Clinician perspectives on what constitutes good practice in community services for people with Complex Emotional Needs: A qualitative thematic meta-synthesis

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NOTE: This preprint reports new research that has not been certified by peer review and should not be used to guide clinical practice.
Abstract

Introduction

The need to improve the quality of community mental health services for people with Complex Emotional Needs (CEN) is recognised internationally and has become a renewed policy priority in England. Such improvement requires positive engagement from clinicians across the service system, and their perspectives on achieving good practice need to be understood.

Aim

To synthesise qualitative evidence on clinician perspectives on what constitutes good practice, and what helps or prevents it being achieved, in community mental health services for people with CEN.

Methods

Six bibliographic databases were searched for studies published since 2003 and supplementary citation tracking was conducted. Studies that used any recognised qualitative method and reported clinician experiences and perspectives on community-based mental health services for adults with CEN were eligible for this review, including generic and specialist settings. Meta-synthesis was used to generate and synthesise over-arching themes across included studies.

Results

Twenty-nine papers were eligible for inclusion. Six over-arching themes were identified: 1. The use and misuse of diagnosis; 2. The patient journey into services: nowhere to go; 3. Therapeutic relationships: connection and distance; 4. The nature of treatment: not doing too much or too little; 5. Managing safety issues and crises: being measured and proactive; 6. Clinician and wider service needs: whose needs are they anyway? The overall quality of the evidence was moderate.
Discussion

Through summarising the literature on clinician perspectives on good practice for people with CEN, over-arching priorities were identified on which there appears to be substantial consensus. In their focus on needs such as for a long-term perspective on treatment journeys, high quality and consistent therapeutic relationships, and a balanced approach to safety, clinician priorities are mainly congruent with those found in studies on service user views. They also identify clinician needs that should be met for good care to be provided, including for supervision, joint working and organisational support.
Introduction

The global prevalence of “personality disorder” in the community is estimated to be around 7.8% (1). This increases to between 40 and 92% among people who use community secondary mental health care services in Europe (2). High rates of comorbidity with other mental health conditions have been identified (3, 4) and people with comorbid conditions appear to have particularly high inpatient and involuntary service use and poor outcomes (5, 6). High rates of comorbid physical conditions have also been found (7-9) and evidence suggests shorter life expectancies (10). Impacts on quality of life are comparable to serious somatic illness (11) and a substantial economic cost has been found for health and social care services and society more generally (12, 13).

The value of “personality disorder” as a diagnostic category is still contested (14-16). It arguably provides a basis for clear explanations for service users and reliable categorisation for research. However, it is also criticised as potentially misogynist, and as associated with a heavy burden of stigma that is likely to be difficult to dispel, and with a lack of progress in improving care (17). The papers included in this review largely use the term “personality disorder”, but given the gravity of critiques, we choose instead to use the alternative term that has recently come into use to identify the cluster of needs that may lead to a “personality disorder” diagnosis - complex emotional needs (CEN).

In the UK, care provided for people with CEN has recurrently been described as of very variable and often poor quality (18). In 2003, new policy guidance was published aimed at greatly increasing provision of specialist services and improving training and support in generic services (19, 20). The number of mental health Trusts providing dedicated services increased fivefold over the following decade, but a national survey in 2015 found persisting deficits in access to specialist therapies and to a full spectrum of biopsychosocial interventions, and it remained unclear as to whether overall quality of care had improved (18). Improving care for people with CEN has since become a renewed priority in England (21-23). The need to improve quality of care, reduce stigma and
deliver effective treatments for CEN is recognised internationally\textsuperscript{24}, with formulation of policies and
guidelines in various countries aimed at improving care\textsuperscript{25, 26}.

Policy focus on improving CEN care has been accompanied by growing evidence that there
are effective psychological treatment options for CEN\textsuperscript{27-32}, but that the translation of policy and
evidence into service provision has been slow\textsuperscript{33}. Service users and clinicians have been found to
agree that access to specialist services and psychological interventions, interventions to reduce
stigma in services, access to specialist consultation services for generic mental health staff, and
positive risk management are priorities, but these do not appear to be widely reflected in service
provision\textsuperscript{34}.

As well as lack of resources, clinician-related barriers to service improvement have
repeatedly been found. Stigma related to “personality disorder” diagnosis has recurrently been
identified among clinicians: feeling powerless to be helpful, perceived un-treatability,
preconceptions about patients and poor CEN understanding have been identified as contributors to
this stigma\textsuperscript{33, 35}. Unmet training needs and lack of a clear framework are reported to contribute to
negative experiences of working with people with CEN\textsuperscript{36}. These do not, however, appear inevitable
consequences of working with CEN: in a relatively well-resourced specialist “personality disorder”
service setting, Crawford et al.\textsuperscript{37} reported relatively low levels of clinician burnout and good
satisfaction among staff working with people with CEN. Thus, understanding the perspectives,
experiences and attitudes of clinicians and the conditions that allow them to work effectively and
without excessive burnout with people with CEN is a crucial element in informing next steps for
improving service provision.

The aim of this review was to synthesise existing qualitative evidence on clinician
perspectives on what constitutes good practice in community mental health settings for people with
CEN, and how this could be achieved. Objectives included conducting a systematic search of the
literature, conducting a meta-synthesis of qualitative data, and assessing the quality of the evidence.
This review is part of a broader programme of work conducted by the NIHR Mental Health Policy Research Unit to inform the development of NHS England specialist pathways and to strengthen the evidence base for service development in this field nationally and internationally. Other reviews include a synthesis of qualitative literature on service user perspectives on good practice (38), systematic reviews on treatment effectiveness and cost-effectiveness (39), and a study of service typologies.
Methods

Information sources and search strategy

The review team developed the protocol in line with PRISMA guidelines\(^{(40)}\) and guidance on qualitative meta-syntheses\(^{(41)}\) in collaboration with a project-specific working group of lived-experience researchers and subject experts. The protocol was registered prospectively on PROSPERO (CRD42019145615), as was the protocol for the wider programme of work (CRD42019131834).

One search strategy was developed for all the reviews in the programme (see Appendix A). Search terms were built around key words and subject headings relevant to CEN and related needs, community mental health services, and eligible study designs including qualitative, quantitative and guidelines. Comprehensive searches were conducted of MEDLINE (January 2003 - December 2019), Embase (January 2003 - December 2019), HMIC (January 2003 - December 2019), Social Policy and Practice (January 2003 - December 2019), CINAHL (January 2003 - December 2019) and ASSIA (January 2003 - January 2019). No limits were placed on the language or country, and a limit of 2003 or later was placed on the date to capture perspectives of greater contemporary relevance.

Citations retrieved during searches were collated in Endnote, a reference management software, and duplicates were removed. Titles and abstracts were double screened by two NIHR Mental Health Policy Research Unit researchers for all the reviews together and full text screening was performed on potentially eligible papers for this review. Supplementary searching included a call for evidence publicised via the study team's networks, relevant professional associations and social media, forward and backward citation tracing of included articles, and reference lists of other relevant systematic reviews found in an additional systematic review search of EMBASE and MEDLINE (January 2003 - November 2019). Grey literature was identified through web searches and the above bibliographic database search. All included studies and 20% of those excluded were double screened, and discussion with senior reviewers achieved consensus.
Eligibility criteria

Studies using recognised qualitative data collection and analysis methods to explore clinician perspectives on good practice in community mental health services for people with CEN were included. Studies were eligible if they reported the relevant perspectives of any mental health professional with experience of working with people with CEN or related needs (e.g., recurrent self-harm). Eligible settings were community-based mental health services, including mental health care in primary care settings, generic community mental health teams, and specialist services for people with CEN. Residential, forensic, or crisis services, or specialist services for different conditions were excluded. Papers were excluded if the service target population were primarily below the age of 16, unless focussing on transition into adult services. Published and grey literature were eligible, except for case studies, dissertations and theses. (See Appendix B for full eligibility criteria). Most of the papers used “personality disorder” to describe the sample, but here we use the term CEN in view of the contentious nature of the “personality disorder” diagnosis.

Quality assessment and analysis

Study characteristics were extracted into a Microsoft Excel form. The Critical Appraisal Skills Programme (CASP) Qualitative Checklist was used to perform quality assessments. Study quality was not used to determine eligibility but is reported below. Text from results sections of included articles was entered verbatim into the coding software NVivo for thematic meta-synthesis and linked to individual study characteristics such as types of clinicians, services, and interventions. For stage one, articles were coded line-by-line by one of two researchers and 20% of papers were double coded to produce an initial framework. A descriptive thematic framework emerged from further discussion between the two researchers for stage two, iteratively developed as codes were merged and grouped hierarchically. Finally, analytic themes were generated to address the research question for stage three. Analysis was finalised collaboratively by a small team of reviewers and
experts by experience and occupation. The analysis process included considering whether there were sub-group differences related to major study characteristics such as country of publication.
Results

A total of 29 papers (drawing on 27 unique datasets) were eligible for inclusion\(^{(37, 43-70)}\) (Fig 1), representing perspectives from at least 550 clinicians. Clinicians represented a variety of professions and included psychologists, social workers, psychiatric nurses, occupational therapists, psychiatrists, family doctors (known as General Practitioners or ‘GPs’ in the UK) and counsellors (Table 1). They worked in a range of settings from primary through tertiary (non-residential) care and offered anything from specific interventions (e.g., Dialectical Behavioural Therapy, Mentalisation-Based Interventions, Cognitive Analytic Therapy, etc.) to more general and varied support. While we use the term “CEN”, service users in most included studies were identified as having “personality disorder” or “borderline personality disorder”.

Fig. 1. PRISMA Diagram

[ insert figure 1 – PRISMA diagram ]
| Table 1. Study Characteristics |
|--------------------------------|
| **First Author, Year, Title.** | **Clinician type** | **Sample size** | **Data collection** | **Service / setting, Location** | **Target population** | **Intervention if applicable** |
|--------------------------------|-------------------|----------------|-------------------|-------------------------------|-----------------------|-------------------------------|
| Bosanc, 2015. | Mentalization-based intervention to recurrent acute presentations and self-harm in a community mental health service setting. | Case managers: psychiatric nurses and occupational therapists | N = 8 | Five 3-monthly focus groups of 3-5 clinicians | Community mental health service, Australia | 8 female service users diagnosed with ‘BPD’ (DSM-IV) and <7 on DIB-R. | MBI |
| Carmel, 2014. | Barriers and solutions to implementing dialectical behavior therapy in a public behavioral health system. | Clinicians NS | N = 19/34 | Structured phone interviews | Community mental health and People with ‘BPD’ substance abuse agencies within a public behavioral health system, Northern California | DBT |
| Crawford, 2007. | Learning the lessons: a multi-method evaluation of dedicated community-based services for people with personality disorder. | Service managers, front-line clinicians (range), referrers, commissioners. | N = 89 service providers, 26 referrers, 13 commissioners from across all 11 dedicated services | Comprehensive evaluation including English ‘Pilot’ dedicated services, in-depth qualitative interviews | People with ‘PD’ – range of criteria across services | Range – psychotherapeutic, social, occupational |
| Crawford, 2007. | Lessons learned from an evaluation of dedicated community-based services for people with personality disorder. | See Crawford 2007a, above |
| Crawford, 2010. | Job satisfaction and burnout among staff working in community-based personality disorder services. | Service managers and ‘front-line’ clinicians: therapists, psychotherapists, nurses, psychologists, social workers, psychiatrists, occupational therapists, art therapists, support workers, and employed service users. | N = 89 from across all 11 dedicated services | Comprehensive evaluation including English ‘Pilot’ dedicated services, in-depth qualitative interviews | People with ‘PD’ | Range – psychotherapeutic, social, occupational |
| Donald, 2017. | Clinician perspectives on recovery and borderline personality disorder. | Social workers, nurses, psychologists, one psychiatry registrar and one consultant psychiatrist | N = 16 | Interviews | Clinicians mostly from one specialist service, and two from a generalist service, Australia | People with ‘PD’ / ‘BPD’ | Range |
| Fontan, 2013. | Improving services for people with personality disorders: Views of experienced clinicians. | Recognised specialists and experts in ‘PD’ | N = 60 | Written group responses to one question during clinical and scientific meeting | Range of public and private services across Australia | NA | NA |
| French, 2019. | GPs’ views and experiences of managing patients with personality disorder: a qualitative interview study. | | | | | | |
General practitioners

- N = 15
- Phone interviews with topic schedule
- GP Practices, West of England
- People suspected by GP to have 'PD'

- Schultz, 2009.

Understanding community mental health service administrators' perspectives on dialectical behaviour therapy implementation. People with a diagnosis of 'BD', some DBT trained and training, people with BPD, some DBT trained and training.

Mental health service administrators

- N = 13 from 9/10 participating organisations
- Semi-structured phone interviews
- Two profit managed behavioural health organisations, one large non profit managed behavioural health organisation, 1 large secondary care provider
- People with a diagnosis of 'BD', some DBT trained and training.

Hogg, 2010.

An evaluation of a managed clinical network for personality disorder: breaking new ground or top dressing? People with a diagnosis of 'BD', some DBT trained and training.

- Network staff from across multiple agencies with diverse backgrounds
- Interviews

Hutton, 2017.

Switching roles: a qualitative study of staff experiences of being dialectical behaviour therapists within the National Health Service in England. People with a diagnosis of 'BD', some DBT trained and training.

- Experts had at least some experience with the treatment of such people, but worked in a general setting.
- A qualitative study exploring professionals' perspectives of working with 'BD' in 2 localities (primary care, England), 3 DBT teams within 1 Trust (alongside secondary care service model, England)

Kœkkœk, 2009.

Clinical problems in community mental health care for patients with severe borderline personality disorder. People with severe BPD (DSM-IV)

- Experts had at least some experience with the treatment of such patients
- Trained and trainee psychologists, clinical psychologists, clinical leaders and IAPT clinical service managers

Lam♣, 2019.

Personally disordered community in primary care: improving access to psychological therapy services. People with BPD (SAP)

- N = 28
- Interviews

Langley, 2005.

Trust as a foundation for the therapeutic intervention for adults with borderline personality disorder. People with a diagnosis of 'BD', some DBT trained and training.

- N = 10
- Individual interviews

Lee, 2008.

A pilot personality disorder outreach service: development, findings and lessons learnt. People with 'BD' (MBI / psychodynamic).

- Pilot 'BD' outreach service
- N = 28
- Semi-structured
- Interviews

Prison practitioners: GP Practices, West of England People suspected by Gp to have 'PD'
Morant, 2003.[^73] A multi-perspective evaluation of a specialist outpatient service for people with personality disorders.

| Service provider | Multi-perspective/multi-method evaluation including semi-structured interviews | People with moderate to severe PD |
|-------------------|---------------------------------------------------------------------------------|-----------------------------------|
| Refers to service: consultant psychiatrists, social workers, one clinical psychologist, one substance misuse worker, and one clinical nurse specialist | Specialist ‘PD’ outreach service (clinicians primarily from CMHTs), England | Individual treatment (cognitive therapy), Group psychotherapy (psychodynamic), Art psychotherapy (group) |

O’Connell, 2013.[^57] Community psychiatric nurses’ experiences of caring for clients with borderline personality disorder.

| N | Interviews | CMHT (secondary care), Ireland |
|---|------------|-------------------------------|
| 12 | | People with ‘BPD’ |

Perseus, 2003.[^60] Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using dialectical behavioral therapy: the patients’ and the therapists’ perceptions.

| N | Individual free-format questionnaire and group interview | People with ‘BPD’ or related symptoms |
|---|--------------------------------------------------------|--------------------------------------|
| 4/4 | | DBT |

Perseus, 2007.[^59] Stress and burnout in psychiatric professionals when starting to use dialectical behavioral therapy in the work with young self-harming women showing borderline personality symptoms.

| N | An individual open question, free text answer questionnaire and a group interview (and burnout inventory) | Women with ‘BPD’ |
|---|----------------------------------------------------------|------------------|
| 22 | | DBT |

Pigott, 2019.[^51] Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services.

| N | Semi-structured interview | Publicly funded open access provider of health and medical services, Australia |
|---|----------------------------|--------------------------------------------------------------------------------|
| 21/46 | | People with ‘PD’, particularly ‘BPD’ |

Priest, 2011.[^51] How can mental health professionals best be supported in working with people who experience significant distress?

| N | Semi-structured interview | CMHT case load / People with ‘PD’ / NA people who experience ‘significant distress’ |
|---|----------------------------|-----------------------------------------------------------------------------------|
| 26 | | People with ‘BPD’ (clinician) |

Rizq, 2012.[^51] ‘There’s always this sense of failure’: an interpretative phenomenological analysis of primary care counsellors’ experiences of working with the borderline client.

| N | Semi-structured interview | Primary care, England |
|---|----------------------------|-----------------------|
| 13 | | People with ‘BPD’ |

[^73]: Morant, 2003. A multi-perspective evaluation of a specialist outpatient service for people with personality disorders.

[^57]: O’Connell, 2013. Community psychiatric nurses’ experiences of caring for clients with borderline personality disorder.

[^60]: Perseus, 2003. Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using dialectical behavioral therapy: the patients’ and the therapists’ perceptions.

[^59]: Perseus, 2007. Stress and burnout in psychiatric professionals when starting to use dialectical behavioral therapy in the work with young self-harming women showing borderline personality symptoms.

[^51]: Pigott, 2019. Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services.

[^51]: Priest, 2011. How can mental health professionals best be supported in working with people who experience significant distress?

[^51]: Rizq, 2012. ‘There’s always this sense of failure’: an interpretative phenomenological analysis of primary care counsellors’ experiences of working with the borderline client.
| N | Interviews | Judgement |
|---|------------|-----------|
| **5** | Stalker, 2005. | "It is a horrible term for someone": service user and provider perspectives on 'personality disorder'. Psychiatrists, three community psychiatric nurses, one clinical psychologist, interviews with one senior social worker and one senior occupational therapist, managers of CMHTs through Mental Health People with 'PD' Resource Centres, Scotland. |
| **12** | Stroud, 2013. | Working with borderline personality disorder: A small-scale qualitative investigation into community psychiatric nurses' constructs of borderline personality disorder. Community psychiatric nurses Semi-structured interviews CMHT, Wales People with 'BPD' |
| **4** | Sulzer, 2016. | Improving patient-centered communication of the borderline personality disorder diagnosis. Psychiatrists, Psychologists, Clinical Social Workers and BPD activists Semi-structured interviews Clinicians from 11 states, America People with 'BPD' |
| **32** | Thompson, 2008. | Multidisciplinary community mental health team staff’s experience of a ‘skills level’ training course in cognitive analytic therapy. All eligible clinicians: social workers and community psychiatric nurses Structured, open-ended interviews CMHT (secondary care), UK People with complex needs e.g., people presenting with features of PD |
| **12** | Vyas, 2017. | Working in a therapeutic community: exploring the impact on staff. Therapeutic Communities: The International Journal of Therapeutic Communities. Clinicians working in a TC Semi-structured interviews A long-standing TC, UK People with ‘EUPD’ / ‘emotional instability’ CAT / MBT |
| **8** | Wilson, 2018. | Experiences of parenting and clinical intervention for mothers affected by personality disorder: a pilot qualitative study combining parent and clinician perspectives. Referring CAMHS clinicians Semi-structured interviews Four CAMHS teams referred into the Helping Families Programme Mothers with ‘PD’ who had a child living with them aged 3–11 years Helping Families Programme – parenting with a behavioural and/or emotional and clinical disorder |
| **5** | Wiskoarcyk, 2018. | Exploring General Practitioners’ Views and Experiences of Providing Care to People with Borderline Personality Disorder in Primary Care: A Qualitative Study in Australia. Any currently practicing GPs Focus groups Primary care, Australia People with ‘BPD’ |

173 Abbreviations: NS = Not Specified. BPD = Borderline Personality Disorder. DSM-IV = Diagnostic and Statistical Manual of Mental Health Disorders Version 4. DI-B-R = Diagnostic Interview for Borderline Patients – Revised. MBT/MBT – Mentalisation Based Intervention / Therapy. DBT = Dialectical Behavioural Therapy. PD = Personality Disorder. GP = General Practitioner. IAPT = Improving Access to Psychological Therapies. CMD = Common Mental Disorders. CBT = Cognitive Behavioural Therapy. SU = Service User. SAP = Standardised Assessment of Personality. CMHT = Community Mental Health Team. CSMT = Community Substance Misuse Team. CAT = Cognitive Analytic Therapy. TC = Therapeutic Community. EUPD = Emotionally Unstable Personality Disorder. CAMHS = Child and Adolescent Mental Health Service.
Quality appraisal indicated that the majority of studies appropriately used qualitative methodology (n=28), employed an appropriate research design (n=28), and described clear findings (n=28). Most studies also presented clear aims (n=27) and used appropriate data collection methods (n=26). However, a number of papers did not provide enough information to determine whether the data analysis was sufficiently rigorous (n=6), whether the recruitment strategy was appropriate (n=11), nor whether ethical issues had been sufficiently considered (n=12). Only 5 papers in total adequately considered the relationship between researcher and participants (Table 2).
Table 2. Quality assessment according to the Critical Appraisal Skills Programme

| First Author, Year | 1. Was there a clear statement of methodology? | 2. Is a qualitative research design appropriate? | 3. Was the research design appropriate to address the aims of the research? | 4. Was the recruitment strategy appropriate to the aims of the research? | 5. Was the data collected in a way that addressed the research issue? | 6. Has the relationship between researcher and participants been adequately considered? | 7. Have ethical issues been taken into consideration? | 8. Was the data analysis rigorous? | 9. Is there a clear statement of findings? | 10. How valuable is the research? |
|--------------------|-----------------------------------------------|-----------------------------------------------|------------------------------------------------|-------------------------------------------------|------------------------------------------------|-------------------------------------------------|------------------------------------------------|------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| Bosanac, 2019       | Yes                                           | Yes                                           | Can’t Tell                                   | Yes                                             | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Unclear                                        |
| Carmel, 2014        | Yes                                           | Yes                                           | No                                           | Yes                                             | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Valuable                                       |
| Crawford, 2007a     | Yes                                           | Yes                                           | Yes                                          | Can’t Tell                                      | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Valuable                                       |
| Crawford, 2007b     | *                                             |                                               |                                              |                                                 |                                                |                                                  |                                                |                                                 |                                               |                                                 |
| Crawford, 2010      | Yes                                           | Yes                                           | Yes                                          | Can’t Tell                                      | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Valuable                                       |
| Donald, 2017        | Yes                                           | Yes                                           | Yes                                          | Can’t Tell                                      | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Valuable                                       |
| Fanaien, 2013       | Yes                                           | Yes                                           | Can’t Tell                                   | Can’t Tell                                      | No                                             | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| French, 2013        | Yes                                           | Yes                                           | Yes                                          | No                                              | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Valuable                                       |
| Henschel, 2009      | No                                            | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Hogard, 2010        | Yes                                           | Yes                                           | Yes                                          | Can’t Tell                                      | No                                             | No                                               | Can’t Tell                                    | Yes                                             | Yes                                           | Unclear                                        |
| Hutton, 2017        | Yes                                           | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Koekkoek, 2009      | Yes                                           | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Lamph, 2019         | Yes                                           | Yes                                           | Yes                                          | No                                              | Can’t Tell                                     | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Langley, 2005       | Yes                                           | Yes                                           | Can’t Tell                                   | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Lee, 2008           | No                                            | Can’t Tell                                    | Can’t Tell                                   | No                                              | Can’t Tell                                     | Yes                                               | Yes                                           | Can’t Tell                                    | No                                             | Unclear                                        |
| Morant, 2003        | Yes                                           | Yes                                           | Yes                                          | No                                              | Can’t Tell                                     | Can’t Tell                                        | Yes                                           | Can’t Tell                                    | Yes                                           | Valuable                                       |
| O’Connell, 2013     | Yes                                           | Yes                                           | Can’t Tell                                   | Can’t Tell                                      | No                                             | Can’t Tell                                        | Yes                                           | Can’t Tell                                    | Yes                                           | Valuable                                       |
| Perseius, 2003      | Yes                                           | Yes                                           | Yes                                          | Can’t Tell                                      | No                                             | Can’t Tell                                        | Yes                                           | Can’t Tell                                    | Yes                                           | Valuable                                       |
| Perseius, 2004      | Yes                                           | Yes                                           | Yes                                          | Yes                                             | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Pigot, 2019         | Yes                                           | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Priest, 2011        | Yes                                           | Yes                                           | Can’t Tell                                   | Yes                                             | No                                              | Can’t Tell                                        | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Rizq, 2012          | Yes                                           | Yes                                           | Yes                                          | Yes                                             | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Stalker, 2006       | Yes                                           | Yes                                           | Can’t Tell                                   | Yes                                             | No                                              | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Stroud, 2015        | Yes                                           | Yes                                           | Can’t Tell                                   | Yes                                             | No                                              | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Suber, 2010         | Yes                                           | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Thompson, 2008      | Yes                                           | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Vyas, 2017          | Yes                                           | Yes                                           | Can’t Tell                                   | Yes                                             | No                                              | Can’t Tell                                        | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Wilson, 2018        | Yes                                           | Yes                                           | Yes                                          | No                                              | Can’t Tell                                     | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |
| Wlodarczyk, 2018    | Yes                                           | Yes                                           | Yes                                          | No                                              | Yes                                           | Yes                                               | Yes                                           | Yes                                             | Yes                                           | Valuable                                       |

*Crawford2007b is a short published paper based on Crawford 2007a which is a long-form report and provides details in full. Only the quality ratings of Crawford 2007a have therefore been provided.
Six overarching themes were identified through meta-synthesis: 1. The use and misuse of
diagnosis; 2. The patient journey through services: nowhere to go; 3. Therapeutic relationships:
connection and distance; 4. The nature of treatment (including intervention models): not doing too
much or too little; 5. Managing safety issues and crises: being measured and proactive; and 6.
Clinician and wider service needs (including clinician support, interagency working and the wider
system, and establishing new services, interventions and skills): whose needs are they anyway?
These themes are further described below. Table 3 gives further supporting quotes from the studies
relevant to each theme. While conducting the analysis, variations by setting or by participant
characteristics were considered. Substantial variations by country or by year of data collection were
not identified but variations between types of clinician and service setting were found: these are
described where relevant.
Table 3. Table of quotes

| Theme | Subtheme | Quotes |
|-------|----------|--------|
| The Use and Misuse of Diagnosis | | “The global, all-encompassing nature of the diagnosis, coupled with the view that it was untreatable, could have a devastating impact on the individual, while also leading to a lack of therapeutic optimism on the part of clinicians. Personality disorder was seen as having all the drawbacks of a mental illness diagnosis, especially in terms of stigma, but none of the benefits, particularly access to services. Likewise, the contested and uncertain nature of personality disorder limited the potential for users to gain some control over their condition through information and control. The diagnosis could lead to people facing discrimination and stereotyping within mental health services, within generic health and social care services and within society at large, with individuals being labelled as attention-seeking and demanding. A different view expressed by some service providers was that personality disorder is best understood as a form of social deviance or cultural rule-breaking. One respondent described people with a personality disorder diagnosis as those whose ‘behaviours, attitudes, lifestyles seem to consistently transgress cultural norms, which brings them into conflict with other people, in the absence of any symptom of an underlying mental illness…’ These respondents believed that a diagnosis of personality disorder could simply serve to medicalize or pathologize an individual’s feelings of distress.” (Stalker et al., 2005) |
| The Patient Journey into Services: Nowhere to Go | | “Several GPs described adopting a strategy of ‘writing-up’, or embellishing descriptions of a patient’s risk status in order to ensure that the patient was seen by secondary care services. On the other hand, faced with an overly cautious response from IAPT, several GPs described emphasising the patient’s more ‘agreeable’ mental health conditions, such as depression or anxiety, to maximise the chances of the patient being accepted into treatment.” “GPs also described patients with PD as having to endure particularly long waits, before being seen—waiting times that often far exceeded those experienced by patients with other mental health problems. Indeed, several GPs described patients with PD having to wait over 12 months for treatment. They felt shortening waiting times would reduce the likelihood of mental health problems escalating or patients disengaging from the health service altogether.” “Unfortunately, because of the model of stepped care in the Trust, there were barriers to primary care staff wishing to refer patients directly into a tertiary service, such as a specialist psychology service for people with PD. ‘Have a real problem in getting through the cycle of exclusion: GPs who identify suitable patients cannot refer to [tertiary psychology service] if they have to refer to the CMHT and get them to take person on… so we cannot keep clients out of mental health services and CMHT’s can say they won’t take them, as don’t meet their criteria.’” “The majority of referrers made reference to the assessment as an important part of the process, and some stated that having an assessment was one of the reasons for referring someone to the service. Referrers linked to two services made specific comment of how much they valued the provision of a comprehensive assessment, even if the service user was not taken on. Benefits included helping the referrer to develop their own management plan or to better understand the service user’s problems and building confidence and trust for the service user.” (Crawford et al., 2007) |
| Therapeutic Relationships: Connection and Distance | | “A few service provider respondents however were careful not to locate ‘the problem’ within individual service users. They believed that unhelpful responses from mental health services were often responsible for compounding people’s problems shown, for example, in judgemental attitudes expressed by some staff who reportedly used words like ‘manipulative’, ‘attention-seeking’ and ‘demanding’ to stereotype people with personality disorder diagnoses.” “Patients have a hard time trusting a therapist and may only do so after quite some time, which professionals tend to underestimate. These people really need a secure attachment, they fight it for a year, claim help and then reject it again. But if one succeeds in breaking that pattern, one can really mean something.” “On the other hand, a dependency relationship may be perceived as dangerous in community mental health care as many patients become long-term users that lay a large claim on scarce resources, according to the experts.” “Clare uses the powerful metaphor of a nursing mother to describe the nature of the relationship. She seems to feel ambivalent about being at the mercy of a newborn baby, whose need to feed on demand cannot be denied. It is as if her capacity to psychologically nourish these clients is being ruthlessly exploited: ‘they latch onto you and it’s like… sick… it’s like… sick… sick.’” |
"For clinicians, the encounter with the depth of their clients’ needs and their sense of emptiness or lack of self-acceptance is an uncomfortable awareness of their own vulnerability and inner emptiness: ‘What you're met with is a needlessness which is bottomless really... and it’s almost collateral to the emptiness is the needlessness and lack of self... what a lot of borderline patients talk about is being in nothingness, their experiences of nothingness, they have the most acute sense of nothingness that I think you’ll ever come across... it’s within that that the draining and the existentialness of it all, because we all experience emptiness to some degree, but I think these clients... they almost get a heightened sense of all these things... so I almost get a heightened sense of what humanity is and vulnerabity." (Rizq, 2012) (63)

The Nature of Treatment: Not doing too much or too little!

"Some of the experts are particularly critical of the apparent denial that can be seen to occur in several settings of the long-term nature of the problems of the patient with a severe BPD. That is, a rather naive and overly "optimistic" attitude characterizes professionals who rapidly discharge such patients. According to the experts, in fact, such optimism is simply "therapeutic nihilism" disguised as optimism... The combination of powerlessness and the blaming of the patient for any lack of progress, may result in non-therapeutic behavior, on both the part of the professional, such as irritation, anger, and even aggression. Less overt but equally destructive is the reduction of the therapeutic encounter to doing as little as possible and simply hoping that a crisis does not arise. Further referral of the patient without substantial justification of the reasons for doing this is another example of really doing nothing. 'Professionals have many strategies to do completely nothing in therapeutic encounters with the patient.' (Koekkoek et al., 2009) (53)

"One respondent used the term "hard to engage services" to describe what she saw as a model of provision too inflexible to find ways of taking on the often chaotic reality of people’s lives." (Stalker et al., 2005) (54)

"A continuum of severity and complexity was referred to, with acknowledgement that those who were deemed less complex could respond well to routine IAPT treatment but people with what was deemed to be more severe presentations would struggle with routine treatment as they could oscillate from one problem to the next on a weekly basis making adherence to the IAPT model and protocol delivered therapies very challenging to deliver. Participant frustration at the lack of treatment options and the constraints of time-limited therapy was commonly reported." (Lamph et al., 2019) (53)

"In recognition of the heterogeneous needs and capacities of people with PD, most of the pilots set out to provide a range of services. Provision of more than one service or treatment option also enabled most pilots to present a choice to potential service users, a capacity that many believed important in promoting engagement." (Koekkoek et al., 2009) (53)

"Look, although I’m not doing my job properly here — I’m seeing people for longer, I’m, you know, they’re dropping in, tapping them up every so often when they need it — so on the one hand I see that as a failing in me, but I think it’s also a response to the needs of this type of client. It’s just not just coincidence, inexperience in this field, in this type of work with personality disorder.”

"Michael’s account exemplifies counsellors’ struggle with what appears to be an insoluble paradox — that the establishment of a much-needed therapeutic relationship is precisely what is most likely to evoke yet further trauma for the borderline client when it ends: ‘They could experience it as a good experience of another — that not everyone’s going to destroy them, if you know, which is their fantasy... But at the same time, you’re then are faced with the whole thing unfolding that. And are you going to do them any good? And are we really just re-traumatising these people again?’ (Rizq, 2012) (63)

Intervention models

"I think an ability to manage their emotions better, because they usually come into our service because, on a day to day basis, their emotions are causing them all sorts of difficulties in their personal life, with regard to employment, education, leisure activities, and they are perhaps just going from one crisis or problem, to another, and no wonder they are anxious and depressed, which obviously brings them into our world.” (Lamph et al., 2019) (53)

"Many relatives have high expectations of the mental health system but are disappointed over time, which also results in a poor relationship between the family of the patient and professionals." (Koekkoek et al., 2009) (53)
Pilots included several day therapeutic communities: none was residential but they achieved a high degree of consistency through the guidance of shared consultants, staff and service users, and the Association of Therapeutic Communities. A TC is: a safe and secure environment, a place of safety, where people can come and learn how to make relationships... It creates an environment where people engage in normal interactions that trigger behaviours and feelings they have difficulty with: it's got to be an emotionally safe environment, where they can reflect on and interpret those feelings, so they don't have adverse consequences. [Crawford et al. 2007]

Managing Safety Concerns around Crises: Being Measured and Proactive

As a CPN if something goes wrong then the buck stops with you and then I think that does not help staff to take positive risks. Staff are very defensive in their practice and very risk adverse and in DBT it is about accepting that this is a risky client group and if we wrap them up in cotton wool all the time that is not treating them and I think it is about having a service that is prepared to take well thought out positive risks and I don’t think we are there yet. Because I think staff are so scared of things going wrong and them getting the blame and being sued it is very hard to allow clients to have some responsibility.” (Stroud and Parsons, 2013)

“There is general recognition that no external agent can stop a person self-harming: responsibility lies with the only person who can change the course of events, the service user themselves. Putting self-harmers into hospital on suicide watch by bodies: it takes responsibility away from them. It is better to talk to them about how it comes about and find something to divert them from it.”

“Several of the pilot services also have guidelines governing staff-client interaction, such as limits on the amount of time clients can spend in one-to-one sessions during crises...Staff suggest that the act of recording messages has advantages over phone calls because it introduces a slight delay which inhibits impulsiveness and allows a natural pause for consideration. Other services have suggested that e-mail messages to the service user have a similar function, even though they will not be read until the next working day...Methods for supporting people in crisis developed by pilot services seek to actively involve service users and tend not to provide an instant response. Service providers report that if people have been helped to prepare for crises, a delayed response can help ensure the service user plays an active role in crisis management.” (Crawford et al., 2007)

Clinician and Wider Service Needs: Whose Needs Are They Anyway?

“Some participants were clear that it was not simply more support that was needed, but a particular type and quality of clinical supervision. Cline was critical of the supervision she was offered in primary care, feeling that it was based on providing expert advice and technical information, rather than examining complex unconscious process issues within the therapeutic relationship. She seems to feel that this is a more general tendency where increasingly managed or professionalised forms of practice now take precedence over the emotional aspects of therapeutic work: ‘... it’s all about have you filled in the right form, rather than ‘what do you need for your work in terms of emotional support?’”

“I think that people with personality disorder need some kind of secure base if you’re going to work with them... I also work in secondary care and you see and when you work in secondary care, it’s easier to manage people with personality disorder because there’s somebody if they do feel suicidal or make a suicide attempt, there’s some structure in place. Whereas in primary care you’re kind of left on your own with somebody, and you don’t have a team to consult, you don’t have the support.” (Rizq, 2012)

“It actually helps workers to survive in their work, if they have a place to think... One of the main theories about, you know, personality disorder is that they don’t have the capacity to reflect on themselves and so if they’re involved in an organization that equally can’t reflect, you’re going to have this sort of mirroring that goes all the way up from the clinician themselves all the way up through the organization that’s trying to help the client.” (Crawford et al., 2010)

“At actualled workers in their work, if they have a place to think... One of the main theories about, you know, personality disorder is that they don’t have the capacity to reflect on themselves and so if they’re involved in an organization that equally can’t reflect, you’re going to have this sort of mirroring that goes all the way up from the clinician themselves all the way up through the organization that’s trying to help the client.” (Crawford et al., 2010)

“Participants noted the flattened hierarchy principle encouraged them to feel that they had a voice in TC and encouraged relational working by bridging the gap between therapists and members: ‘I felt more confident, I felt like I did have a voice in the group.’” (Vyas et al., 2017)

“In effect, there are all sorts of expectations on the part of all the players in the system, which may mean that those with the least power are the least likely to have their expectations met.”

“Differences in models of understanding might at times be helpful: ‘The opportunity to have a number of disciplines, and talk through a particularly difficult case... that’s the strength of the team... it is that exchange of ideas and it does alleviate things an awful lot’. When asked, ‘what helps you keep working with someone when you feel you’ve tried everything and nothing seems to have helped’, workers reported that joint working, attention to the needs of workers, including good clinical supervision, trying alternative interventions and working with people who have different models of understanding and alternative perspectives were all potentially helpful... It can also depend on mutual understanding and respect: ’If you can look at the immediate thing, it might be that you’ve got different ideas but somewhere above that, the motivation
might be common, where the aims overarch. "[Priest et al., 2011]"

The high but inefficient use of the services of several agencies by patients... contributes further to this lack of continuity, the diffused nature of the treatment being offered by professionals, and responsibility for treatment." [Koekkoek et al., 2009]

"We get very little feedback from the talk therapies team as to how they felt things went. We obviously get the feedback on how treatment is going. It’s important I feel because if the service works closely with you it helps you to support the patient better. Added to which many of these patients have other health complaints and better communication can only lead to better treatment." [French et al., 2019]

Almost all groups of clinicians reported the need for more training in working with persons who have a personality disorder, particularly for generalist mental health workers and frontline and ancillary staff. Similarly, several groups of clinicians also emphasized the need for a coordinated and cross-agency approach to training, including staff from other government agencies that have more frequent contact with clients with personality disorders, such as social service organizations. This is in order to encourage an intensive and integrated case management approach (e.g., coordinated whole of team training), and cross-agency training within local areas: health, police, community mental health, custodial services, community services.

Another theme that emerged was the need for better acknowledgement of the existence of personality disorder as a diagnostic group, and a recognition of the costs and time required to help these clients (e.g., ‘acknowledge the disorder: it exists, is treatable, worthwhile, and economically good to treat’, ‘seeing treatment of personality disorder as core business, alongside mood and psychotic disorders’, and ‘recognition of the enormous cost of the disorder in terms of health service resources, clinician time, [and] administration’). [Fanoian et al., 2013]

Establishing new services, interventions and skills

Clinicians felt their confidence to recall theory and detail post training could fade, as they relied on daily case management activity. [Bosanac et al., 2015]

Several administrators described the importance of ongoing training to accommodate staff turnover, exemplified by the administrator who said: "There is no provision for training new people once the training is over. We don’t like that [the trainers are] out after that instead of providing training on an ongoing basis." [Herschell et al., 2009]

The respondents were asked to provide general feedback on how training stran address the challenges of implementing DBT mentioned above. Several respondents discussed the difficulties in establishing collaboration between teams of different agencies and viewed this collaboration as key to sustainability of their DBT program, due in part, to the changing of staffing and the loss of many team members due to financial cutbacks. [Carmel et al., 2014]

Because of the fact the network was initially a pilot there was limited access to funding and resources and their capacity to coordinate care for a large number of clients was restricted. It appeared to the referring bodies that the network was unable to cope with the scale of need. [Hogard and Ellis, 2010]

"Training alone was perceived as insufficient for practice, but a combination of training and hands-on experience was useful to build confidence. One participant stated ‘that could perhaps be a good thing if it was—if everyone saw at least one person through it... they felt comfortable in it, they felt that they could relax... they could actually engage better with the person.’ [Pigott et al., 2019]

However, there were some clear areas in which the participants were less satisfied, for example, with the viability of post-training implementation of methods, most notably associated with a perception of an increased time pressure created by some of the practices suggested. [Thompson et al., 2008]
1. The use and misuse of diagnosis

Our main aim was to synthesise evidence on clinician views of good practice, but it was clear that underlying beliefs about the nature of such difficulties and the appropriate use of diagnosis influenced clinicians’ perspectives on care. A few studies reported that some clinicians found conceptualising and diagnosing difficulties as “personality disorder” helpful. They saw it as offering a ‘common language’, and a useful way to understand service users’ difficulties, while also helping to ensure that service users were seen as having genuine needs.

However, across a number of studies, clinicians questioned the use, meaning and validity of this diagnosis. They saw it as being associated with stigma, discrimination and exclusion from services, felt it could be difficult to ‘shake off’, and risked becoming “the person’s entirety”\(^{(47)}\).

*Patients with a psychosis were seen as not accountable and in need of support. Borderline patients, however, were considered theatrical, posing, and in need of punishment.*

Psychologist describing a crisis intervention team (Koekkoek et al., 2009)\(^{(53)}\)

Accounts of the use of “personality disorder” diagnoses in non-specialist primary and secondary care services suggested it was made at times on a basis of “gut instinct”\(^{(54)}\) or “gut feeling”\(^{(70)}\) or because other diagnoses did not ‘fit’. An investigation of clinician views in generic community and voluntary sector services found that some perceived “personality disorder” as essentially “a form of social deviance or cultural rule-breaking”\(^{(64)}\), while others felt that the label was an unhelpful medicalisation of legitimate feelings of distress, especially among women. In this study, as in several studies examining perspectives of specialist clinicians, a majority of clinicians saw trauma and adversity as major causes of “personality disorder”. As a result of concerns about diagnosis, clinicians were reported in several studies to be reluctant to use this label and to avoid discussing it with service users. Some opted for alternative diagnoses (e.g., complex post-traumatic stress disorder) or employed what they considered to be ‘euphemisms’ like “difficulty managing
Other specialist clinicians reported that they preferred a focus on narrative descriptions of presenting difficulties rather than relying on a "personality disorder" diagnosis.

2. The patient journey into services: nowhere to go

Access to services for people with CEN was reported in several studies to be a persistent difficulty, with GPs in one study\(^{(49)}\) reporting longer waiting times than for any other group of mental health service users. Referrals for specialist support were impeded by factors such as a lack of local services, lack of awareness of services, frequent changes to services, and poorly established referral pathways. This was felt to risk disengagement, escalation of distress, or missing windows of opportunity to provide effective support.

Thresholds for acceptance by specialist services were reported in some studies to be inconsistent and influenced by subjective judgements regarding for example ‘severity’, ‘stuck’ness or ‘motivation to engage’. Many service users were excluded from specialist support due to being perceived as a risk to others (e.g., through having a forensic history), having substance misuse problems, exhibiting behaviour considered too ‘problematic’ or ‘chaotic’, or being seen as ‘non-psychologically minded’.

Referrers such as GPs in several studies also reported difficulties getting service users accepted by generic, mainstream community mental health teams or psychological treatment services. However, in other studies, clinicians working in these generic teams saw their eligibility criteria as over-inclusive, with one study describing them as a “dumping ground” for anyone who did not ‘fit’ elsewhere\(^{(62)}\). Stepped care pathways could also contribute to difficulties accessing appropriate treatment. For example, clinicians in the UK reported being encouraged to refer initially to primary care Improving Access to Psychological Therapy (IAPT) or mainstream secondary care services, rather than to specialist teams. However, knowledge and capacity for treating CEN were often seen as lacking in these generic services, with people with CEN not prioritised and clinicians feeling they did not have the skills to deliver expected care. Some referrers described ‘embellishing’
referral information to meet thresholds for specialist support. However, in other cases, GPs as well as assessors in secondary care services, ‘downplayed’ service users’ difficulties or risk levels and emphasised ‘more agreeable’ traits to meet thresholds for primary care support, such as IAPT services. Service users could end up being passed back and forth in “a tennis ball effect”\(^{(54)}\) with a high but inefficient use of services.

> You know if you mention ‘PD’ there will be nowhere at all for them to go so I’m usually very careful not to put it down in their notes. I usually say depressed or a bit anxious. Something that won’t make them think the patient is risky. It’s about knowing the hoops that you’ve got to jump through.

GP (French et al., 2019)\(^{(49)}\)

The referral process was reported to be facilitated by good working relationships and communication between receiving clinicians and referrers, outreach by specialist services to raise visibility and explain service models, and acceptance of self-referrals, which some felt could be empowering and inclusive. Some referrers valued holistic, in-depth assessments and formulations from specialist clinicians, particularly non-medical, non-psychiatric or psychodynamic formulations, even if service users ultimately weren’t taken on, as these could inform treatment plans and facilitate therapeutic relationships.

3. Therapeutic relationships: connection and distance

Strong, trusting relationships between clinicians and service users were seen as key to treatment success across many studies, but clinicians’ experiences of such relationships varied greatly both between and within studies. In several studies, clinicians were keen to emphasise the positives of working with people with CEN, describing them as ‘relatable’, ‘honest’ and ‘creative’, and seeing the role of the clinician as being to “harness that”\(^{(37)}\). However, negative feelings and a sense of burnout were also frequently described, with clinicians viewing (or reporting that other clinicians viewed) service users as ‘demanding’, ‘challenging’, ‘risky’, ‘dependant’, ‘self-destructive’,
‘manipulative’, ‘non-compliant’, ‘untreatable’, and likely to ‘push boundaries’. Service users’ difficulties were seen as enduring but urgent, and clinicians could feel overwhelmed by “a bottomless pool of need” especially as comorbid diagnoses and wider social issues with housing, employment, finances and social networks were often also present. Clinicians described feeling both idealised by service users and as though nothing they did was good enough. While establishing an authentic connection with service users was seen as vital, clinicians admitted to fears of being “sucked dry” and “emotionally swamped”, experiencing feelings of vulnerability and of being dangerously on the edge of losing their sense of self.

Participants spoke repeatedly about the need to maintain a psychological distance from clients in order to prevent themselves from becoming overwhelmed or burned out. (Langley & Klopper, 2005)

In a few studies, however, clinicians reported they felt able to make use of their unsettling feelings to connect with service users’ own feelings. Although there were exceptions, negative attitudes and experiences appeared particularly prevalent in mainstream primary and secondary care services. This was attributed to poor understanding of CEN in these settings, to staff being overburdened but inadequately supported, and to observing poor outcomes, leading to frustration, hopelessness, and sometimes feelings of aggression and blame towards service users. Suggestions to combat negative attitudes included better supervision and training by specialists to improve understanding, compassion, and perceptions of treatment effectiveness, along with more support from services for clinicians to engage with supervision and training.

Overall, the impression across studies was that clinicians described the need to be authentic, non-judgemental, empathic, collaborative, hopeful, motivating, consistent and dependable to build trust with service users, whom they understood often to have had histories of abuse or abandonment by key attachment figures. The importance of ‘knowing’ service users, holding them in mind, and acknowledging the reality of their experiences was emphasised. When relationships went
well, clinicians described successfully negotiating connection and distance in the therapeutic relationship: being open, warm and available, but also retaining boundaries, structure and a degree of emotional detachment. Clinicians spoke of a need to create a sense of shared responsibility for progress with service users, and of the value of adopting a curious, non-expert stance to help develop a safe space where strong emotions could be processed, tolerated and “radically accepted” (47).

Clinicians who reported more positive relationships tended to be those who felt better supported, for example describing better team working, supervision, and informal support from their colleagues, as well as longer-term treatment frameworks, which allowed time for relationships to develop. Such support appeared to be much more available in more specialised services.

4. The nature of treatment: not doing too much or too little

Clinicians’ beliefs regarding appropriate duration of treatment, and how best to negotiate not doing ‘too much’ or ‘too little’, were complex. There was consensus across studies that people with CEN had long-term needs, but in a few studies clinicians voiced concerns that open-ended, long-term support could be too demanding for service users to engage with, too resource-intensive, or could result in ‘dependency’ and a lack of delivery of interventions with clear therapeutic content, particularly in generic secondary care services. Clinicians felt that it was important to be realistic about what they could achieve and to avoid setting expectations that they could ‘fix’ everything. At the same time, in several studies clinicians emphasised that not offering sufficient long-term support could result in unrealistic expectations for recovery, disappointment and undertreatment. Several studies reported a perceived lack of well-developed, longer-term support programmes at a medium level of intensity.
The requirements of the system do not always fit with the needs of the people who are using the service: The expectation is that you will recover... you will get out of the service... we can only work with you for a certain amount of time... It just doesn’t work as simply as that.

Mainstream secondary care clinician (Priest et al., 2011)

Across studies, clinicians described a need for balance between recognising the limits of what could be achieved, managing the expectations of both clinicians and service users, and maintaining hope. In one study, clinicians saw a tendency in mainstream settings for clinicians to “do completely nothing” in therapeutic encounters with people with CEN, or alternatively to display ‘false optimism’ or ‘therapeutic nihilism’, rapidly discharging service users due to underlying feelings of powerlessness and demoralisation. Paradoxically, however, such undertreatment then had the effect of increasing the very ‘dependency’ clinicians feared, as service users had to keep ‘coming back for more’.

Premature discharge was identified as common and was put down to clinicians seeking to ‘escape’ from work they found challenging, to service recovery models conflicting with service users’ needs, and to pressures to move people on. Yet, there was consensus across several studies that discharge could be particularly challenging for people with CEN and needed to be managed sensitively, especially because of associated safety issues (e.g., due to service users feeling abandoned by clinicians). Views diverged, however, about the best way to approach discharge. For example, in one study evaluating specialist services for CEN, some clinicians feared that open-ended service use without a clear plan for discharge could reduce service users’ motivation to develop coping skills, affect the service’s capacity to take on new referrals, and encourage ‘dependency’. These clinicians felt having discharge or self-sufficiency as a time-specific goal from the beginning of care was helpful. However, other clinicians in the same study favoured offering continuing support at a lower level of intensity (for example through peer support), rather than
absolute discharge following a period of intensive treatment, with clear provisions for re-engaging
with services if required.

Short-term therapy, such as that offered by IAPT in the UK, tended to be seen as
insufficiently flexible and intensive for people with CEN. In one study, primary care clinicians
described a sense that they were “short-changing” service users. In a few studies, clinicians also
expressed fears that short-term support could potentially be harmful or experienced by service users
as ‘abandoning’ and ‘retraumatising’. However, in a small number of studies clinicians did argue that
short-term support had value, either at specific points in service users’ treatment journeys, or for
those with less severe difficulties.

Clinicians in multiple studies also underlined the need to deliver both psychotherapeutic
interventions and pragmatic social support to meet the varied and fluctuating needs of this
population. Pragmatic support, which was reportedly offered more often in specialist services, could
include vocational, educational, social, substance misuse, or parenting support, as well as skills to
promote independence.

Intervention models

Specific treatment models that clinicians reported as having therapeutic benefits included
Dialectic Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT), Cognitive Analytic Therapy
(CAT) and psychodynamic formulations. However, in several studies clinicians also emphasised that
‘one size does not fit all’, that diverse, flexible treatment options were needed within mental health
services and in primary care, and that more formulation-driven treatments could be more beneficial
than those based on diagnosis or driven by manuals.

There was a consensus across studies that a variety of approaches could be taken to some
core therapeutic tasks, making a range of interventions similarly effective in achieving good
outcomes. Clinicians tended to see difficulties with managing emotions as central in CEN, and
prioritised interventions that promoted development of skills relating to emotion regulation, distress
tolerance, or developing a capacity for thinking and feeling rather than doing. Similarly, models that
helped service users to practice their interpersonal skills (e.g., via groups, peer support, or
therapeutic communities) were seen as valuable in several studies. DBT was the specific therapeutic
intervention most often discussed in studies and clinicians identified several benefits from this. As
well as helping service users develop better relationships and emotion regulation, clinicians felt it
was based on a clear model and manual, and that it promoted hope, decreased medication use,
encouraged service users to take responsibility for treatment, and helped encourage compassion,
understanding and team working on the part of clinicians. Clinicians in some studies did, however,
also report that delivering DBT placed considerable demands on them and their services, including
the need for intensive training, implementation of a complex model allowing relatively little
flexibility, and being contactable outside of working hours.

Formats like groups, peer support, and therapeutic communities were also valued for
broadening the range of available options and promoting collaborative, user-led models of care and
empowering service users to have ownership over their treatment in a more democratic way. Finally, support for family and friends was identified in several studies as important but as an area
where even well-resourced specialist services often fall short despite the perception that people
with CEN often experience difficulties with relationships.

5. Managing safety issues and crises: being measured and proactive

Managing safety issues was considered vital across all treatment settings. The nature of
deliberate self-harm and other safety issues in the context of CEN was seen as differing from acute
presentations in other mental health conditions because of its chronic, recurrent and to some extent
predictable nature. As such, clinicians felt it could be prepared for proactively, through open
dialogue with service users to agree parameters within which clinicians would respond.
In a small number of studies, clinicians suggested that ‘rescuing’ or stepping in too quickly at times of crisis could be detrimental or disempowering for service users. However, there was a competing need not to become neglectful, with a lack of consensus regarding how available clinicians should make themselves. Views about out of hours service provision varied. In one study of community-based mental health services implementing DBT, some clinicians described 24/7 availability or an ‘on call’ system as a ‘step backwards’ and ineffective. But in other studies clinicians argued that this was important, and that greater availability of support in fact usually reduced the need for it. Some clinicians felt that people with CEN were seen as ‘bad’ for posing a safety risk, in contrast to those with other diagnoses, such as psychosis, who were seen as ‘mad’.

Practice in mainstream services was described in some studies as risk-averse and reactive, sometimes creating a vicious cycle wherein service users felt they had to present in crisis to get more input. Clinicians used to dealing with crises in the context of conditions such as depression or psychosis were reported to struggle to manage the specific dynamics of safety concerns for people with CEN. Specialist services were seen as adopting more proactive approaches, negotiating plans for managing safety issues in collaboration with service users, moving away from action-reaction or fearful responses from clinicians, and fostering ownership of the management of safety issues among service users.

6. Clinician and wider service needs: whose needs are they anyway?

Clinician needs

A recurring challenge across studies was for clinicians to reconcile their own needs with those of service users. This dilemma was particularly acute where clinicians lacked organisational support or adequate supervision. Clinicians found themselves negotiating between meeting the needs of service users, their own needs, and wider service needs. When synthesising studies, it was complex at times to disentangle whose needs were in reality met by particular practices. For
example, when clinicians described a need to reduce service users’ alleged ‘dependency’ and promote ‘self-sufficiency’, this seemed in part connected to clinicians’ own feelings of being overwhelmed, as well as to wider service pressures to conserve resources. One study of clinicians working in ‘personality disorder’ services suggested that service users’ perceived difficulties (e.g., with reflection) could be ‘mirrored’ further up the organisation. This study also reported that service leads across several teams appeared to be ‘charismatic’ but also ‘autocratic’, seeking to ‘quell dissent’ among clinicians by adopting firm, unequivocal stances. In other studies, it was clear that services, rather than service users, were at times experienced by clinicians as ‘difficult to engage with’.

It’s not the patients that make you frustrated nowadays, it’s the organization around that is troublesome.

DBT Therapist (Perseius et al., 2003)

The importance of clinicians feeling supported in their work was a common theme across studies. Working effectively with people with CEN without becoming burnt out was seen as achievable, but the organisational support needed to do so was often missing, with the low priority and investment accorded to treatment of people with CEN affecting both service users and clinicians. Clinicians valued both supportive relationships with colleagues and formal supervision in a variety of formats, including individual and whole team supervision and input from external experts. The importance of addressing clinicians’ own emotional needs, engaging in reflective practice and enabling clinicians to process their own vulnerabilities and ‘destructive’ emotions was emphasised, but provision was frequently described as inadequate.

Good team-working and sharing responsibilities for treatment and decisions regarding safety also helped clinicians to feel supported. This appeared to be reported most often regarding specialist teams, especially in those using DBT and CAT models, and in therapeutic communities, and least frequently in primary care settings – where “you’re kind of left on your own with
somerbody”[63]. There could also be challenges in teams where only one or two clinicians in a team were trained in a particular therapeutic intervention or skill set. While clinicians saw value in including a range of clinicians with diverse backgrounds and approaches they also felt this could encourage “splitting”, making it more difficult to develop a shared language or model of understanding across team members.

Having divided caseloads (i.e., not fully CEN) was considered by some to be beneficial for integration of CEN work into generic teams and for staff wellbeing. However, having competing clinical priorities could impede therapeutic work, and the ‘psychological shift’ between various roles was experienced by some as challenging. One study noted that specialist services tended to promote broad, combined roles where all clinicians contributed to delivering the therapeutic model, but this required significant training. Specialist services sometimes had ‘flat hierarchies’ which could be empowering but also frustrating for clinicians when responsibility was equal but authority or pay, for example, was not.

**Interagency working and the wider system**

Effective inter-team and inter-agency working was considered important for management of the resource-intensive, multi-agency, and often out-of-hours service use by people with CEN. However, reports of inadequate communication between services were common at all levels of care. Challenges included high staff turnover, staff cutbacks due to reduced budgets, time constraints, and disagreements between clinicians or competing priorities, with poor interagency working leaving clinicians feeling more anxious and less contained. Pre-existing, personal, or good professional relationships and clearly assigned responsibilities (taking into account service user preferences regarding clinicians and services where possible) facilitated interagency working.

Clinicians in mainstream services reported in several studies that they valued support from specialist services, such as in hub and spoke models, where specialist staff provide expert assessments, case consultation, supervision, and staff training to mainstream services. This model
was perceived as making efficient use of specialist staff, allowing them to support not only those on
their small caseload for intensive therapy but also a much wider group beyond the dedicated
services. However, reservations about such models were described in a few studies, including that
specialist input from specialists could undermine professional roles in mainstream service, may be
ineffective on an ad hoc rather than sustained basis, and risks specialist clinicians having
unsustainable workloads. There were also some tensions identified between mainstream and
specialist services, where mainstream services were seen as having to ‘firefight’ whereas specialist
services were perceived to have greater freedom to ‘select’ service users, refuse certain
responsibilities, and prioritise time for reflection.

**Establishing new services, interventions and skills**

Finally, a number of studies were conducted in the context of establishing a new service or
intervention programme, and thus themes emerged relating to good practice in initial
implementation. Factors that were considered helpful for developing new services or interventions
included: managerial support, recruitment of appropriate staff, leadership that embraced
uncertainty and allowed clinicians freedom to innovate, team building, cross-agency and whole team
training, and having realistic plans, timescales and budgets. Ongoing sustainability of new services
was facilitated by integrating them into existing service systems, effective interagency working, and
measuring and demonstrating good outcomes. Clinicians trained in new models described feeling
like ‘beginners’ despite their clinical expertise, and being required to make significant time
commitments for implementation and ongoing practice and learning. There was widespread
recognition of the need for ongoing support and training beyond the initial phase to support
knowledge retention and ensure programme sustainability. Some questioned the suitability of
mental health service settings for delivering services given previous unsatisfactory or traumatic
experiences for service users. However, acquiring alternative premises was often challenging.
Several overall proposals can be drawn from this synthesis of clinicians’ perspectives for good practice in treating this population effectively and respectfully and at the same time supporting the clinicians working with them. Areas of consensus between the findings of eligible studies included the need for high quality, holistic assessments and care plans encompassing physical, psychological and social needs; easily navigable referral systems enabling good continuity of care; and the need for a proactive, collaborative approach to safety management. Therapeutic relationships were seen as key and as a major common factor in the success of different approaches, and clinicians in participating studies believed that they could be improved through greater therapeutic optimism, overcoming pejorative attitudes, developing partnerships between service users and clinicians through shared responsibility and decision making, radical acceptance and a non-expert stance, and sustainable models for service user involvement in care.

Some dilemmas and variations in opinion were also identified, especially regarding the balance between doing ‘too much’ or ‘too little.’ Potential positive and negative consequences were identified both for open-ended long-term input and for time-limited input, as for 24 hour availability of clinicians in specialist services. Those who advocate for long-term support may be more in tune with service users, reported often to see periods of treatment as too short and continuing support between periods of intensive therapy as lacking\(^\text{(38)}\). Whether or not services were time-limited, there was agreement that careful collaborative discharge planning was required to mitigate some of the frequently experienced challenges and help service users work towards self-sufficiency.

Many of these findings align with those identified in our accompanying meta-synthesis of the perspectives and experiences of service users with CEN\(^\text{(38)}\). For example, service users also appear to prioritise individualised care, preferring clinicians to focus on individual needs and aspirations rather than diagnosis or intervention fidelity. Clinicians were called upon in papers on service user perspectives to sustain hope and provide encouragement while at the same time
maintaining realistic expectations and not invalidating service user distress. The centrality of the therapeutic relationship is a further point of consensus. While both clinicians and service users emphasised the need to offer a variety of treatment options to meet service users' heterogeneous needs, service users also prioritised structure, stability and a long-term perspective in their care. These are not inconsistent demands as options can be flexible and varied, yet the delivery of such can remain structured and consistent on an individual level.

Concerns around the usefulness and impact of using “personality disorder” labels were also similar to those reported from studies of service user perspectives. However, the included papers on clinician perspectives tended less to reflect recent calls by service user advocates and some clinicians, supported by patient testimonials and growing evidence, to give trauma a central role in the assessment and treatment of CEN(71, 72), a call also reinforced by feminist critiques of “personality disorder” as a mechanism for pathologising understandable responses to oppression, abuse and structural inequalities(17). This omission may in part reflect the fact that most studies were conducted before the rise of the ‘Trauma not PD’ movement(71, 72). We suggest that alongside the priorities identified above, incorporating trauma-informed approaches to care and preventing re-traumatisation within mental health settings should probably be seen as key elements in good practice if a shared agenda for service improvement is to be agreed on by service users and clinicians(73).

The value of exploring clinician perspectives is particularly in identifying ways of promoting positive change and of removing clinician-related barriers to this. This review echoes much other literature in identifying pejorative clinician attitudes and behaviours as an important obstacle to delivering care that is even adequate, especially in non-specialist settings. Developing and evaluating ways to challenge and change such behaviours is thus a pressing need. This review also identifies the need to extend more support to clinicians working with people with CEN; across several studies clinicians reported on the significant emotional toll of their work, which could potentially fuel
negative behaviours and a lack of therapeutic optimism. Several of our themes related to the need for clinicians to strike a balance, including balancing connection against distance, doing too much or too little in terms of treatment provision and balancing service user empowerment and independence with service pressures of risk-aversion. Needs of different stakeholders also require balancing: for example, do some clinicians warn against long-term input for the benefit of service users (to promote independence), for the benefit of themselves (to avoid challenging work), or for the benefit of services (to meet capacity constraints)? This balancing act, together with caseload and referral pressures, may well contribute to the emotional toll of working with people with CEN.

However, clinicians, especially in specialist services, also described many ways of alleviating this burden, including through supervision, reflective practice and informal support between colleagues. The burdens associated with difficult therapeutic decisions, especially regarding safety, were clearly alleviated by being shared, both with colleagues and service users. As such, multidisciplinary co-produced formulations, maintaining the centrality of the therapeutic relationship, and ‘holding in mind’ the SU could provide some guiding principles for clinicians when navigating these complex balances and would be a useful focus for further research.

Constraints on good practice relating to the wider service system were recurrently described, including exclusive thresholds and referral pathways, inflexibility of services to meet diverse and long-term needs and manage co-occurring conditions, and lack of time for reflection and training. Lack of recognition of the needs of people with CEN and lack of resourcing to meet these needs were widely reported and likely to contribute. These deficits may also reflect a lack of evidence and strategic thinking on how to optimise service design to result in coherent pathways allowing smooth transitions between accessible services corresponding to service users’ needs and delivery of a full range of evidence-based psychosocial interventions in all relevant settings. The major focus of research on CEN has been on the effectiveness and cost-effectiveness of relatively short-term psychological therapies: co-produced research taking a whole-system perspective on
how to design systems of care that meet the varying needs of diverse service users at different stages in their pathways through services now appears to be an important need.

Limitations

We aimed to include papers regarding management in the community of people with a range of “personality disorder” diagnoses or who might have related difficulties, such as recurrent self-harm, but not have received such a diagnosis. However, in practice most studies focused on people who had received a diagnosis of “borderline personality disorder”. As such, our findings relate mainly to this group, with some heterogeneity in the ways in which study samples were identified. There was a good variety of professional backgrounds and levels of care across included papers, but little literature about voluntary organisations and other community services outside the secondary mental health care system. This may reflect limitations of the search strategy, but probably also indicates a scarcity of research in these areas. This may mean that the voices of staff who support individuals who have disengaged or been excluded from the mainstream mental health system are not included.

As this is a meta-synthesis identifying and cross-validating over-arching themes across many studies, a level of nuance and specificity will have inevitably been lost, with findings pooled from a variety of contexts, dates and countries. The two researchers who worked the most closely on synthesis (JT and BLT) both have clinical experience of providing mental health care, while three other authors (JR, TJ, EB) bring relevant lived experience of service use—the results presented here and their interpretation may well be shaped by their perceptions born from these experiences.

Efforts were made to counter this through adopting an inductive approach to analysis, double coding a portion of papers, discussing themes together and iteratively, and through the collaboration of the review team and experts by experience and occupation.
Conclusion

Clinicians’ experiences of and perspectives on good practice for providing community care for people with CEN offer valuable insight into how to better meet the needs of this population and the needs of the clinicians supporting them and are largely in harmony with the perspectives of service users(38). In further research, a focus is now needed on how to implement these principles of good practice across the service system to improve service user outcomes and the experiences of service users and clinicians. Previous research has tended to focus on individual psychological interventions: a focus on designing a whole system of care that can meet the longer-term needs of people with CEN in a sustainable way is now desirable. Development and evaluation of fidelity measures that reflect agreed good practice(74,75), and of approaches to support services in achieving and maintaining high fidelity, is a potential approach to meeting this need. The apparent congruence on many values and principles between service users and clinicians suggests that a co-produced approach to future research, service development and policy formulation is likely to be fruitful.

Finally, an overarching emerging issue deserving further research and policy development is of equity: clinicians echo service users in arguing that people with CEN tend to be a marginal group, often not prioritised for resources and attracting negative attitudes and behaviour. Change is not likely to be achieved unless the needs of people with CEN are placed on an equal footing with the needs of people with other long-term physical and mental health conditions.

Lived Experience Commentaries

In line with service user critiques and our own lived experience, this meta-synthesis provides further evidence that for many people with CEN, current mental health services are simply not fit for purpose. From clinician burnout and pejorative attitudes, to a clinical victim-blaming culture when a service cannot meet service users’ needs, the signs of a system at breaking point are undeniable.

Since clinicians themselves seem to recognise the wider social context, i.e., that trauma and adversity are major contributors to the distress experienced by people with CEN, it begs the
question: why do most services still regard the medical model as the panacea? It appears that we
need major systemic change and services should truly embrace inclusive, co-designed approaches
that value lived experience and also support user-led models of care.

Clinicians’ concerns around diagnostic utility are noted and shared. However, ‘dancing
around the diagnosis’ due to fears of stigma and exclusion - no matter how well intentioned - may
actually be counterproductive and inadvertently further perpetuate the stigma. It only underscores
the urgent need to address this controversial terminology.

Despite the awareness of a gender bias that results in women with CEN being
disproportionately more likely to receive a “borderline personality disorder” label than men, there is
no mention of the overlap with Autism Spectrum Conditions (ASC)\(^{(76)}\) and the fact that women are
conversely under-diagnosed with ASC. This may have serious implications for potentially mis-
diagnosed service users who may end up trapped on unsuitable treatment pathways and therefore
constitutes a significant gap in the evidence base warranting investment in further research.

While we support inter- and multi-agency working in principle, stakeholders need to be
mindful of its potential pitfalls. For example, as if pathologising legitimate feelings of distress wasn’t
problematic enough, collaborating with law enforcement (e.g., through the “Serenity Integrated
Mentoring” programme)\(^{(77)}\) can exacerbate the risk of going as far as criminalising CEN. Such
misconceived interventions can not only permanently destroy service users’ trust in mental health
services, but can also have absolutely devastating effects on their life chances, negating any attempt
at meaningful recovery.

Overall, it is encouraging that there are clinicians who share our views after all, and the
answer to “Whose needs are they anyway?” should be a resounding “Everyone’s!”

After all, service users don’t benefit from working with stressed and burnt-out clinicians,
either; therefore, the desire to improve staff training and support is mutual. Unfortunately, the
prevailing systemic flaws are not conducive to either individual practitioner or service improvement.

Likewise, influencing those clinicians who are steadfast in holding onto stigmatising views of people with CEN is going to be a major challenge that should ideally be addressed with co-production throughout service development and delivery.

Broken Mirrors

Whilst reading this review, I was struck by the allegory of a mirror. The focus is on clinicians, but its sister paper with a service user focus\(^{(38)}\) reflects the same issues. The mirror allegory goes beyond similar themes being reflected. The opinions of each side are fragmented – like a broken mirror. The broken fragments of each side appear as perfect replicas of the other, yet can only see each other in reverse, appearing as polar opposites.

The data here is constricted to what is within the literature, with both papers dutifully reporting this. This data is limited in providing an understanding of why, despite appearing to want the same thing, there is such a relational divide between service user and service provider.

The roles of people working within the Lived Experience Professions (i.e., peer support workers, service user consultants, lived experience researchers) could be described as roles that bridge between the two polarised worlds, communicating sameness and difference between the two. Literature exploring how this could relate to developing relational bridges within the field of trauma/complex emotional needs/“personality disorder” is not included – potentially because it does not exist or exists in a format that does not fit within the search criteria. This highlights the importance of being able to value experiential data as a valid consideration within research, in order to lessen the phenomenon of studies giving a perfect view of one small fragment of the broken mirror, whilst disregarding the rest. Services benefit more from a full view of the broken mirror, even if the individual shards are more blurred than one perfect piece.
This gave me pause for thought when researchers described their experiences of working in
services as a potential limitation in the review. Once they have acknowledged their own perspective,
understanding the line between this and the data, their ‘limitation’ is in fact a strength – and this
knowledge needs to be recognised, valued and encouraged more. The literature we use to inform
and shape policy is not being practiced under lab conditions, but in the messy world where broken
mirrors exist.

Tamar Jeynes
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