The Provision of Psychological Services for Borderline Personality Disorder in Private Hospital Settings

Final Report

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Private Mental Health Alliance Quality Improvement Project

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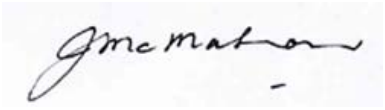
Foreword

There is increasing national and international interest in the treatment of people with diagnoses of BPD, and there is growing evidence of a range of effective psychological therapies for the treatment of BPD, evidence which contradicts the previous perception of BPD as an untreatable condition. Yet, despite our having one of the most comprehensive health care systems in the world, it is relatively difficult for people with diagnoses of BPD to access effective psychological treatments. There is also clear evidence that consumers and carers are seeking psychological treatment (McMahon & Lawn, 2011).

The private mental health sector has an important role to play in the provision of psychological therapies to people with diagnoses of BPD, but we have not previously been able to describe the range of services available.

The Hospital Managers who responded to the survey on which this report is based gave information about the private sector services their hospitals provide; the issues they and their staff face in working with people with BPD diagnoses; issues of staff training; their perceptions of the involvement of other agencies and professionals in the care of their patients; and the impact of BPD on families and carers.

This report provides important information regarding the psychological services available in the private hospital sector, and demonstrates the commitment of the private sector to the treatment of people with diagnoses of BPD.



Ms Janne McMahon
Director and Chair
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Executive Summary

Of the 49 respondents, most (73.3%) were Hospital Managers of stand-alone private psychiatric hospitals whilst the remainder (26.7%) were Hospital Managers of co-located psychiatric units within private general hospitals.

Hospital Managers recorded a median of 10% of patients treated in the last usual month with a primary diagnosis of borderline personality disorder, and 15% with a secondary diagnosis.

Most hospitals (86.5%) provided different group psychological treatment programmes during episodes of overnight inpatient care or episodes of ambulatory care (day patients).

- The principal group psychological treatment approach during episodes of overnight inpatient care was Cognitive Behaviour Therapy (CBT) (37%).
- The principal group psychological treatment approach during episodes of ambulatory care (day patients) was Dialectical Behaviour Therapy (DBT) for most hospitals (78%).
- The principal individual psychological treatment approach during episodes of overnight inpatient care was reported as CBT (48%), with DBT the second most prevalent (22%).
- The principal individual psychological treatment approach during episodes of ambulatory care (day patients) was DBT (43%), with CBT the second most prevalent (22%).

The significant issues arising for clinical staff in the care of patients with diagnoses of BPD, identified by Hospital Managers, were that:

- Patients with BPD diagnoses can be challenging to work with;
- require dedicated, educated, and skilled staff, and
- a coherent, mutually agreed-on approach.

Most Hospital Managers value staff training for various forms of BPD treatment, though training availability, financial constraints, and obtaining the backing of their management pose challenges.

Regarding the use of other agencies and professionals by patients with BPD diagnoses, Hospital Managers agreed on the need for cross agency coordination and case management; and felt that private sector patients did not receive adequate public sector services.

Hospital Managers differed in opinion of the therapeutic value of the involvement of people with BPD diagnoses in a range of services; some viewed it positively and others felt involvement with many agencies could be difficult to coordinate and inhibit the development of patient autonomy.

Hospital Managers felt that family members and carers of patients with BPD diagnoses could become worn out and more education and assistance for family members regarding BPD management was required. There were similar issues of patient-defined confidentiality with family members as with patients with other diagnoses.

Hospital Managers felt hospital admissions for patients with BPD diagnoses needed to be thoughtfully managed for best patient outcomes, and that increased community resources would reduce admission rates.

Background

This Final Report describes the background, methodology and findings of an online survey of Australian private Hospital Managers about psychological services provided to their patients with a diagnosis of Borderline Personality Disorder (BPD). The survey was conducted under the aegis of the Private Mental Health Alliance's (PMHA) Quality Improvement Project (QIP). In 2010 an anonymous donor provided monies to the PMHA to support work to improve consumers' mental health outcomes. This enabled the PMHA to fund a number of projects, including the BPD Project, collectively known as the QIP and conducted over the years 2011 and 2012.

Over the last two decades there has been a national and international groundswell of research into effective treatment for people with diagnoses of personality disorders generally (Bateman and Tyrer, 2004), and Borderline Personality Disorder (BPD) in particular, a condition previously considered untreatable. The National Health and Medical Research Council (NHMRC) has recently published a Clinical Practice Guideline for the Management of Borderline Personality Disorder (NHMRC, 2012). In the context of this burgeoning interest, there is a need for comprehensive information about the sorts of treatments provided by Australian private psychiatric services. We can ascertain some of the types of group programmes offered to people with BPD in specific settings, but group psychotherapy is only one form of treatment. What sorts of psychotherapeutic modalities are used when treating patients individually? Do doctors and hospitals work in conjunction with other community professionals with these patients, and if so with whom? What issues arise for family members or carers?

The Private Mental Health Consumer Carer Network (PMHCCN) has recently undertaken a review of the experiences of BPD consumers and carers (McMahon and Lawn, 2011), which includes information about their experience of psychiatric services. An online survey of Australian psychiatrists was conducted in 2012 which will elucidate information about their treatment of BPD. Information from the unique perspective of Hospital Managers is rare, and lends an additional important dimension to the greater goal of providing optimal services for people with BPD diagnoses.

Using a mental health diagnostic category such as BPD to define a group of consumers who receive mental health services in private hospital settings is a complex task. Though BPD is considered a personality disorder rather than a "mental illness",[1] people with a diagnosis of BPD (either primary or secondary) frequently have diagnoses of other mental illness (discussed below), the symptoms of which compound their condition. The following section presents a brief background of the symptoms and behaviours that attract a diagnosis of BPD, issues of prevalence, co-morbidity, health utilisation and treatment.

[1] There is an ongoing Literature debate about the nomenclature of BPD as "illness" or "disorder;" proponents of conceptualising BPD as an illness rather than disorder cite genetic, familial studies of heritability in support of their biological claim for illness, and or for shifting BPD to being categorised an Axis I illness. See also Meares et al (1999) regarding the Jacksonian model, which contends that many BPD symptoms: affect dysregulation; identity disturbance; somatization; and dissociation are due to disrupted connectivity between the prefrontal cortex and other brain regions; and the growing body of Literature about cognitive deficits (Miller, 2007, p.77).

BPD Definition and Diagnosis

Borderline Personality Disorder is considered a type of personality disorder. Five of the following criteria need to be present for diagnosis under the American Diagnostic System of Classification (DSM) IV:

- frantic efforts to avoid real or perceived abandonment;
- a pattern of unstable and intense interpersonal relationships, characterized by alternating between idealization and devaluation ("love-hate" relationships);
- extreme, persistently unstable self-image and sense of self;
- impulsive behaviour in at least two areas (such as spending, sex, substance abuse, reckless driving, binge eating);
- recurrent suicidal behaviour, gestures, or threats, or recurring acts of self-mutilation (such as cutting or burning oneself);
- unstable mood caused by brief but intense episodes of depression, irritability, or anxiety;
- chronic feelings of emptiness;
- inappropriate and intense anger, or difficulty controlling anger displayed through temper outbursts, physical fights, and or sarcasm;
- stress-related paranoia that passes fairly quickly and or severe dissociative symptoms—feeling disconnected from one's self, as if one is an observer of one's own actions (American Psychiatric Association, 1994, p. 654).

The DSM-IV places personality disorders on a separate axis (Axis II) from other mental disorders (Axis 1), grouping them into Clusters. Borderline Personality Disorder is considered a Cluster B personality disorder, “dramatic, emotional or erratic” (DSM-IV code 301.83).

The International Statistical Classification of Diseases and Related Health Problems (ICD-10), a European system and medical classification list of the World Health Organisation (WHO), defines BPD as: “characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability to outbursts of emotion, and incapacity to control behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.” (WHO, 2005). People may experience marked mood instability, disturbances of self-image, rapid mood shifts, intense, unstable relationships and recurring impulsive self-harming behaviour (NICE, 2009). As with the DSM-IV, organic disease, injury or other psychiatric diagnosis are required to be excluded before a BPD diagnosis is assigned.

Both sets of criteria have been critiqued and are considered poorly validated. Existing classification systems do not account for severity (Tyrer et al, 2010) and generate the frequent comorbidity of several personality disorders across different clusters (Bowden-Jones et al, 2004). The World Psychiatric Association (WPA) Section on Personality Disorders is considering revising descriptions of the major personality disorder groupings so that they make good clinical sense, and enable separation from other disorders with which they are frequently confused, such as attention-deficit hyperactivity disorder (ADHD) (Tyrer et al, 2010; Philipsen et al, 2008).

While there is classification criticism about the classification systems, there is little research about how doctors actually **use** them. Personality disorder (PD) itself is difficult to diagnose (Manning, 2000; Mulder, 1997), and applying these classifications in psychiatric practice is a matter of ongoing debate. Studies also suggest psychiatrists are ambivalent about making a BPD diagnosis because of

the pervasive stigma both in society and from within mental health services themselves, or fearing negative effects for the patient's employment or insurance (Brown, 1987; Whooley, 2010). In addition to these factors, psychiatrists vary in how they perceive and use the diagnostic categories (Whooley, 2010).

BPD Prevalence and Associated Factors

Borderline Personality Disorder is considered the major form of personality disorder (PD), both the most common and most serious (Chanen et al, 2007). There are differing United States (US) estimates of prevalence ranging from 0.7 to 4.6% of the general population (Swartz et al, 1990; Weissman, 1993; Samuels et al 2002; Coid, 2003; Crawford et al 2007). A conservative mid-range of approximately 2% may not seem very much, but people with BPD diagnoses make up about 20% of psychiatric inpatients and 10% of outpatients receiving services (Lieb et al, 2004). Patients with BPD diagnoses make more intensive use of mental health services than some other groups of patients: when followed prospectively over three years, for example patients with BPD diagnoses have been found to use more resources of various types than patients with major depressive disorders (Bender et al, 2006).

The 2% population estimate was challenged by the first large community study of personality disorders, which found a lifetime prevalence of 5.9%, with no significant difference in the rate of prevalence in men (5.6%) and women (6.2%) (Grant et al, 2008). The authors concluded that BPD is far more prevalent than previously recognized, equally prevalent among men and women, and is associated with considerable mental and physical disability. Importantly, 5.9% is much higher than the lifetime prevalence of 0.4% for schizophrenia (Saha et al, 2005) and 1.4% for bipolar disorder (Kessler et al, 2005). Though there are cultural differences between US and Australian populations, for example, in levels of unemployment,[2] socio-economic disadvantage, and availability of health care, this study indicates that the numbers of people whose lives are affected by BPD may be greater than previously recognised.

Most people (74%) diagnosed with BPD have at least one co-occurring Axis II disorder (Barrachina et al, 2011), and strong co-morbidity with Axis I conditions such as serious depressive episodes, and bipolar II disorder (Stone, 2006), making accurate assessment of prevalence difficult. Many databases of mental illness enter a primary diagnosis only, or at best primary and secondary. There is an association of Cluster B personality disorders, including BPD, for example, with major depressive disorders. In a 2001-2002 national US survey when 1,996 participants with major depressive disorder were interviewed three years later, the association with BPD was clearly demonstrated, leading the authors to recommend assessment for BPD in all patients with major depressive disorders (Skodol et al, 2011). People who meet criteria for BPD are more likely to experience substance abuse than people with other psychiatric disorders, except for Anti-Social Personality Disorder (ASPD) (McCann, Flynn and Gersh, 1992). They have high rates of suicide and suicide attempt, with up to one in ten people with BPD diagnoses dying by completed suicide (Paris, 2002; NICE, 2009).

The gender of consumers with BPD remains contentious, with more young women diagnosed than men (Widiger and Weissman, 1991). No gender difference, however, is found in population studies (Lenzeweger et al, 2007; Torgersen, Kringlen and Cramer, 2001). Several studies have looked at

[2] Current US estimate 9.1%, US Bureau of Labour Statistics, 2011; Aus. 5.3% ABS, 2011.

gender differences in DSM personality disorders generally, some of which found Cluster B prevalence higher in **men** than in women (Carter et al, 1999; Samuels et al 2002). The United Kingdom (UK) Office for National Statistics (ONS) 2000 survey for psychiatric morbidity confirmed this finding, with lower rates of BPD in women than men (four per 1,000 compared with 10 per 1,000 in men) (Brazier et al, 2006).

The association of personality disorders including BPD with childhood sexual or other abuse is clearly established (Johnson et al, 1999; Mullen, King and Tonge, 2000), but the clinical picture of adults with a history of childhood sexual abuse (CSA) is highly variable (Mullen, King and Tonge, 2000). Sexual abuse, especially in young children of eight years and under is a significant predictor of both BPD and Post Traumatic Stress Disorder (PTSD) whether or not the perpetrator is a family member. Nevertheless, having this sort of traumatic childhood experience is not a "pre-requisite" criterion for BPD, and a history of CSA is associated with a broad range of emotional and psychological disturbance other than BPD (Mullen, King and Tonge, 2000).

There is limited research about cultural and socio-economic issues associated with personality disorders. Unemployment has been found to be positively related to BPD (Kessler and Merikangas, 2004). In the Baltimore Hopkins Epidemiology of Personality Disorder Study, Cluster B disorders were found to be most prevalent in people who had not graduated from high school (Samuels et al, 2002), and least prevalent in people who continued education after high school. The odds of having a Cluster B disorder declined by approximately 6% for every additional year of age; that is, the older the person was, the less likely he or she was to have a diagnosis of BPD. A significantly higher prevalence of personality disorders has been noted in urban rather than rural communities (Amer and Molinari, 1994), and the prevalence is higher in places of concentrated social disadvantage such as prisons, boarding houses and slums (Mulder, 1997).

There is some evidence for a genetic component to BPD. In a large multinational twin study of community samples in Holland, Belgium and Australia, Distel et al (2008) found genetic influences explained 42% of the variation in BPD features in both men and women, with the variability estimate being similar in all three countries. The relationship between symptoms, psychological mechanisms and neurobiology is unclear (Kernberg and Michels, 2009). Linehan (1993) suggests a Biosocial Theory of BPD essentially as a disorder of self-regulation. People with BPD are viewed as very volatile or unusual in temperament, their condition compounded by repeated experiences of invalidation (Palmer, 2002).

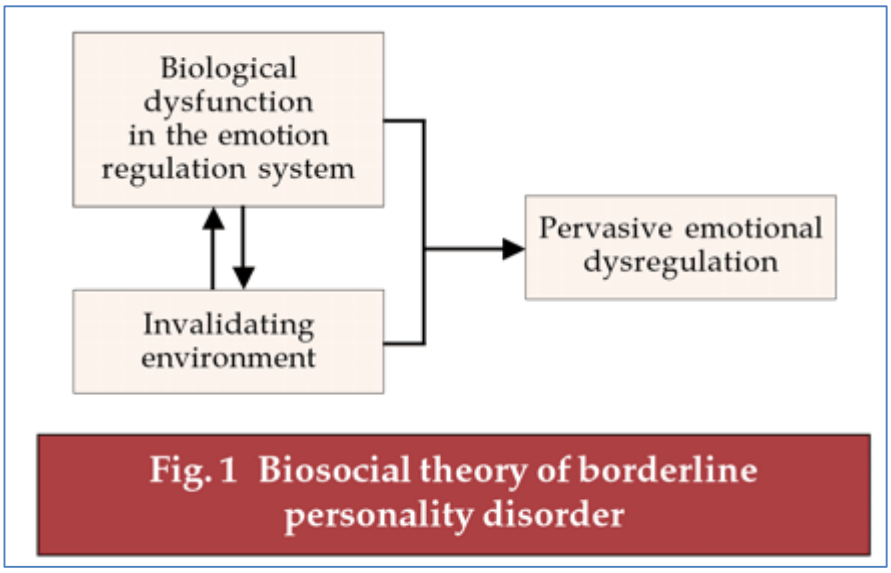

Figure 1: Biosocial Theory of Borderline Personality Disorder (from Palmer, 2002)

Use of Private Hospital–based Psychiatric Services

Compared with psychiatric inpatients without BPD diagnoses, consumers with BPD diagnoses have higher utilisation of mental health services over a range of indicators: in number of presentation times, length of hospital stay for mental health and or substance abuse, number of psychiatrists ever seen, and number of courses of psychotherapeutic treatment (Sansone, Songer and Miller, 2005).

It is difficult to accurately gauge the readmission rates of Australians with any form of mental illness, including people with a diagnosis of BPD. In the public system, it has been suggested that states and territories differ in their ability to track post-discharge follow-up between hospitals and community services, and or other hospitals. During the 2011-2012 financial year, all private hospitals with psychiatric beds participated in the services provided by the PMHA's CDMS. Of those 55 hospitals all stand-alone psychiatric hospitals and the majority of psychiatric units located in private general hospitals were able to submit data to the CDMS. The following analysis is based on the diagnostic details contained within the Hospital Casemix Protocol (HCP) episode records submitted by those hospitals. The data was analysed at two levels.

First, all separations during the period 1 July 2011 through to 30 June 2012 for each patient were aggregated to obtain an indication of the overall number of people who had been given a diagnosis of BPD in respect of any episode of care provided. Patients were identified as having had a primary diagnosis of BPD if any separation, whether for acute overnight inpatient care or ambulatory care (including sameday and overnight for sameday admissions), if they had had a principal ICD-10-AM diagnosis of F60.31 "Emotionally unstable personality disorder, borderline type." Patients were identified as having a secondary diagnosis of BPD if they had any separations with an additional diagnosis of F60.31 but no separations with a principal diagnosis of F60.31. The results of that analysis are given below in Table 1.

Second, the episode level data was disaggregated into days of care, with each day of care being assigned diagnoses on the basis of the diagnoses given to the episode within which the day of care was provided. That data was then aggregated to obtain an indication of the volume of care provided

in situations where BPD was explicitly identified as one of the diagnoses for which that care was required. The results of that analysis were stratified by service setting, and are given in Table 2. To obtain an indication of the variability between hospitals in the provision of care to patients with BPD, the results were also stratified by hospital and then ranked, both in terms of the order of the within-hospital proportion of care provided for BPD, and also in terms of the overall between-hospital proportion of care provided for BPD.

Table 1: Patients seen at any time during the 2011-2012 Financial Year

Total number of patients for which valid HCP episode records were available	26,108
Having any admission where their primary diagnosis was BPD	1.63%
Having any admission where BPD was given as a secondary diagnosis	5.72%
Having any admission with a primary or secondary diagnosis of BPD (F60.31)	7.99%

Table 2: Total days of care provided during the 2011-2012 Financial Year.

Acute Overnight Inpatient Care	634,272 days of care
With a Primary diagnosis of BPD	1.36%
With a Secondary diagnosis of BPD	6.40%
With either a Primary or Secondary diagnosis of BPD	7.77%
Ambulatory Care (Sameday admissions, etc.)	171,487 days of care
With a Primary diagnosis of BPD	2.67%
With a Secondary diagnosis of BPD	4.51%
With either a Primary or Secondary diagnosis of BPD	7.18%

Variability between Hospitals in the proportion of Total Days of Care provided for BPD in the Acute Overnight Inpatient Care service setting

There is substantial variability in the volume of acute overnight inpatient care provided for BPD by hospitals. Figure 2 ranks hospitals according to the proportion of each hospital's total days of acute overnight inpatient care provided for BPD. The median of the distribution is 6.0% and the interquartile range is 2.2% to 9.2%.

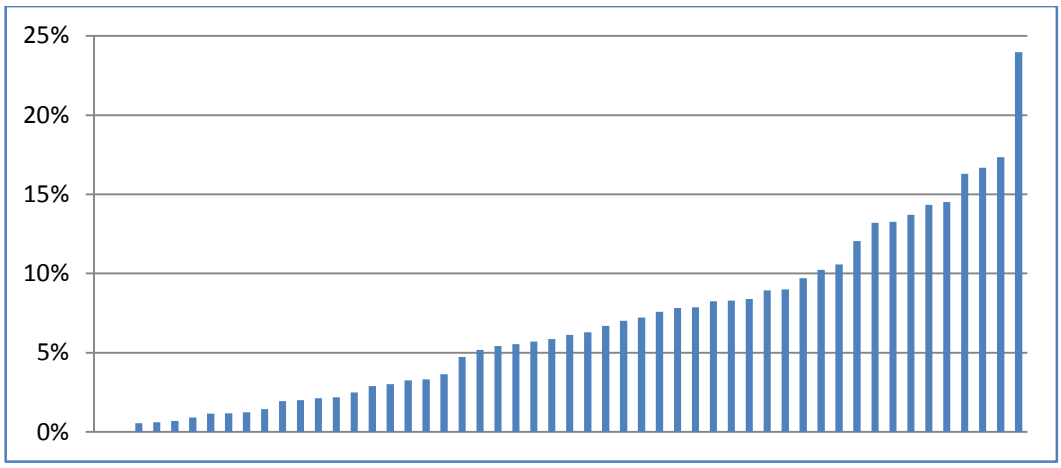

Figure 2: Within-hospital variability in the proportion of Acute Overnight Inpatient Care provided by all hospitals for BPD.

Figure 3 ranks hospitals in terms of the relative volume of care for BPD they provided as a proportion of the total days of acute overnight inpatient care for BPD provided in sum by all hospitals. Just over half (51.2%) of all such care for BPD was provided by 7 hospitals, whilst just under three quarters (74.4%) was provided by 17 of the 51 hospitals on which the analysis was based.

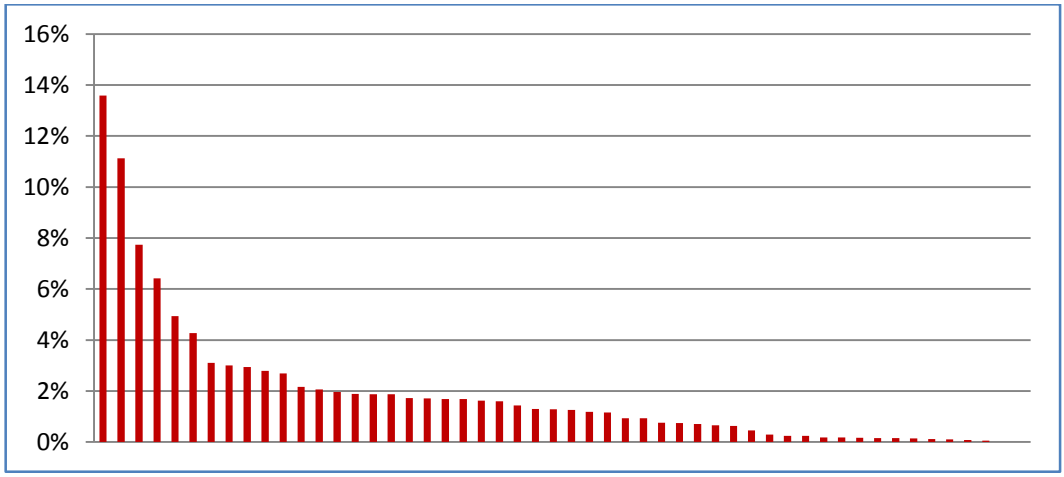

Figure 3: Between-hospital variability in the proportion of Acute Overnight Inpatient Care provided by all hospitals for BPD.

Variability between Hospitals in the proportion of Total Days of Care provided for BPD in the Ambulatory Care (Sameday, etc.) service setting

There is also very substantial variability in the volume of ambulatory care provided for BPD by hospitals. Figure 4 ranks hospitals according to the proportion of each hospital's total days of ambulatory care that was provided for BPD. The median of the distribution is 2.8% and the interquartile range is 0.0% to 6.1%.

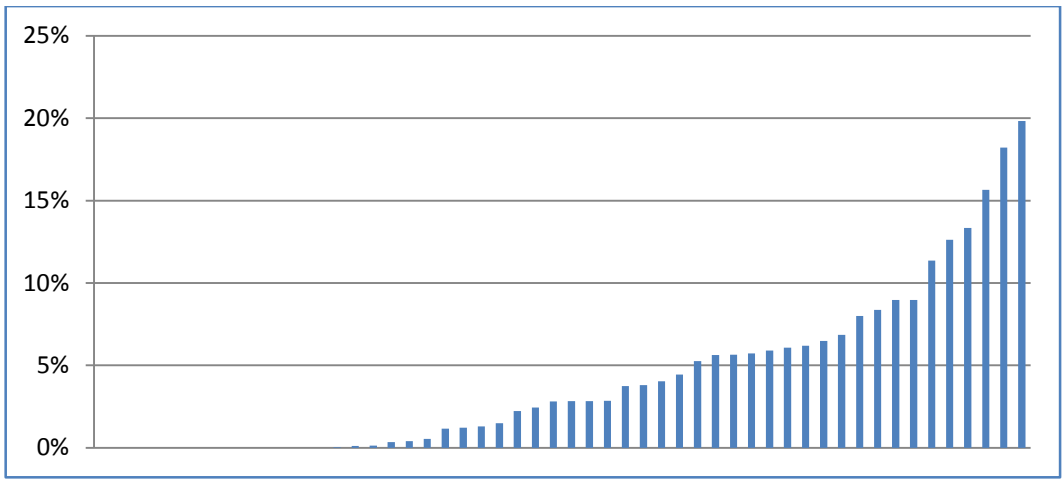

Figure 4: Within-hospital variability in the proportion of Ambulatory Care provided by each hospital for BPD.

Figure 5 ranks hospitals in terms of the relative volume of care for BPD they provided as a proportion of the total days of ambulatory care for BPD provided in sum by all hospitals. Just under half (48.8%) of all such care for BPD was provided by just three hospitals, whilst just over three quarters (75.2%) was provided by seven hospitals. Thirteen of the 51 hospitals on which the analysis was based did not provide any ambulatory care for BPD.

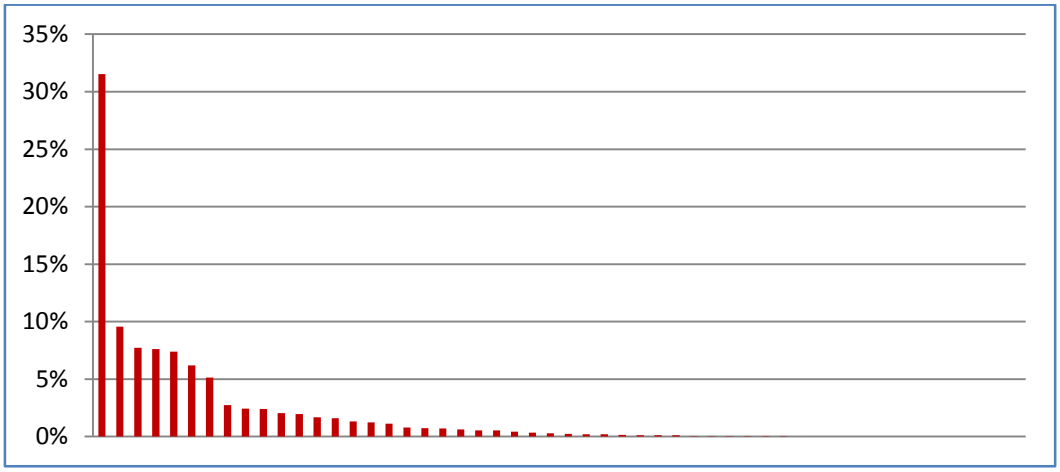

Figure 5: Between-hospital variability in the proportion of Ambulatory Care provided by all hospitals for BPD.

Psychological Treatments for Borderline Personality Disorder

The Australian Clinical Practice Guideline for the Management of Borderline Personality Disorder Recommendation is that people with BPD diagnoses should be provided with structured psychological therapies specifically designed for BPD, conducted by one or more health professionals who are adequately trained and supervised (NHMRC, 2012, p.2)

It is only in the last two decades that a concerted effort has been applied to the development of effective psychological treatments for people with diagnoses of BPD, dispelling the notion of BPD as untreatable (Bateman & Tyrer, 2004). Psychotherapy for people with diagnoses of BPD has been

broadly described in three main categories: psycho-analytically oriented, cognitive behavioural and supportive. In practice, therapists often use different strategies borrowed from all three of these approaches (Morris-Yates, Rosenfeld and Pring, 2012).

Psycho-analytical models are based on the theory that unconscious conflicts underpin the extreme swings of temperament and behaviour experienced by people with diagnoses of BPD. Psychic "integration" is sought through careful review of the person's radically divergent attitudes (Stone, 2006). In the process the emotions people feel about important early figures such as parents are theoretically attributed or transferred to the therapist, the concept of transference. The therapist then uses these emotional attributions to raise awareness in the person about his or her inner conflicts. Kernberg, Clarkin and Yeomans' (2002) transference-focussed therapy (TFP), Young's schema-focussed therapy or schema-focussed cognitive therapy (SFT; Bricker and Young, 1993) and Bateman and Fonagy's mentalization-based therapy [3](MBT; Bateman and Fonagy, 2004; 2006) are some examples of approaches using elements of psychodynamic psychotherapy, also known as Insight-oriented therapy, which is informed by psychoanalytic theory.

Mentalization-based therapy perceives the basic problem for patients with BPD diagnosis as a reduced capacity to "mentalize" or reflect on their internal experiences and mental states. Therapy focuses on improving the capacity to consider one's intentions and motivations, hence improving the quality of satisfying relationships; at increasing tolerance for distress; and at minimising impulsive, destructive behaviour (Yeomans, Levy and Meehan, 2012).

Cognitive behavioural approaches focus on observable behaviours and patterns of thought with the aim of reducing "all or nothing" ways of seeing the world, improving emotional regulation and increasing feelings of self-worth and identity. Their efficacy is most clearly demonstrated in Linehan's Dialectical Behaviour Therapy (DBT) (1993), which has gained momentum internationally. Though there is evidence of efficacy across a broad range of approaches, much of the research about efficacy and outcomes of psychological treatment has been demonstrated for DBT. DBT treatment combines validation techniques and problem solving strategies and is conducted principally in groups. A key concept of DBT is the Zen Buddhist notion of mindfulness, teaching people to be somewhat detached and observing of their experiences, rather than feeling overwhelmed by them, therefore having more mastery of them (Palmer, 2002).

An Australian example of DBT is Pasieczny and Connor's (2011) randomised controlled study comparing 84 women and six men from a large inner city mental health service who received six months of DBT consisting of individual psychotherapy once a week, weekly group skills training, phone coaching access between sessions, and therapist attendance at weekly DBT consultation sessions. A control group received treatment as usual (TAU): clinical case management engagement, ongoing assessment, planning, linking with community services, carer consultations, and assistance with expanding social networks. The study found that DBT was more clinically effective and cost effective than TAU, despite the staff having modest training, no external supervision and using multidisciplinary staff as non-dedicated therapists. Clinical improvements were made on measures of suicidal behaviour, non-suicidal self-injury, levels of service utilisation, depression, anxiety and general symptom severity within six months (Pasieczny and Connor, 2011).

[3] Mentalizing is described as: "the process by which we make sense of others and ourselves, implicitly and explicitly, in terms of subjective states and mental processes" (Bateman and Fonagy, 2010, p. 11). People who are vulnerable constitutionally and/or subject to early trauma are viewed as having diminished social/cognitive capacities.

Systems Training for Emotional Predictability and Problem Solving, (STEPPS) is a 20-week manual CBT-based group treatment programme for BPD outpatients combining cognitive behavioural elements and skills training with a systems component (Blum et al, 2008). In a trial comparing a group who experienced STEPPS and TAU with another group who only had usual treatment, the intervention group had less depression and broad-based improvements in affective, cognitive, impulsive, and disturbed relationship domains assessed by the Zanarini Rating Scale for Borderline Personality Disorder (Zanarini et al, 2003). Impulsivity was significantly reduced, as were levels of negative thoughts and feelings. There was a reduction in suicidal and self-harm behaviour and less crisis utilization, with the reduction of emergency department presentations being statistically significant (Blum et al, 2008). STEPPS originated in the University of Iowa and is widely used in mental health facilities in the Netherlands (Bos et al, 2010).

Supportive therapies emphasise a therapeutically empathic attitude to a person's sense of being very alone. An example is interpersonal therapy (IPT), a time-limited structured supportive therapy first developed for people with major depressive illness (Robertson, Rushton and Wurm, 2008).

The schema-focussed cognitive therapy (SFT) described above is an example of the aggregation of several approaches, combining aspects of cognitive-behavioural, interpersonal, experiential and psychoanalytic therapies in working with life-long patterns of maladaptive behaviours (Bricker and Young, 1993). Limited re-parenting has been described as central to schema-focused therapy, based on the assumption that patients' fundamental emotional needs were not met by their parents, or that the parents traumatized the patient. The therapist in this model provides the experience of having basic emotional needs met by offering himself or herself as a parent figure (Yeomans, Levy and Meehan, 2012). Altieri (2011, p. 57) notes that though there is limited research about the treatment efficacy of SFT, the evidence base is nevertheless steadily expanding (Giesen-Bloo et al, 2006; Farrell, Shaw and Webber, 2009; Bamelis, Evers and Arntz, 2012). Some Australian psychologists offer SFT treatment, and veterans with PTSD who experienced SFT have demonstrated decreased psychopathology (Cockram, 2009). Western Australia is currently hosting a large international multi-site randomised controlled trial of group schema therapy for BPD to investigate its efficacy in six countries, and training has been conducted in Australia and NZ since 1993.

Studies of clinical trials of psychological treatments for BPD are difficult to assess on a number of levels. Few use control groups for comparison of the effect of interventions. Randomised trials are almost always run in short time-frames of 12 months or 18 months, in contrast to the clinical view that long term treatments are essential for BPD (Kernberg and Michels, 2009). There is a great deal of difference in the way populations are defined. The co-occurrence of other personality and Axis I disorders discussed above, needing only five of the nine operational criteria present for diagnosis, make for a degree of variation in the people who take part in trials (NICE, 2009). Psychological interventions are typically delivered by psychiatrists, psychologists and mental health nurses with extensive experience and training in treating people with BPD diagnoses, making it hard to assess treatment models independent from the effect of those delivering them. Studies use different outcome measures which may not apply to all people with BPD, such as rates of self-harming behaviour, hostility and impulsivity (NICE, 2009). Lastly, trials run by the proponents of particular therapies are more likely to have positive findings than those independently run, irrespective of the rigour of methodology (Luborsky et al, 1999).

Pharmacological Treatments for Borderline Personality Disorder

Treatments for BPD often combine psychotherapy and medication, though there is little consensus about, and controversy over the use of medications (Crawford, 2007; NICE, 2009). [4] The Clinical Practice Guideline Recommendation is that doctors should not choose medicines as a primary treatment for BPD, as medicines have only modest and inconsistent effects, but do not change the nature and course of BPD itself; and that the use of medicines can be considered in acute crisis situations where psychological treatments are not sufficient (NHMRC, 2012). The National Institute for Health and Clinical Excellence (NICE) clinical guideline recommends against any drug treatment for people with diagnoses of BPD specifically, except for use in people with comorbid conditions (NICE, 2009). The guidelines concede there is some evidence that drug treatments can reduce the severity of specific symptoms in the short term, that for example where there is a diagnosis of comorbid depression, psychosis or bipolar disorder, the use of antidepressants, antipsychotics and mood stabilisers respectively would be within their licensed indications (NICE, 2009, p. 26), but state that antipsychotic drugs should not be used for medium or long term treatment of BPD, given no evidence that they alter the fundamental nature of the disorder in the longer term. The American Psychiatry Association (APA) guidelines recommend pharmacological treatment for symptoms of affective dysregulation, problems of behaviour and impulse control and cognitive-perceptual difficulties (APA, 2001).

There is a literature exploring the efficacy of pharmacotherapy in the treatment of BPD. The current evidence from a Cochrane Collaboration systematic review of randomised controlled trials suggests that drug treatment, especially with mood stabilisers and second-generation antipsychotics, may be effective for treating a number of core symptoms and associated psychopathology, but the evidence does not currently support effectiveness for overall severity of borderline personality disorder. Pharmacotherapy should therefore be targeted at specific symptoms (Lieb et al, 2004). With regard to the use of the atypical neuroleptic olanzapine, for example, in a 12 week randomised double-blind placebo-controlled study of olanzapine treatment for BPD, both olanzapine and control groups showed significant though not statistically significant improvements on over-all symptoms (Zanarini and Frankenburg, 2008).

In practice many people with BPD diagnoses have been found to take multiple medications (Lieb et al, 2004; Zanarini et al, 2004), some for comorbid Axis 1 conditions.[5] In Pascual et al's (2007) prospective study, for example, most people with BPD diagnoses who presented to the psychiatric emergency department had medication prescribed; psychotropic drugs were prescribed more often to men, and were associated with high risk of danger to others, less ability to take care of self, and higher use of drugs and psychosis.

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[4] High proportions of people with BPD diagnoses take medications (Lieb et al, 2004). In the McLean Study of Adult Development, a longitudinal study of BPD (Zanarini et al, 2003), 75% of BPD participants had been prescribed combinations of drugs at some time, and antidepressants, mood stabilisers and antipsychotics were commonly prescribed. No psychotropic drug is specifically licensed for BPD management (NICE, 2009). Haw and Stubbs (2011) conducted a study of medication use in 79 patients with BPD diagnoses in a secure hospital offering services to people with "severe" BPD, finding the use of off-label psychotropic drugs, particularly clozapine, to be very common. Of these 79 patients, 80% received one of more psychotropic medications, and almost half (48%) received two or more.

[5] Joel Paris, McGill Professor of Psychiatry, stated at an APA meeting that drugs were vastly overused in treatment of all the personality disorders (Psychiatric News, July 7, 2006). "*The problem is that there is no science to support polypharmacy.*" (Gans and Grohl, 2007).

Descriptive Studies of BPD Models of Care and Treatment

Though there is a plethora of studies and trials focussing on various forms of treatment efficacy, there are few research studies trying to assess how BPD is actually treated in everyday clinical services. Research has generally focussed on assessing the efficacy of specific treatment delivery, not service configuration (NICE, 2009). In Australia recent mapping of BPD services has occurred at both state and federal levels. The following section describes the few descriptive studies available about services for people with diagnoses of BPD, both overseas and in Australia.

A survey of Mental Health Trusts in England in 2002 (National Institute for Mental Health in England, NIMHE, 2003) found that 17% provided a dedicated PD service, 40% provided some level of service and 28% provided no identified service at all. In 2004, the Department of Health and the Home Office commissioned NIMHE to deliver a National Workforce and Training Programme aimed at improving access to treatment by investing in workforce capabilities and continuing professional development. In 2005 local UK commissioners and stakeholders developed Capacity Plans for personality disorder services aimed to facilitate and support the development of appropriate services locally and regionally by mapping current services; highlighting need and demand in services; defining pathways through services; identifying the capacity of current services and outlining development targets (Crawford et al, 2007). There were subsequently 11 PD-dedicated pilot community based programmes established to complement these activities. Diagnoses of BPD or PD were made when participants entered the services.

The evaluation of these dedicated services provided information about "the shape" of BPD services in the UK from the perspective of both users and service providers. Despite a great deal of heterogeneity in terms of organisations and content of interventions, the research team concluded that in general, services needed to deliver psychological and social interventions, provide opportunities for peer support and help people access leisure activities, training and employment. They should take on responsibility for coordinating care and consider accepting self-referrals. There was consensus about the principles underpinning service delivery, including the need for open communication, explicit boundaries, consistency of approach and support for service providers (see below 5.5). Services needed to be delivered over relatively long periods of time, and to have transition planning in place before people left. There was disagreement however, about important issues such as the role of outreach services and the place of medication. Service users valued the personal qualities of staff and the availability of peer support. Staff identified a need to be robust in the face of risk, and skilled and confident in using behavioural models of treatment. Managers needed to accept regular staff turnover as some staff found people with PDs difficult to work with. Complex diagnostic questions occurred with clients with comorbid BPD and ASPD, leading to the need for increased flexibility working with people with ASPD (Crawford et al, 2007).

Other studies have examined users' perspectives of services, some in community mental health service settings in the UK. In a qualitative study about recovery[6] from BPD, for example, by Katsakou

[6] Just under half the consumers (48%; n=24/50) objected to the word "Recovery" to describe their progress, feeling it implied too dichotomous a classification of problems, in which Recovery is the improbable goal of being entirely symptom free. (Katsakou et al, 2012). It is interesting to note that recovery for these people meant developing confidence and acceptance of self, learning to control their emotions, improving their relationships and employment prospects, and making progress in symptoms of suicidality and self-harm. Recovery was perceived to be a process of dynamic fluctuation, with periods of improvement followed by times when life was difficult, rather than a linear experience.

et al (2012), service users expressed the view that some of the therapies they received such as DBT or MBT had too narrow a focus on subjects like relationships or self-harm.

There have been British surveys of psychiatric hospital services **in general** aimed, among other things, at acquiring information on service provision, which describe PD services. A national survey of 79 psychiatric day hospitals providing various degrees of crisis intervention, psychotherapy, rehabilitation for chronic disorders, and social rehabilitation and support was conducted, providing diagnostic information and treatment activities about all groups of patients, including people with PDs. Of the clients admitted in the prior 12 months, 75% had diagnoses of PD. In terms of the day hospitals' aims and functions psychotherapy and social rehabilitation were positively correlated.[7] The authors recommended further research into the effectiveness of day hospitals (Briscoe et al, 2004).

In response to the US House of Representatives' Committee on Appropriations request in House Report 111-220, the Substance Abuse and Mental Health Services Administration (SAMHSA) conducted an extensive literature review and gathered input from leading experts in the field of BPD research, treatment, and services; consumers and family members; and national organizations (US Department of Health and Human Services, 2011). Though this report describes programmes for forensic patients with BPD specifically designed to reduce recidivism, and the types of therapeutic programmes currently available, it does not provide details of the extent of services. SAMHSA's National Registry of Evidence-based Programmes and Practices (NREPP) lists DBT and Psycho-educational Multifamily Groups as two specific evidence-based practices for BPD.

Some surveys have described clinicians' lack of education, resources and confidence in treating BPD in outpatient settings. Ogrodniczuk, Kealy and Howell-Jones (2009) developed a 13 Item on-line questionnaire distributed to clinicians in British Columbia, Canada. The questionnaire was emailed to all 291 clinicians working in community mental health centres and outpatient clinics in the largest health authority within the province of British Columbia. The survey asked respondents if they provided treatment for BPD, and the type, format and duration of any treatment provided. It also inquired about the level of confidence clinicians had in treating BPD, their opinions about optimal treatment and availability of treatment. Nearly all the respondents perceived significant unmet needs for people with BPD diagnoses, citing the following three barriers: lack of resources (86%); lack of education or support for clinicians (79%) and lack of clinician confidence in treating BPD (68%). Only a third provided psychotherapy for BPD, with DBT being the most prevalent, and respondents demonstrated a relatively low degree of awareness of the efficacy of psychodynamic therapies. The authors concluded that many clinicians "are simply doing what they can, on an ad hoc basis, with limited confidence in their ability to manage a difficult-to-treat condition" (Ogrodniczuk, Kealy and Howell-Jones, 2009, p. 453).

Surveys about specific treatment models such as DBT may incorporate more generic questions about services for people with diagnoses of BPD. In a Report about the use of DBT in New Zealand (NZ), Te Pou (2008), the National Centre of Mental Health Research, Information and Workforce Development researched the views of 21 district health board general managers and clinical leaders, together with a sample of consumer advisors, DBT leaders and clinicians. This was done through phone calls and email, with follow up to clarify issues of service provision and views about treatment. They found that nine district health boards provided specialist services for people with BPD, while 11 had no specialist services. Of the 11 district health boards that did not have a specialist service for

[7] Spearman's rank correlation coefficient (rs=0.234, *P*=0.045).

BPD, six used DBT to some extent within their general service, and others as only one of a selection of treatments in a range of options as they worked individually with clients. Two health boards focussed on other treatment alternatives, with staff attending MBT and Clinical Behavioural Therapy trainings in preference to DBT. Canterbury, the only district health board with a specialist service for BPD not using DBT, used an MBT programme (Te Pou, 2009).

There are currently Australian initiatives to describe the kinds of services available for people with diagnoses of BPD in the public sector at both state and national levels. As described above the Australian BPD Expert Reference Group (ERG) is in the process of mapping services in both public and private sectors. The South Australian public sector has also undertaken a review of the current status of BPD service provision.

Objectives, Design and Conduct of the Survey

Objectives

The objective of the Hospital Managers' Borderline Personality Disorder Project is to conduct a scoping exercise of models of care currently used for the treatment of people with a diagnosis of BPD who are admitted to private hospitals with psychiatric beds.

The project brief identifies the following information to be collected:

- diagnosis of BPD;
- number of people being treated for BPD;
- types of treatments being used for BPD;
- other health professionals involved in the care of people with BPD diagnoses;
- services hospitals are able to offer; and
- issues clinicians or managers may have encountered in delivering BPD services.

Oversight and Governance of the Borderline Personality Disorder Survey

The oversight and governance of the Hospital Managers' Borderline Personality Disorder Survey was conducted by the PMHA QIP Steering Committee, with ongoing review from the Director of the PMHA CDMS and the PMHA Expert Adviser.

Survey Methodology

The following section provides a description of the methodology of the PMHA Hospital Managers' Borderline Personality Disorder Survey.

Survey Delivery Mode

Online surveys are increasingly popular, precluding the costs and time of data entry and printing. Online surveys have been found, however to have a 10-11% lower response rate than other modes of survey delivery (Manfreda et al, 2008). Ultimately an online survey was considered the most appropriate and cost effective form of survey delivery, whilst acknowledging the inherent biases and the QIP's limited time-frame and resources. SurveyMonkey was chosen as the online questionnaire software.

Development of the Survey Instrument

A brief literature search was conducted for similar studies as described above (see 1.5). As no specifically comparable instrument for use with Hospital Managers could be found, an original survey was compiled.

Recruitment and Sampling Frame

The advice of the Australian Private Hospitals' Association (APHA) Psychiatry Committee was sought with regard to the most effective ways of recruiting Hospital Managers to the survey. Information about the survey was distributed via APHA electronic bulletins and through the informal networks of APHA Psychiatry Committee members. The 58 Hospital Managers or Managers of co-located

psychiatric units within private general hospitals whose hospitals contribute data to the PMHA CDMS were emailed with an invitation to participate which included a link to the survey site.

Conduct of the Survey

The survey was conducted from the 15th October until November the 11th 2012.

Data Analysis

Data collected in the course of the survey was exported from SurveyMonkey and cleaned prior to the conduct of analyses of quantitative data within MS Excel. Thematic analysis of open ended responses was undertaken, a process of identifying and defining major themes and patterns in the text, and looking closely at the relationships between them (Boyatzis, 1998).

Findings

Response rate and characteristics of those who responded

The overall response rate was 84% (n=49/58).

Of the 49 respondents, most (73.3%) were Hospital Managers of stand-alone private psychiatric hospitals and over a quarter (26.7%) were Hospital Managers of co-located psychiatric units within private general hospitals. Given stand-alone hospitals constitute approximately 53% of CDMS data contributors, and co-located units 47%, this sample was more representative of the BPD services of stand-alone hospitals than of co-located units.

The hospitals and co-located units were from each state of Australia, with 31.1% being from South Australia (SA), Western Australia (WA) or Tasmania; 31.1% from New South Wales (NSW) or the Australian Capital Territory (ACT); 26.7% being from Victoria and 11.1% from Queensland. The geographic distribution of PMHA CDMS contributing hospitals is approximately 19% from SA, WA and Tasmania combined; approximately 40% from NSW and the ACT; 21% from Victoria; and 19% from Queensland. As could be expected with such a high response rate, all Australian states and territories were well represented, though NSW and the ACT, and Queensland hospitals were somewhat under-represented, and the remaining states and territories were somewhat over-represented in the sample.

In a relatively small sample of Hospital Managers, and with a very high response rate, maintaining confidentiality was essential, hence further information that would characterise responders from the small number of non-responders was not sought.

Estimates of the proportion of patients with BPD

Hospital Managers were asked what proportion of patients treated in their facility in their last usual month had a **primary** diagnosis of BPD and most (61%; n=30/49) responded. Managers were then asked approximately how many of the patients treated in their facility in their last usual month had a **secondary** diagnosis of BPD, and 55% (n=27/49) responded.

The median proportion of patients with a **primary** diagnosis of BPD who received treatment either as inpatients or day patients in the last usual month was estimated by Hospital Managers at 10%, with the 25th percentile at 3.5 and the 75th percentile at 18.0. The median proportion of patients with a **secondary** diagnosis of BPD who received treatment either as inpatients or day patients was 15%, with the 25th percentile at 5.0 and the 75th percentile at 32.5. When the primary and secondary diagnoses were combined, Hospital Managers estimated a median of 25% of patients who received treatment in the last usual month had BPD diagnoses.

The average estimate of combined primary and secondary diagnoses is higher than that found overall the CDMS report cited above. This could be due in part to Managers' recognising the fact that psychiatrists tend to "under-diagnose" BPD in official records to protect patients from pervasive stigma (Brown, 1987; Whooley, 2010), a reflection of the fact that the actual proportion of patients may be somewhat higher than that registered in the hospital's database. It could also be due in part to demands on services being higher than the quantum of services provided particularly people

whose illness related life crises may result in sequential admissions or repeated participation in day programmes.

Psychological Treatments

As described above there are a number of psychological treatments offered therapeutically to patients with BPD in both hospital and community settings. The following section outlines respondents' descriptions of psychological services provided in their hospitals.

The Provision of Group Treatment Programmes

Managers were asked if their hospital provided any group treatment programmes, either for inpatients or day-based patients with diagnoses of BPD. Three quarters of survey participants (75%; n=37/49) provided answers to this Item. The majority (86.5%) responded that they provided group treatment programmes for in-patients or day-based patients; a small proportion (8.1%) did not provide group treatment programmes, and an even smaller proportion (5.4%) did not provide group programmes but referred patients with BPD diagnoses to group therapy in other private or public services.

Group Treatment Approaches

Managers were asked to identify the kinds of group-based treatment approaches currently used in their hospitals in inpatient and day patient settings, and 61% (n=30/49) provided responses. The principal group-based treatment approach for overnight inpatients was cognitive behaviour therapy (CBT) with 37% of respondents nominating this group-based treatment approach, followed by DBT (22%) and Mindfulness (15%). The second nominated other important group-based approaches for overnight inpatients were Acceptance and Commitment Therapy (ACT) (25%); Mindfulness (21%); and DBT (17%). The third nominated other important group-based approaches were Mindfulness (23%); Psychoeducation (18%); Skills Training (14%); CBT (14%) and DBT (14%).

The principal group-based treatment approach for day patients was predictably and overwhelmingly DBT for most hospitals (78%); followed by CBT (7%); ACT (4%); Mindfulness (4%); Supportive Therapy (4%) and Art Therapy (4%). The second nominated other important group-based approaches for day patients were CBT (26%); ACT (17%); Mindfulness (13%); and Skills Training (13%). Third level nominated other important group-based approaches for day patients were Mindfulness for a third of hospitals (33%); Art Therapy (14%); followed by Insight-oriented Therapies (9%); Psychoeducation (9%) and Skills Training (9%).

Individual Treatment Approaches

Managers were also asked to identify the kinds of individual treatment approaches currently used in their hospitals in inpatient and day patient settings, and 55% (n=27/49) provided responses. This may be perceived as a complex question to ask hospital managers, who may know about the treatment approaches of the nurses, psychologists or psychotherapists on their staff, but not know the treatment approaches of psychiatrists who are not on staff but visit inpatients, or who may rent rooms for private consultations in hospitals.

The principal individual psychological treatment approach for overnight inpatients was reported as CBT (48%), with DBT the second most prevalent (22%) followed by Insight-oriented Therapies (9%). The second nominated other individual approaches for overnight inpatients were DBT (18%);

followed by CBT, ACT, Mindfulness and Supportive Therapy at just under 14% respectively; and Psychodynamic Psychotherapy and Psychoeducation at 9%. The third nominated other important individual approaches for overnight inpatients were Mindfulness (32%); followed by CBT and Psychoeducation at 16%; and Insight-oriented Therapy and Supportive Therapy at 10%.

The principal individual psychological treatment approach for day patients was DBT (43%), with CBT the second most prevalent (22%), followed by ACT and Psychoeducation at 9%. The second nominated other individual approaches for day patients were CBT (26%), Mindfulness (21%) and ACT (16%). Third level additional individual approaches for day patients were CBT (19%), followed by Interpersonal Therapy and Psychoeducation at 12% respectively; one hospital each (6%) nominated ACT, Mindfulness, Life Matters, Couples Therapy, Family or Carer-focussed Therapies or Interventions, Art and Music Therapy as other individual treatments provided in their hospitals.

Mastusiewicz et al (2010, p. 2) argue that CBT incorporates a broad range of strategies, including cognitive restructuring, behaviour modification, exposure, psychoeducation and skills training, well suited to address the distorted beliefs about self and others, environmental factors reinforcing problem behaviour, and skills deficits often found with people with PDs. They also contend that CBT emphasises the importance of a supportive, collaborative and well-defined therapeutic relationship.

The CBT cited by Hospital Managers may well have been provided to patients in the clinical context of a primary diagnosis of Major Depression and or an Anxiety Disorder, with BPD as a secondary diagnosis. A Cochrane Database Systematic Review of 28 randomised psychotherapy studies for BPD, for example, found no statistically significant effects for CBT on outcomes for BPD core pathology and associated psychopathology (Stoffers et al, 2012). Davidson et al (2006) reported some benefits from the first randomised controlled trial (RCT) to gauge the effectiveness of traditionally delivered CBT for people with BPD diagnoses, the Borderline PD Study of Cognitive Therapy (BOSCOT) Trial which compared people who received CBT in addition to usual treatment compared with others who had only TAU. Gains were found in both groups during treatment and at follow-up. There were no significant differences between the groups in inpatient admission and emergency department presentations, however there was a significant reduction in the mean number of suicidal acts over a two year period for the CBT group, a result maintained at six year follow-up (Davidson, 2010). The CBT participants also reported less anxiety, lower symptom distress and less cognitive dysfunction. Other research such as Cottraux et al's (2009) study of cognitive therapy versus Rogerian supportive therapy found the CBT group had more rapid improvements in sense of hopelessness or impulsivity, higher ratings of therapeutic relationship and better treatment retention, however there was no difference on measures of depression, anxiety, cognitive dysfunction, suicidal behaviour and quality of life, and high rates of drop-outs[8] and people lost to follow-up. Manual Assisted Cognitive Therapy (MACT) has been randomised to a group compared to another having TAU, finding a significant decrease in the frequency and severity of non-suicidal self-injury despite no difference in levels of suicidal ideation. The study did not find any over-all benefit from MACT, possibly due to the fact that 40% of participants were non-attenders at one session (Matusiewicz et al, 2010).

The fact that DBT (78% or 21 hospitals) was by far the most common principal group-based treatment approach for day patients and the second most common for inpatients is unsurprising,

[8] A meta-analysis of 41 studies of Barnicot et al (2010) found an overall non-completion rate of 25% for BPD psychotherapy under 12 months' duration and 29% for psychotherapy longer than 12 months.

given its evidence base, general acceptance and dominance of use (Robins and Chapman, 2004; Lynch et al, 2007). Altieri (2011) assessed the efficacy of the DBT course offered by an Australian private hospital outpatient day programme by considering changes in participants' scores from a group of standardised questionnaires and evaluating the outcomes of participation in an eight week Mindfulness course based on Linehan's treatment module (1993). Clinically and statistically significant positive changes occurred at the conclusion of the programme in measures of dysregulation of emotion, behaviour, cognition and sense of self, with some, though not all gains maintained at six months' follow-up. The Clinical Practice Guidelines Recommendation is that the standardised, manual-based DBT developed by the originators should be used, in particular where reductions of self-harm, anger, anxiety or depression are treatment goals for women with BPD (NHMRC, 2012).

Mindfulness is one of the core skills of DBT (Linehan, 1993) and has been found in at least one non-randomised Australian study to be effective as a group therapy in reducing symptoms of psychological distress among people with BPD diagnoses (Altieri, 2011). It is not clear from the survey choices Managers made from a drop-down list whether they meant Mindfulness modules affiliated with DBT or self-contained programmes. For the purposes of this research they were considered discrete approaches. It is of note that approximately 15% ranked Mindfulness as their principal inpatient treatment approach, 21% considered it a second "other important" therapy for day patients and 23% a third "other important" therapy.

In the Hospital Managers BPD Survey, DBT was confirmed as the most commonly employed psychological approach for day patients, with only one hospital citing MBT as an "other important" group-based treatment approach; two hospitals citing SFT and no hospitals using the STEPPS programme. The Victorian Personality Disorder Service Spectrum offers MBT based therapy, but it seems yet to be more widely disseminated in the private sector.

There is an emerging Literature demonstrating that though DBT may be the most prevalent psychological treatment approach, accruing the most robust evidence of efficacy, a number of studies also show efficacy in the use of MBT, TFP, SFT and STEPPS. When the core components of all approaches empirically demonstrated to improve outcomes for people with BPD diagnoses are analysed, it is apparent that a number of different approaches achieve the same aim. Clarkin et al (2007), for example, compared TFP, DBT and Supportive Psychotherapy finding outcomes generally equivalent in all three treatments.

Bateman (2012, p. 561) asks the question: what makes people with BPD diagnoses improve on similar outcome measures, considering a plethora of disparate treatments and contrasting interventions? He suggests the following common features of therapies:

1. They provide a structured manual which supports the therapist and provides recommendations for common clinical problems;
2. They are designed to encourage increased activity, proactivity, and self-agency in patients;
3. They focus on the procession of emotions, especially on creating strong connections between acts and feelings;
4. They help the person understand BPD, increasing knowledge of their subjective experience in the early phase of treatment by including a model of pathology that is carefully explained to the patient;
5. They encourage an active stance by the therapist, which invariably includes an explicit intent to validate, demonstrate empathy and generate a strong attachment relationship to create a foundation of alliance.

Additional common features of effective psychotherapies for BPD are that they spend considerable effort on enhancing compliance with therapies, have a clear focus, whether on problem behaviour such as self-harm or an aspect of interpersonal relationship patterns, are relatively long term, and well integrated with other services available to the patient (Bateman and Tyrer, 2003). For Bateman (2012) these components can be summarised by advocating that people with BPD diagnoses need specialised treatment primarily structured and organised round core symptoms, whilst not neglecting the protracted affective disturbance and social dysfunction that many people with BPD endure years after therapeutic interventions (Zanarini et al, 2010; Davidson et al 2010).

Significant Issues for Staff

Managers were asked to comment on any significant issues arising for clinical staff in the care of patients with a diagnosis of BPD, and just over half (51%; n=25/49) of the participants responded.

These responses were roughly in two thematic categories, though the two are intrinsically related: issues arising from patient behaviours, the impact on staff and the management of that impact; and issues focussed primarily on the staff skills required for working with patients with BPD diagnoses. The major message was: patients with BPD diagnoses can be challenging for staff to work with, a theme described in other studies (McGrath and Dowling, 2012); the work requires dedicated, educated, skilled staff, a coherent, mutually agreed-on approach to patient care from all staff including psychiatrists, and ongoing psychodynamic team supervision to ensure effective care is provided.

The most commonly cited issue for staff regarding patient behaviour was “splitting.” The concept of splitting has evolved semantically in psychiatry and mental health services to have different layers of meaning which can be conflated and confusing. Splitting is a term originally used in psychoanalysis to describe the capacity or psychological process of perceiving disparate facets of people’s personalities to make up the whole person[9].

[9] A central feature of BPD has been theoretically described by the self-psychology stream of psychoanalysis (Kohut, 1984) as a lack of a sense of self, “the pathological splitting of the ego and object” (Winston, 2000, p. 212), considered conceptually as either a “primitive” defence mechanism in the face of abuse, or alternatively, a relatively sophisticated psychological strategy for dealing with past traumatic experiences (Calverley et al, 1994). The person finds it difficult to reconcile that

It has also been used in the common parlance of mental health services to describe a "divide and conquer" approach by some patients with staff, and the divergent responses of staff to extreme emotions and behaviours in patients. The outward manifestation of the inability to reconcile seemingly opposite traits in people may result in a propensity to idealise or denigrate certain staff members as "good" or "bad," leading to powerful and divided feelings among members of treating teams and requiring sophisticated management to achieve optimal therapeutic outcomes for the patient:

> *"Patients' use of primitive defences such as splitting, regression and projective identification*[10]*, (which) are the prominent primitive defences in BPD….can lead to intense emotional responses in clinicians, differences of opinion and conflict with clinical team... This is often enacted within teams in such a way as to induce staff members to react emotionally and be placed in 'good' camp or the 'bad' camp which and then adversely affect team functioning."*

Staff members need the capacity to reflect on this process rather than act upon the emotions engendered and to avoid working alone, especially in the absence of supervision (Bradley and Westen, 2005; Lubman et al, 2011). The respondent's comments below illustrate this concern:

> *"All teams treating BPD have difficulty tolerating the intense emotional reactions that can be stirred up. This can create difficulty in 'reflecting' on what is going on so it is essential to provide psychodynamic supervision and specific DBT supervision for teams so team functioning does not deteriorate ... (demoralisation, physical or emotional illness can occur in teams)."*

Less experienced staff members were particularly susceptible to the effects of splitting which could cause conflict. Effective lines of communication and a commonly decided on approach including treatment and discharge planning mitigated these issues, but if even one staff member disagreed, it could cause difficulty:

> *"Either staff feel personally injured by the client's behaviour, and feel the need to become punitive, or they lose sight of where the therapeutic boundary is and become over involved with the client and easily manipulated. This is easily managed with nursing staff because we have good communication and develop management strategies we adhere to. The Therapies Team do fairly well as they communicate with each other and the nursing team, and we do well usually as a united team".*

The issue of clinical consensus reflects the Clinical Practice Guidelines for BPD, which cite consistency and reliability (also care, respect and compassion) as some of the general principles of care for all

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another person may simultaneously have both positive, caring traits and negative or inimical traits, and tends to idealise or demonise people according to which category they assign them.

[10] The concept of "projective identification" was originally described by Melanie Klein (1946), which she perceived as hatred at certain aspects of self being directed toward one's mother. The notion has been further elaborated by many other theorists (Rosenfeld, 1952; Segal, 1974; Ogden, 1979). Waska (1999, p. 156) describes projective identification as "an unconscious fantasy of loving and hateful feelings being evacuated into the internal and external object…….which can lead to countertransference distress and subsequent pathological interactions between patient and therapist."

health professionals working with people with BPD diagnoses (NHMRC, 2012). Duggan (2002) identified the key competencies of staff working with people with diagnoses of BPD, some of which were described by respondents: emotional resilience; clarity about personal and interpersonal boundaries and the ability to tolerate the intense emotional impact some patients may have on them, some of which are illustrated in the Findings above. The emphasis on team communication is reflected in the NIMHE (2003) findings and in international guidelines for working with BPD. The American Psychiatric Association (APA), for example, recommends clinicians should communicate regularly to avoid "splitting" within the treatment team (Oldham et al, 2001), as do the NICE Guidelines, which advocates regular meetings where all staff refer to the same patient care plan (NICE, 2009).

A small group of respondents cited the lack of consensus between nursing staff and psychiatrists as a difficult issue. Psychiatrists did not always stick to the treatment plan, had difficulties setting boundaries and were constantly "moving the goal posts:"

> *"We do have problems with a doctor who refuses to listen to either nursing or therapies staff and does their own thing, constantly undermining management plans and strategies, (which is) very disruptive for the clients and staff."*

Several respondents raised managing patient dependence, risk of self-harm and emotional dysregulation, requiring safety plans completed with patient and clinician. The longer stay patients became progressively more unwell, which had a deleterious effect on other patients, particularly when small units had several patients with BPD at the same time. Staff then needed to spend extra time with other patients addressing their disturbance. Psychiatrists were not always helpful in the management of these behaviours.

One respondent stated that issues for staff were no different from patients with other diagnoses, though there were some issues of dependence or self-harm.

The alignment of psychiatrists and hospital staff regarding BPD treatment raises the issue of how psychiatrists manage patients with BPD diagnoses generally, something we have little reliable information about in Australia.

The second thematic category related more directly to staff issues. There was a lack of staff education and training about BPD and sometimes a lack of clinical supervision. Bland and Rossen (2005) identified the gap between APA recommendations for the clinical supervision of nurses working with patients with BPD diagnoses, and the reality in North America, where few clinical settings provided ongoing supervision for nurses.

Staff members were not adequately prepared or sufficiently experienced for more complex presentations, and could become traumatised or burned-out. Several respondents felt it was difficult to find staff with a dedicated interest in working with people with BPD diagnoses; there was still a level of intolerance, judgement and preconceived attitudes.

Staff Training

Hospital Managers were asked what kind of training their clinical staff currently had in psychological treatment approaches to BPD, and again over half (51%; n=25/49) responded. Three hospitals (12%; n=3/24) had either no staff training over and above the usual mental health services requirements or

had difficulty sending staff to a major metropolitan city to access BPD training, stating that any level of BPD training would be of value.

The most prevalent form of training was DBT, variously described as "specialist" or "advanced" training; internal or in-service training using the Marsha Linehan model, two day workshops, online access to DBT training, and annual DBT training for allied health and nursing staff. The importance of supervision of DBT was cited as an adjunct to DBT training and group processes. A small number of Managers cited training in Mindfulness and ACT therapy, and another small group had staff trained in CBT and Psychoeducation. Other training cited was in narrative and art therapy, online training in mental health nursing, Wesley courses such as Accidental Counsellor, Time Management; Therapeutic Nursing Interventions and university courses.

Hospital Managers were then asked what kind of specific training they felt their clinical staff **needed** in the care and treatment of patients with diagnoses of BPD, and slightly less than half (49%; n=24/49) responded. Training in DBT was again the most frequently cited, in tandem with the importance of clinical supervision and or having mentors. A small group of respondents suggested schema focussed therapy as another effective therapy with a proven evidence base, or clinically effective proven approaches **other than** DBT. Other forms of training suggested were ACT, Mindfulness, Interpersonal therapy, the management of self-injurious behaviour (SIB), problem solving, and training in best practice services such SPECTRUM, the Victorian PD service, for example their Wise Choices groups based on ACT, and training focussed on nursing management and maintaining consistency.

A respondent echoed the comment above about the need for training in reflective rather than reactive practice:

> *"The most important skill they (staff) need to have is the skill of self-reflection, to look at their own emotions and reactions to the client and separate their personal feelings from the clinical situation. You can never be 100% detached from your client but the more detached you can be the better…. so I think all clinicians need to be trained in emotional intelligence and reflective practice."*

Only one respondent stated there was no specific training required for staff working with patients with BPD diagnoses.

Respondents were asked what issues if any arose with regard to staff training and 45% (n=22/49) of them offered opinions. For three respondents, there were no specific issues to report. For most of the remaining Managers the major theme was availability of training. It was difficult to access in Australia generally, particularly difficult for hospitals far from major centres and there was a limited number of possible trainers. In addition BPD training was expensive; management did not always support the need for training, and sending staff to courses required back filling which was not easy to roster.

As suggested above the Clinical Practice Guidelines Recommendation is that Managers and health system planners who provide care for people with BPD diagnoses should ensure that health professionals receive training in BPD management (NHMRC, 2012). It seems clear that staff perceive a need for further training and education about BPD treatment, and are motivated to acquire it (Krawitz, 2001; Cleary, Siegfried and Walter, 2002). Most (95%) of the 516 staff surveyed in a public area Mental Health Service in New South Wales (NSW), for example, acknowledged a need for

further BPD education and training (Cleary, Siegfried and Walter, 2002). Australian qualitative research with 140 registered health practitioners in Victoria and NZ also revealed that clinicians want further education and training in BPD (Commons Treloar, 2009).

There is some evidence that staff training in psychological treatments has a bearing on treatment efficacy. In an Australian randomised trial, for example, the level of clinician training appeared to influence the degree of clinical improvement in DBT groups, with consumers who received treatment from intensively trained therapists showing greater reduction in suicide attempts and non-suicidal self-injury (Pasieczny and Connor, 2011).

Training and the setting of the service also have a mitigating effect on negative staff attitudes towards patients with a BPD diagnosis (Krawitz, 2004). Professionals' level of experience, where they work, and whether they have had targeted BPD training was found to have an effect on the attitudes of Australian and NZ clinicians in an Australian study, with a large and statistically significant difference between the attitude ratings of clinicians in a mental health service compared with emergency medicine clinicians (Commons Treloar and Lewis, 2008). Staff DBT training in a NSW regional area, even in a two day workshop period, resulted in a "pervasive therapeutic pessimism being displaced by more optimistic understandings" (Hazelton, Rossiter and Milner, 2006, p. 120).

The findings above illustrate that though most Managers value BPD staff training for various forms of BPD treatment, an approach consonant with the Clinical Guidelines (NHMRC, 2012), accessing training is somewhat problematic. Issues of availability, financial constraints, or of hospitals being physically distant from urban centres of training all continue to pose challenges. Australia shares similar barriers to psychotherapy expertise and training with NZ: cost, access and available expert knowledge (Te Pou, 2009). The findings confirm a central thesis of the general BPD literature, that the burgeoning evidence base for treatment efficacy is not yet well translated to disseminating practical services, the so-called "science to service gap" (DHHS, 2011) for BPD.

Involvement of other Agencies and Professionals

People accessing mental health services in the private sector typically also receive services from a range of other agencies and professionals. Managers were asked if they had any comments about the involvement of other agencies and or professionals in the treatment of their patients with BPD diagnoses. Nearly half the respondents (47%; n=23/49) made comments.

For six of the respondents (12%), including the Manager of a regional service where contact with external agencies was difficult; there was no stated involvement with external agencies and or professionals. For the remainder the identified themes were: difference of opinion about the therapeutic value of the involvement of people with BPD diagnoses in a range of services; consensus regarding the need for coordination and case management; and the view that private sector patients with BPD diagnoses did not receive adequate public sector services.

Several participants discussed a constant process of interaction with other agencies, working closely with individual community therapists or housing agencies. For this group the support of other services was perceived as beneficial for clients:

> *"Those patients who are supported by other agencies prior to admission do better than those without. Patients who can be linked with other agencies and services after discharge cope better in the long run."*

Some Managers felt it could be also be unhelpful for consumers with BPD diagnoses to receive services from too many agencies, which was seen as reducing their autonomy:

> *"Clients can be over serviced, and sometimes it is not beneficial to the client to have too many people involved in their care. Clients need to be encouraged to accept responsibility for their lives instead of farming this responsibility out to different services all the time."*

Despite these differences, there was consensus on the need for an overarching management role for one professional or agency, and the necessity for coordination and case management so that hospitals were clearly advised of processes:

> *"There are often already too many people involved with these individuals complicating the process. Unless there is a central and co-ordinated system, the current system remains ineffective."*

If agencies worked in isolation, people's health and welfare were affected:

> *"Multiple agencies working in isolation can be counter therapeutic."*

Sometimes linkages with GPs, psychologists and other agencies worked well, and at other times they were "*seriously deficient, especially with public hospitals*."

Hospital Managers' call for an overarching coordination role between agencies aligns closely with the Clinical Practice Recommendation, which states that if more than one health service is involved in a person's care, services should nominate one person as the primary contact or main clinician, responsible for coordinating care across all services (NHMRC, 2012).

Several respondents raised the issue of their patients experiencing stigma and less than optimal services in the public system, and the need for the public sector to accept that they are funded to treat people in crisis.[11]

There was confusion in working with public sector case managers and consultants, making it very difficult to provide consistent care:

> *"It would appear that patients with a BPD diagnosis are not readily accepted, understood and treated in our local public hospital. We send them a copy of our plan for our well known BPD patients, however, the public health system does not appear to support our private BPD patient especially after hours. Their approach at times seems unprofessional and non-therapeutic regarding BPD patients. There is nil consistency with case managers and consultants in the public system. Patients are continually moved around. The left hand does not know what the right hand is doing which is very confusing for the BPD patient and private agencies. It would be nice if we could work together to provide a consistent therapeutic approach."*

The provision of a management plan with the local public hospital is again in accord with the BPD Clinical Guidelines, which state that a management plan, which includes a clear, brief crisis plan, should be shared with all health professionals involved in a person's care (NHMRC, 2012). There

[11] .[11] The Clinical Practice Guidelines for BPD Management statement that health professionals at all levels of the healthcare system including general practice and emergency departments should recognise BPD treatment as a legitimate use of healthcare services, seeks to address the issue of some patients' negative public sector experiences (NHMRC, 2012, p. 3) .

were long waiting lists for public sector services, and the public system seemed unaware that the private sector was able to provide similar or even better care to patients with BPD diagnoses. This is a significant problem for people with BPD diagnoses, given a substantial proportion of people using private mental health services also access public services. In Altieri's (2011) study of participants of an Australian private hospital DBT group, for example, half (n=44/88) had received treatment from public mental health services at some stage of their illness. The Clinical Guidelines Recommendation is that most BPD treatment should be provided by community-based mental health services, both public and private. The quality of the linkages between the sectors is important in ensuring optimal care, as reflected in the further Recommendation that health professionals in various services should set up links to facilitate referral and collaboration (NHMRC, 2012).

It is recognised that people with PDs use a broad services and agencies, seeking assistance from a number of community services sometimes unable or unwilling to provide it. Policy documents such as "The Personality Disorder Capabilities Framework" of the National Institute for Mental Health in England (NIMHE, 2003) recognise the need for cross-agency practice. Ongoing communication between all treatment providers has been described as essential, and a designated case coordinator is recommended to reduce the risk of "splitting," (Lubman et al, 2011) however in practice, as the above findings indicate, a coordinated response and effective linkages may be difficult to maintain. Australian agencies, for example, agree on the need for a common response to people with BPD diagnoses, and on collaboration between agencies, but they may respond in different ways reflecting their ideological differences (Little et al, 2010).

Family Members and or Carers

Managers were asked to comment on any significant issues arising either for or with family members or carers of patients with a diagnosis of BPD, and just under half (49%; n=24/49) of the participants responded. The major themes were: factors associated with family members and carers becoming worn out with the behaviours of consumers with BPD diagnoses[12]; the need of family members for more education regarding BPD management, and issues pertaining to patient confidentiality.

Hospital Managers felt that family members of patients with BPD diagnoses could become exhausted coping with consumers' behaviours and labile emotions. It was understood that the occasional "family respite" admission was not considered appropriate grounds for admission under the law, but after repeated crises it could grant a family some breathing space:

> *"Sometimes psychiatrists will admit patients for family respite……we all know it isn't wholly appropriate but after multiple suicide attempts families need a break."*

It was challenging for family members to cope with many years of difficult behaviour on the part of their child, sibling or partner. Sometimes families were estranged from the person entirely. Inpatients could sever connection with family members but expect their support once discharged.

[12] The stressful experience of being a family member or partner of a person with a BPD diagnosis has been described as an important but relatively neglected aspect of outcomes studies (Gerrull et al, 2008). The stress and crises families frequently experience in caring for an unwell family member can seem unrelenting.

Support and education for families understanding the dynamics of BPD and gaining coping skills was the theme related to the ongoing challenge of dealing with the behaviour of a family member with BPD; a theme which again accords with the Clinical Guidelines Recommendation that health professionals should provide family members, carers and partners with clear, reliable information and refer them to support services and psychoeducation programmes about BPD (NHMRC, 2012).

This was particularly the case in the management of multiple suicidal behaviours and threats of suicide. Family members were confused about the most appropriate course of action in the face of sequential suicide attempts:

> *"There is an inability to care for the family member at home, and fear about the best approach to manage risky behaviour, that is, self-harm. Do you apply first aid then ignore it, or take the person to the Emergency Department and facilitate admission?"*

Carers could be afraid to set boundaries in the face of multiple suicide threats. Hospital Managers felt they sometimes did not have a good understanding of the condition of BPD, feeling that hospitals and staff were not doing enough to assist, or perceiving the hospital as uncaring when their family member had a crisis. This lack of understanding could be ameliorated with education and counselling. Respondents described the hospital offering family and carer support and education workshops, sessions in inpatient units and family and carer evenings and support groups for people who had completed DBT programmes. These strategies could provide consistency with the person's home environment so that skills could be consolidated.

A small group of respondents' experience was that the patient's family setting was dysfunctional though the aetiology of this was not explored, as illustrated by the Manager's comment below:

> *"Usually the whole social system related to this person is chaotic and dysfunctional and this includes the family."*

For a small group of Hospital Managers the only issue regarding family members and carers was the same as that of other patients, of respecting patient directions about information provision.

The issue of optimal management of chronic suicide attempt is central to the experience of many families and carers of a person with a BPD diagnosis.[13] The Clinical Practice Guidelines for BPD Management state that family members should be given information about how best to deal with suicide attempts and self-harming behaviour (NHMRC, 2012).. The Guidelines also suggest that admission to hospitals or other inpatient facilities should not be used as a standard BPD treatment, and should be generally limited to short terms stays to deal with a crisis when someone is at risk of suicide or serious self-harm (NHMRC, 2012). The Chief Psychiatrist of Western Australia has offered draft recommendations that inpatient care should be preferably for short-term crisis intervention, and that long term inpatient care avoided for people at high risk of suicide or medically serious self-harm and when used, inpatient care should brief and directed towards specific identified goals (34

[13] The recent Public Consultation Draft of the Guideline also discusses the issue, suggesting that the management of chronic suicidality is different from the management of acute suicidality (Paris, 2007), and that in chronically suicidal people, active attempts to prevent suicide, such as hospital admission and close observation may be unhelpful, escalate risk (Linehan, 1993: Paris, 2004; 2007) and be counter-therapeutic. The Guideline Recommendation is that long-term inpatient care should be avoided, unless in the context of specialised BPD services (NHMRC, 2012).

and 35). With regard to family and carers, draft recommendation 37 states that when considering inpatient care, clinicians should involve the patient and if possible family and carers in the decision which should be based on an explicit, joint understanding of the potential benefits and harms that may result from the admission, and agree in advance on the length and purpose of the admission (Davidson, 2012).

The APA 2001 Practice Guidelines for the Treatment of Patients with BPD recommends brief hospitalization when patients present an imminent danger to others, lose control of suicidal impulses or make a serious suicide attempt, have transient psychotic episodes, and have symptoms of sufficient severity to interfere with functioning. Pascual et al (2007) point out that despite APA recommendations, few Spanish patients are actually hospitalised. In a Spanish prospective study of 11, 578 consecutive visits 2002-2006 to a psychiatric emergency department, 9% of patients had a BPD diagnosis. Severity of Psychiatric Illness (SPI; Lyons et al, 1997) scores were higher than patients without BPD diagnoses in total score of severity (11.62 vs 8.97: $p<.001$); higher risk of suicide (.79 vs .41; $p<.001$); and danger to others (.53 vs .36; $p<.001$), and substance use and dual diagnosis were more common. Their rate of hospitalization however was **lower** than among patients without BPD diagnoses. Patients with BPD diagnoses who **were** admitted were more likely to have had a previous psychiatric history, previous contact with psychiatric services, higher risk of suicide or being a danger to others, higher levels of symptom severity, less ability to take care of themselves, more medical problems, higher levels of family disruption, home instability and greater noncompliance with treatment. The anomaly of greater clinical severity and lower rates of hospitalization was attributed to emergency clinicians' perception that patients' crises would resolve swiftly, that hospitalization was unhelpful and can be disruptive for other patients (Pascual et al, 2007).

Bateman and Tyrer (2004) concede that extended hospital admission may theoretically create dependency and regression (Linehan, 1987), but point out that there is no clear empirical evidence for this, and no real consensus about the indications for hospitalisation for people with BPD diagnoses (Pascual et al, 2007). A study in the Netherlands (Bartak et al, 2011) which compared the effectiveness of outpatient, day hospital and inpatient psychotherapeutic treatment found that patients with Cluster B personality disorders in all three settings improved significantly in terms of psychiatric symptoms, social and interpersonal functioning from baseline to 18 months with the largest improvement in the inpatient group.

There seems no clearly defined effective response for carers and family to episodes of chronic suicidality for people with BPD diagnoses, hence Hospital Managers' perception of confusion in the families expressed above. Distressed family members expect professionals to respond in a crisis, to give their family member care and asylum in the traditional sense of being in a place of protection. The contentious debate about the efficacy of inpatient admission is understandably irrelevant to the stressful experience of their family member's suicide attempt. Unless they have discussed the complexity of the evidence about admission efficacy previously with the treating psychiatrist or other staff, or have been party to a priori planned admissions, family members may remain baffled by clinical decisions not to admit patients.

Other Issues

Participants were asked if there were any issues about service provision relevant to patients with a diagnosis of BPD that were not covered elsewhere in the survey, and 29% (n=14/49) made comments.

For some respondents BPD was an illness like any other. There was no need for "different" treatment for these patients. In the main private sector services worked well in supporting people with a diagnosis of BPD. On the other hand access to private funding could be viewed as anti-therapeutic, and providing limitless opportunities for services. Clinicians tried to contain this phenomenon, but perhaps there needed to be more focus on non-inpatient resources:

> *"The patients with cover feel there are no limits as they have a golden pass into private services. Maybe the access to services in the private sector for people with cover needs to have some limits if they are over using services. Suicide becomes the password to get admission whenever one wants. Maybe we need to provide additional supports and increased access to non-inpatient care and treatment and reappraise the level of risk we are prepared to tolerate with people who keep using the suicide password."*

Setting structures in place regarding the terms of admission, agreed on in advance with the patient worked well for the following Hospital which had a high intake of clients with BPD diagnoses:

> *"In many instance they respond best to structure and boundaries from the beginning. To this end we have developed a Code of Conduct for all clients which are discussed with them when admission is first discussed over the phone by myself. I outline the expectations of their behaviour, what they can reasonably expect from us and consequences. They then decide if they can accept these terms, this is discussed again with them on admission and signed by all clients. Breaches are dealt with as discussed but clients are also made aware that if they are discharged, it is not permanent; if they decide they want to try again and they agree to the terms of the Code of Conduct they will be readmitted. We also do planned admissions for some clients and these have worked very well."*

The approach of this Hospital Manager reflect the Clinical Guidelines, which state that hospital stays should aim to achieve specific goals mutually agreed on by the person and their doctors (NHMRC, 2012). The model is broadly described in the literature (Van Kessel, Lambie and Stewart, 2002; Bateman and Tyrer, 2004) in studies in which informal patient-determined admission and discharge organised around specific goals agreed between the patient, psychiatrist and nursing staff are advocated. The admission should be brief, time limited and goal determined, and the patient can be discharged if the goals of admission are not met.

There was concern expressed about the numbers of young people described as having an "emerging" BPD diagnosis:

> *"We are dealing with a lot of young patients who may have an "emerging" diagnosis of BPD. I think we need to be very mindful of this label."*

There has been traditionally a reluctance to assign BPD diagnoses to adolescents and young adults, whose labile moods and at times erratic behaviours often fall within the range of normal evolution of

personality (Miller, Muehlekamp and Jacobson, 2008)[14]. Clinicians have demonstrated their aversion to using BPD diagnoses in Australian public sector Child and Adolescent Mental Health services (Koehne et al, 2012). The NICE Guidelines advise that any diagnosis of BPD be made by professionals who work specifically with children and young people, and that considering a BPD diagnosis in adolescence is predictive of both axis I and axis II problems in adulthood (Cohen et al, 2007; Daley *et al.*, 1999; Johnson *et al.*, 1999b). Failing to make the diagnosis early may mean that appropriate early interventions to address the difficulties for this group of young people are not offered. Advocates of this approach cite Chanen's (2008) study comparing CAT to manualised "good practice" which demonstrated some reduction in self-harm, and concluded that *in the absence of any compelling evidence to the contrary* the general principles and treatment guidelines for adults could be applied to young people (NICE, 2009).

In the last few years in Australia there has been a trend towards diagnosing so-called sub-syndromal or full threshold BPD in adolescence (Orygen Youth Health Research Centre, 2009), with the claim that there is a compelling case made internationally for early intervention in adolescent BPD (Chanen et al, 2008). The recent National Health and Medical Research Council (NHMRC) Public Consultation Draft of the Clinical Practice Guideline for the Management of BPD determined that there was insufficient evidence to formulate evidence-based recommendations about identifying BPD in young people, but nevertheless advocate a process of early BPD identification and intervention. The final Recommendation of the Clinical Practice Guidelines for BPD is that health professionals should consider BPD assessment or referral for psychiatric assessment in 12-18 year olds with any of the following: frequent suicide or self-harming behaviour; marked emotional stability; multiple co-occurring psychiatric conditions; non-response to established treatments and a high level of functional impairment (NHMRC, 2012).[15]Hospital Managers felt there was a need for far more complementary Drug and Alcohol services for these patients, so that these services could be provided and accessed "*hand in glove with our work*."

The need for further education in BPD was reiterated. There was a suggestion for online e-learning packages to allow staff to keep up to date and to give them a "*shared language for discussion*." Further access to seminars and conferences could assist:

> *"BPD is still poorly understood…..we all need far more education from experts in this field, day seminars, and conferences such as the recent one in Adelaide. This should apply to psychiatrists as well as some of ours openly acknowledge their lack of confidence."*

[14] The DSM-IV-TR states that clinicians are discouraged from diagnosing anyone with BPD before the age of 18, in which case the features must have been present and consistent for at least one year.

[15] The Clinical Guidelines also recommend that adolescents should be referred to structured psychological therapies specifically designed for their age group; and that where these are unavailable they should be referred to youth mental health services. The diagnosis should be applied to pre-pubescent children (NHMRC, 2012).

Conclusions

Describing the existing services offered by private hospitals to people with diagnoses of BPD is an important exercise in the broader task of gaining an understanding about BPD services in Australia generally. Hospital Managers' responses raise complex questions of treatment efficacy based on research evidence, the affordability of providing BPD services, the training and availability of staff, and how BPD services are provided within the broader service provision of private sector patients with mental health diagnoses other than BPD. Despite these challenges their approach to the provision of psychological services for their patients is generally in accord with recent Recommendations of Clinical Practice Guidelines for BPD Management.

Australian private hospitals are providing a range of different group-based and individual treatments for their patients with BPD diagnoses, as the variety of effective evidence-based treatment is steadily evolving internationally. The general sense from research findings is that there is a substantial place for treatment of BPD using psychotherapy but that there is still an ongoing project to build sufficient evidence to firmly establish the efficacy of various psychotherapies by replicating studies (Stoffers et al, 2012). As previously identified in this report, in an update to the review of BPD services of 2006 in the Cochrane Database of Systematic Reviews, the most intensively studied was found to be DBT, followed by MBT, TFP, SFT and STEPPS (Stoffers et al 2012). Addressing the current need for stronger evidence through replicatory studies is an ongoing project, giving hope that there will be a more widely disseminated range of evidence based psychotherapies for BPD treatment available in the future in both private and public sectors.

It is clear that people with diagnoses of BPD value targeted psychotherapeutic interventions provided by any sector. The Australian online BPD consumer survey of 115 respondents revealed psychotherapy as the most helpful form of professional support in managing BPD (averaging 4.28 on a 0-5 scale) followed by community support such as art therapy and friendship groups (4.10), with hypnotherapy rated as the least helpful (2.30) (McMahon and Lawn, 2011). Though most respondents indicated a high motivation to seek support, over half (52%) said that they had not been able to access these professional services, most citing problems with waiting lists, financial barriers, services being too distant, or having their concerns dismissed as not severe enough to warrant services. Consistent supportive care was the most valued factor perceived to contribute to Recovery.

Many private patients with BPD have had public sector treatment but access to evidence based treatment for BPD in Australia generally is limited, despite Australia having one of the best resourced systems of public health in the world (MHCA, 2005; in Pasieczny and Connor, 2010). Spectrum in Victoria is the only state-wide specialist public sector response for personality disorders in Australia, offering MBT, ACT, Body Mind therapy and DBT to severe BPD patients at high risk. Spectrum estimates it is able to treat only 15% of the 60,000 Victorians with a BPD diagnosis (Rao, 2012), and advocates the expansion and extrapolation of similar public sector services throughout Australia.

Issues of both internal service provision and the availability of services in the broader community are important elements of ongoing service provision for the management and staff of the Australian private hospital sector. The high Hospital Manager response rate of this descriptive survey of psychological services, and Managers' practical and informed observations of the parameters of optimal services within their hospitals indicate an ongoing commitment on the part of the Australian private hospital sector to the provision of effective BPD services for their patients.

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Acronyms

ACT	Acceptance and Commitment Therapy
ADHD	Attention Deficit Hyperactivity Disorder
AMA	Australian Medical Association
APA	American Psychiatric Association
APHA	Australian Private Hospitals Association
ASPD	Anti-Social Personality Disorder
BPD	Borderline Personality Disorder
CBT	Cognitive Behaviour Therapy
CDMS	Centralised Data Management Service
CEO	Chief Executive Officer
CSA	Childhood Sexual Abuse
CVT	Comprehensive Validation Theory
DBT	Dialectical Behaviour Therapy
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency Department
ERG	Expert Reference Group
HCP	Health Care Provider
ICD-10	International Classification of Diseases – 10th Edition
IPT	Interpersonal Therapy
LOS	Length of Stay
MACT	Manual Assisted Cognitive Behaviour Therapy
MBT	Mentalization-based Therapy
MBCT	Mindfulness-Based Cognitive Therapy
NCS-R	National Comorbidity Survey Replication
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NREPP	National Registry of Evidence-based Programmes and Practices

NSW	New South Wales
NZ	New Zealand
ONS	Office of National Statistics (UK)
PD	Personality Disorder
PMHA	Private Mental Health Alliance
PMHCCN	Private Mental Health Alliance Consumer and Carer Network
PTSD	Post Traumatic Stress Disorder
QIP	Quality Improvement Project
QOL	Quality of Life
RCT	Randomised Controlled Trial
SAMHSA	Substance Abuse and Mental Health Services Administration
SFT	Schema-focussed Therapy
SIB	Self Injurious Behaviour
SA	South Australia
SPI	Severity of Psychiatric Illness
SRO	Senior Research Officer
STEPPS	Systems Training for Emotional Predictability and Problem Solving
TAU	Treatment as Usual
TFP	Transference-focussed Psychotherapy
TOR	Terms of Reference
UK	United Kingdom
USA	United States of America
WA	West Australia
WHO	World Health Organisation
WPA	World Psychiatric Association

Appendix 1 – Hospital Managers' BPD Survey Instrument

Hospitals BPD Survey

Introduction

The nature and extent of psychiatric treatment provided to Australian patients who have diagnoses of Borderline Personality Disorder (BPD), either primary or secondary, are unclear. The OBJECTIVE of this survey is to describe the psychological treatments this consumer group receives from Australian private hospital–based psychiatric services. This is a unique research project in Australia. Your participation will be greatly appreciated and will contribute to the broader aim of improving the care that people with diagnoses of BPD currently receive.

Neither you nor your hospital will be identified in this study. All responses will be aggregated for analysis and reporting. The survey asks about the numbers of patients you offer services to, the types of psychological treatments the hospital provides for them, other service providers and agencies involved in patient care, and any particular issues that the hospital may face in the treatment of patients with a diagnosis of BPD.

The survey takes approximately 15–20 minutes to complete.

The oversight and conduct of this survey has been approved by the PMHA QIP Steering Committee. The survey information will be stored and analysed in accordance with the PMHA Centralised Data Management Service's (CDMS) policies.

Please read the following statement about survey participation, and then indicate if you agree to participate:

> *In participating in this survey I understand that all information provided will be treated as strictly confidential, and not released by the investigator to any other party unless required by law. I have been advised as to what data are being collected, and the purpose of the survey. I agree that the research data gathered for the study may be published provided that neither my name nor that of the organisation I represent or any other identifying information is used.*

1. Do you agree?

- ○ I do NOT wish to participate
- ○ I agree and wish to participate

Hospitals BPD Survey

About your psychiatric hospital service

***2. Is your psychiatric hospital service a:**

- Stand-alone, private psychiatric hospital?
- Psychiatric unit within a private general hospital?

***3. In which of the following states or territory is your private psychiatric service?**

- NSW or the ACT
- VIC
- QLD
- SA, WA or TAS

Hospitals BPD Survey

Of the patients treated by your hospital, what proportion have a diagnosis ...

4. Approximately what percentage of ALL the psychiatric patients treated in your facility in your MOST RECENT USUAL MONTH had a PRIMARY DIAGNOSIS of BPD? (please give your answer as a %)

5. Approximately what percentage of ALL the psychiatric patients treated in your facility in your MOST RECENT USUAL MONTH had a SECONDARY DIAGNOSIS of BPD? (please give your answer as a %)

About the psychological treatment programmes offered to patients with a dia...

6. Does your hospital provide any GROUP TREATMENT PROGRAMMES (either inpatient or day-based) to patients with a diagnosis of BPD?

- Yes
- No
- No, but patients with BPD are referred to group therapy offered by other services (private or public)

About group treatment programmes offered to patients with a diagnosis of BP...

7. Please identify the kinds of GROUP-BASED TREATMENT APPROACHES currently used in your hospital for patients with a diagnosis of BPD, in the Inpatient and Day Patient settings:

	Principal approach	Other important	Other important
for Overnight Inpatients			
for Day Patients			

If you have any comments you wish to make about the group-based treatment approaches used in your hospital, please record them here:

List of psychological therapies that may be selected in answer to Q7: Cognitive Behaviour Therapy (CBT); Dialectical Behaviour Therapy (DBT); Acceptance and Commitment Therapy (ACT); Interpersonal Therapy (IPT); Insight-oriented Therapies; Mindfulness; Life Matters; Psychoeducation; Couple Therapy; Schema Focussed Therapy (SFT); STEPPS (Systems Training for Emotional Predictability and Problem Solving); Skills Training; Psychodynamic Therapy; Mentalisation-based Therapy (MBT); Narrative Therapy; Family/carer-focussed Therapies and Interventions; Supportive Therapy; Art Therapy; Music Therapy.

About individual psychological treatment approaches for patients with a dia...

8. Please identify the kinds of INDIVIDUAL PSYCHOLOGICAL TREATMENT APPROACHES currently used by your hospital's clinical staff for patients with a diagnosis of BPD, in the Inpatient and Day Patient settings:

	Principal approach	Other additional	Other additional
for Overnight Inpatients			
for Day Patients			

If you have any comments you wish to make about the individual psychological treatment approaches, please record them here:

List of psychological therapies that may be selected in answer to Q8: Cognitive Behaviour Therapy (CBT); Dialectical Behaviour Therapy (DBT); Acceptance and Commitment Therapy (ACT); Interpersonal Therapy (IPT); Insight-oriented Therapies; Mindfulness; Life Matters; Psychoeducation; Couple Therapy; Schema Focussed Therapy (SFT); STEPPS (Systems Training for Emotional Predictability and Problem Solving); Skills Training; Psychodynamic Therapy; Mentalisation-based Therapy (MBT); Narrative Therapy; Family/carer-focussed Therapies and Interventions; Supportive Therapy; Art Therapy; Music Therapy.

Hospitals BPD Survey

About your clinical staff caring for patients with a diagnosis of BPD

9. Please comment below about any significant issues that arise for CLINICAL STAFF in the care of patients with a diagnosis of BPD:

10. What kind of TRAINING do your hospital's clinical staff have in psychological treatment approaches for patients with a diagnosis of BPD?

11. In your view, what kind of specific TRAINING do clinical staff NEED in the care and treatment of patients with a diagnosis of BPD?

12. What issues, if any, arise regarding that training?

Hospitals BPD Survey

Other issues

13. Do you have any comments about the involvement of OTHER AGENCIES and/or PROFESSIONALS in the treatment of your patients with a diagnosis of BPD?

14. Please comment below on any significant issues that arise, either for or with, FAMILY MEMBERS or CARERS of patients with a diagnosis of BPD?

15. If there are any other issues NOT COVERED in this survey about your service provision relevant to PATIENTS with a diagnosis of BPD, please record them here:

Hospitals BPD Survey

We thank you very sincerely for the time you took to participate in this survey.