly interpret their own actions and others’ actions

Mindfulness – the psychological process of purposefully bringing attention to experiences occurring in the present moment. A key component of therapies such as ACT and DBT.

Psychodynamic therapy – involves identifying and exploring unconscious experiences that cause difficulties in day-to-day life, based on psychoanalytic theory

Schema therapy – focuses on allowing people to meet their emotional needs by implementing adaptive coping styles and healing maladaptive schemas (patterns of thoughts and behaviour)

Transference-focused psychotherapy – a specialised form of psychodynamic therapy with an emphasis on reducing suicidally and self-injurious behaviours and improving relationships