Australian BPD Foundation
Level 1, 110 Church St, Richmond 3121.
PO Box 942, Bayswater 3153
p: +61 458 400 329
e: admin@bpdfoundation.org.au
w: www.bpdfoundation.org.au
ABN: 83 163 173 439

# Australian BPD Foundation 2022-23 Pre-budget submission

# The National BPD Awareness, Training and Professional Development Strategy

## *Raising awareness and upskilling and engaging clinicians working with people borderline personality disorder and their families*

**For further information on this submission contact:**

Rita Brown: Telephone 04 39 400 329 or email: rbrown@bpdfoundation.org.au

# TABLE OF CONTENTS

1. OVERVIEW ..... 4
1. Australian BPD Foundation Ltd ..... 4
1.2. National Borderline Personality Disorder (BPD) Training and Professional Development Strategy ..... 4
1.3. Borderline Personality Disorder (BPD) prevalence and issues ..... 5
1.4. Borderline Personality Disorder and Complex Post Traumatic Stress Disorder ..... 6
1.5. The need for ongoing education and professional development ..... 6
1.5.1. Current lack of skills and knowledge of clinicians to work with people with BPD and their families ..... 6
1.5.2. The prevailing (erroneous) belied that people with BPD require 'specialist' therapies. ..... 7
1.5.3. Quality of the BPD Core Competency Workshop ..... 8
1.6. Alignment of the National BPD Awareness and Training Strategy with the recommendations of the Productivity Commission Inquiry into Mental Health ..... 9
1.6.1 - A Person-Centred Mental Health System ..... 9
1.6.2 - Social inclusion and stigma reduction ..... 11
1.6.3 - Approach to suicide prevention ..... 13
1.6.4 - Improve emergency mental health service experiences ..... 14
1.6.5 - Improving care for people with concurrent mental illness and physical health conditions ..... 14
1.6.6 - Improved mental health training for medical practitioners ..... 15
1.6.7 - Family and carer-inclusive practices ..... 15
1.7. Alignment of the National BPD Awareness, Training & Professional Development Strategy with the recommendations of the National Mental Health and Suicide Prevention Plan 2021 ..... 16
1.8. Outline of submission ..... 16
1.9. Proposal Budget and Timeline ..... 18
2. APPENDIX A – part 1 National BPD Awareness Campaign ..... 19
2.1. BPD awareness in Australia ..... 19
2.2. Strategy for BPD Awareness: ..... 20
2.2.1. Reduce stigma and discrimination by: ..... 20
2.2.2. Increase appropriate responses to People living with BPD by: ..... 21
2.3. Vision ..... 21
2.4. Budget and Timeline ..... 22
3. APPENDIX B - part 2 Webinars & Virtual Library ..... 22
3.1. Introduction ..... 23
3.2. Professional Development Webinar Series ..... 23

3.2.1. Delivery of 10 x online professional development webinars ..... 23
3.2.2. Advantages of Webinars ..... 24
3.3. Virtual Resource Library for Practitioners ..... 24
3.4. Budget and Timeline ..... 25
4. APPENDIX C – Part 3_eLearning Modules ..... 25
4.1. Introduction ..... 25
4.2. Scope for Ongoing delivery eLearning Modules ..... 26
4.3. Project Budget and Timeline ..... 27
4. APPENDIX D - Part 4 BPD Core Competency Workshops Train The Trainer Program Including Post-Training Support ..... 27
4.1. Introduction ..... 27
4.1.1 Future Scope ..... 28
4.1.2. Deliverables ..... 29
4.2. Relevance and Quality of the BPD Core Competency Workshop ..... 29
4.3. Train the Trainer Program ..... 30
4.3.1. Future Scope ..... 31
4.4. Post Training Support ..... 31
4.4.1 Future Scope ..... 31
4.5. Budget and Timeline ..... 31
5. Conclusion ..... 32

# 1. OVERVIEW

## 1. Australian BPD Foundation Ltd

The Australian BPD Foundation was formed in 2011 by a group of volunteer consumers, carers and clinicians who were concerned about the erroneous views and myths and the negative culture that existed in relation to borderline personality disorder (BPD) within mainstream mental health services. Many people diagnosed with BPD and their family/carers were denied access to mental health treatment and support, based solely on their diagnosis. Our current membership is close to 1300 members.

We are an incorporated body and have been registered with ACNC since 2013. Over time, we have witnessed a change in people's attitudes and also in services – however we still have a long way to go to overcome the stigma and discrimination experienced by many with this diagnosis.

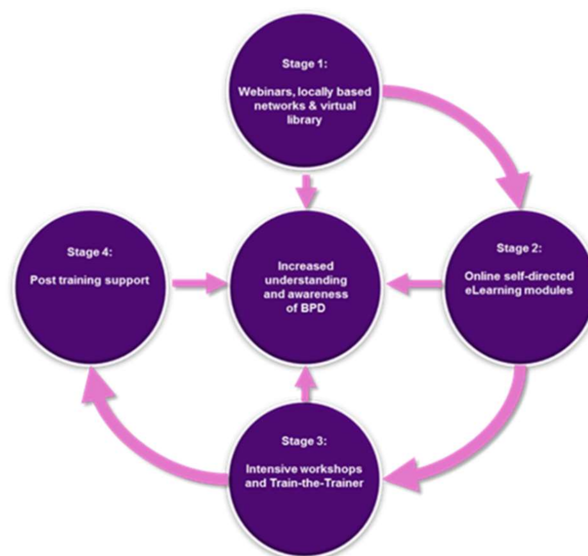
We aim to maintain an open dialogue developing an open dialogue between consumers, carers, clinicians and researchers to encourage a positive culture around the complex mental health issue known as borderline personality disorder (BPD).

## 1.2. National Borderline Personality Disorder (BPD) Training and Professional Development Strategy

Between 2017 and 2021, the Australian BPD Foundation in partnership with various organisations with funding from the National Mental Health Commission have delivered the National Borderline Personality Disorder (BPD) Training and Professional Development Strategy (National Training Strategy) to improve the capacity of clinicians[1] to recognise, respond to and treat people with BPD and be inclusive of families[2].

The original model of the National Training Strategy included four stages with each stage providing a model of education and training with increasing participant interaction (Refer to Figure 1).

Figure 1 Stages of the National Training Strategy




[1] Includes mental health workers, allied health workers, psychiatrists, psychologists, social workers, occupational therapists, nurses and medical practitioners etc., that work with people with mental health issues.
[2] The term family includes the diverse range of relationships of those who support someone with BPD in a voluntary capacity. It is inclusive of biological/non-biological family members (parents, grandparents and chilidren), partners, friends and carers.

Stages 1, 2 and 3 have been successfully completed and Stage 4 Post-training support is due for completion on 30th June 2022.

Overall, the National Training Strategy has been successful in achieving its aim in increasing clinicians' skills and knowledge in and attitudes towards working with people with BPD (Refer to Appendix 1, 2 & 3). With the last stage of the National Training Strategy close to completion, the purpose of this proposal is to seek funding to extend the National Training Strategy for another three years.

This document will outline the need for further professional development and upskilling of clinicians to improve their capacity to deliver appropriate treatment, care and support to people living with BPD (in addition to their family and friends [carers/supporters]),

Since research shows, that much of the stigma and discrimination experienced by people with BPD is perpetuated by mental health clinicians[3] we believe that expanding the current BPD Awareness Week campaign to be embedded and wrap around the National Training Strategy will considerably enhance the training offered by the strategy.

The project scope of the extension project including the Awareness component and associated costings are also included.

## 1.3. Borderline Personality Disorder (BPD) prevalence and issues

Personality Disorder affects up to 6% of the population[4], with rates of 40-50% estimated in psychiatric patients. An estimated 22% of psychiatric outpatients are diagnosed with borderline personality disorder (BPD).[5] Additionally, 31.4% of patients with an Axis I Disorder have a comorbid diagnosis of DSM-V personality disorder.[6] The prevalence of personality disorders is the same in both men and women. BPD is considered to be the "general" personality disorder, from which others are specific variants (e.g. paranoid, narcissistic).[7] This helps to account for why the majority of research in personality disorders is on BPD, as it is the most commonly presenting problem to health services and is a priority for the health of the nation [8]

BPD is characterised by difficulties with emotions, impulses and unstable interpersonal relationships and unstable self–image[9]. People with BPD experience significant distress and impairment due to difficulties in relating to other people and the world around them. In turn this results in much distress for their family and carers.[10] People frequently experience challenging relationships with themselves, close relationships, within their place of education/workplace and society in general.

[3] Daniel Ring & Sharon Lawn (2019): Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder, Journal of Mental Health, DOI: 10.1080/09638237.2019.1581337

[4]Tyrer, P., Mulder, R., Crawford, M., Newton-Howes, G. I. L. E. S., Simonsen, E., Ndetei, D., & Barrett, B. (2010). Personality disorder: a new global perspective. *World Psychiatry*, *9*(1), 56-60.

[5] Korzekwa, Dell, Links, Thabane, & Webb (2008). Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Comprehensive Psychiatry, 49*(4), 380-386.

[6] Zimmerman, Rothschild, & Chelminski (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *American Journal of Psychiatry, 162*(10), 1911-1918.

[7] Sharp, C., Wright, A. G. C., Fowler, J. C., Frueh, B. C., Allen, J. G., Oldham, J., & Clark, L. A. (2015). The structure of personality pathology: Both general ('g) and specific ('s') factors? Journal of Abnormal Psychology, 124, 387-398.

[8] Grenyer, B. F. S., Ng, F. Y. Y., Townsend, M. L., & Rao, S. (2017). Personality disorder: A mental health priority area. Australian and New Zealand Journal of Psychiatry, 51(9), 872-875.

[9] https://www.yourhealthinmind.org/getmedia/e4a256bf-e2b8-4870-8ee5-54fd0a1d3acc/Borderline-personality-disorder-YHIM.pdf.aspx?ext=.pdf

[10] Bailey, R. C., & Grenyer, B. F. S. (2014). Supporting a person with personality disorder: A study of carer burden and well-being. Journal of Personality Disorders, 28(6), 796-810.

People with the diagnosis of BPD are among those with the highest usage of mental health services, drug and alcohol services, emergency departments, intensive care units, housing, shelters and the justice system.[11]

## 1.4. Borderline Personality Disorder and Complex Post Traumatic Stress Disorder

The new edition of the World Health Organization's (WHO) 11th edition of the International Classification of Diseases (ICD-11) which was implemented from January 1, 2022 outlines an overarching diagnosis of 'Personality Disorder' and describes one of the predominant traits as 'borderline pattern'. The ICD 11 also includes a new diagnosis of complex Post Traumatic Stress Disorder[12] (Complex PTSD or CPTSD) to describe a disorder that may develop following exposure to a single or series of traumatic events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse).

The ramifications of these changes of broadening the diagnostic criteria for personality disorder and the inclusion of CPTSD is unknown. Until we have greater clarity the treatment for personality disorder and CPTSD will be mainly based on the research done to date for BPD.

The National Training Strategy increases psychological literacy and embeds the core skills required to work with people with experiences of trauma such as compassion, collaboration, listening, and working with the person (eg to prepare a plan of treatment), being trauma sensitive and recovery focused.

These skills are minimally if at all included in traditional training for mental health workers. Clinical experience to date shows that these skills will be equally as effective for complex PTSD increasing the capacity to upskill clinicians to work with people experiencing personality disorders and/or CPTSD (and to support those that support them).

The Core Competency Training (Stage 3) also highlights the important role of 'carers' (family, friends, supporters) and this will be expanded with the proposed extensions to Parts 2 (webinars) and Part 3 eLearning modules.

For simplicity, in this summary and the attached proposals reference to BPD is inclusive of the ICD11 diagnostic criteria for Personality Disorder and Complex Post Traumatic Stress Disorder.

## 1.5. The need for ongoing education and professional development

### 1.5.1. Current lack of skills and knowledge of clinicians to work with people with BPD and their families

Anecdotally, the foundation regularly is contacted by people seeking treatment and support and telling us they are frequently being turned away by services ….."we don't treat people BPD" and contact we have had with a number of the Gateway / Directory services highlight the lack of knowledge about BPD (some still perceive that BPD is bipolar disorder).

A study investigating the confidence of psychiatry trainees in diagnosing, supporting, and treating borderline personality disorder found that the respondent's confidence scores with respect to BPD were overall considerably lower in comparison to schizophrenia. The biggest difference was found in delivering treatment, as well as developing a management plan, assessment and management of

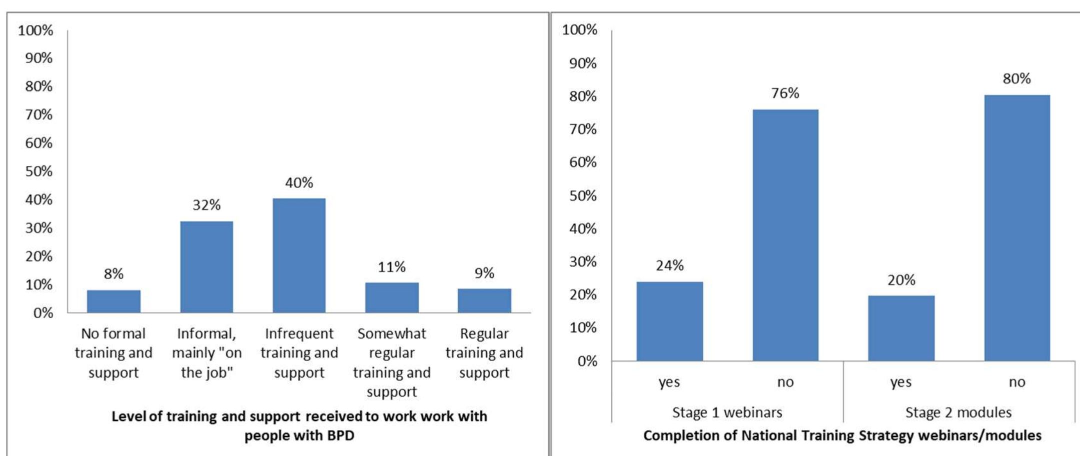
[11] Grenyer, B. F. S., Ng, F. Y. Y., Townsend, M. L., & Rao, S. (2017). Personality disorder: A mental health priority area. Australian and New Zealand Journal of Psychiatry, 51(9), 872-875.
[12] https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559 [accessed 17/12/2021]

suicide risk and working therapeutically with the person. The study also found that trainees want to learn the skills required to treat BPD however, due to the lack of training they feel unable to offer little beyond crisis management and a sense of therapeutic nihilism pervaded.

The lack of clinician training in BPD is evident in **Error! Reference source not found.**. As shown in **Error! Reference source not found.**, only 9% of participants had received regular training and support in BPD. Most participants had received either informal on the job training or infrequent training and support. Most participants had not completed the Stage 1 webinars or Stage 2 modules, although this was not a prerequisite to attend the BPD Core Competency Workshop. These results highlight how important formal training in BPD (such as this National Training Strategy) is made available to all mental health clinicians across Australia.

Whatever the motivation is for clinicians to attend the workshops, the important outcome is that they have an increased understanding of the person with BPD and how to help them using the therapeutic principles outlined in the workshop. The evaluation of the workshops found a shift in attitudes towards people with BPD with an increased willingness to treat which hopefully results in a decrease in stigma and discrimination experienced by the person with BPD (refer to quality of workshops section below).

*Figure 1 Level of training in BPD*




## 1.5.2. The prevailing (erroneous) belied that people with BPD require 'specialist' therapies.

The core competency curriculum developed by the Australian BPD and Spectrum is based on the common factors approach as outlined in the NHMRC *Clinical Guidelines for the Management of Borderline Personality Disorder'* developed by the National Health and Medical Research Council in 2012. It is regrettable that these high quality guidelines have never been implemented.

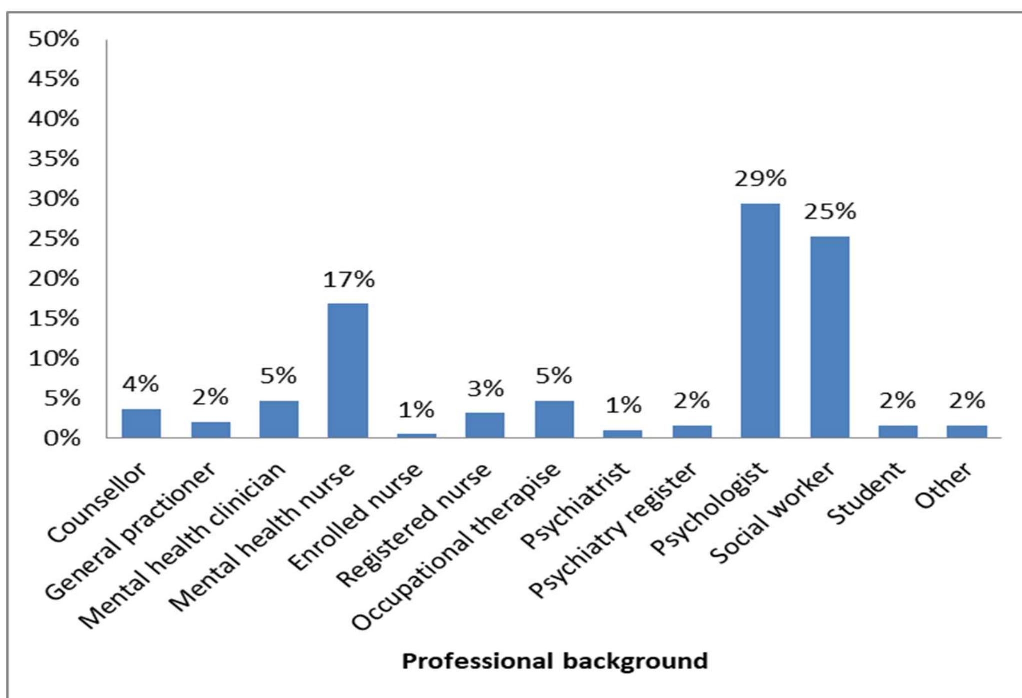
There are highly specialised treatments that are effective in the treatment of BPD, however, they are expensive to deliver and clinicians providing these treatments require expensive, extensive and intense training. Access to effective management and evidence-based psychological treatments for people with BPD is limited across Australia. Therefore, these treatments are less suitable for a national population health approach. However, studies have demonstrated that BPD-specific generalist treatments are as effective as the specialist treatments (Gunderson 2016, Cristea, Gentili

et al. 2017, Oud, Arntz et al. 2018). Research has identified the commonalities shared by both specialist and generalist treatments and these are referred to as the 'common factors' in psychological treatment (Weinberg, Ronningstam et al. 2011, Bateman and Krawitz 2013, Beatson and Rao 2014, Gunderson 2016, Paris 2017, Bateman, Campbell et al. 2018).

Based on the common factors approach, the BPD Core Competency Workshop has been developed with consideration of these common factors and includes the knowledge, skills, attributes and attitudes to detect, diagnose and provide therapeutic interventions during every clinical interaction, even in the absence of a formal long-term psychotherapeutic intervention. An understanding of the core competencies may assist clinicians to contribute to the recovery journey of people with BPD.

The BPD Core Competency Workshop and the 10 core competencies it covers, has thus become attractive to a range of professions and services (refer to **Error! Reference source not found.**).

*Figure 2 Profession of participants that attended training*




Regardless of their professional background and service, the core competencies guide the clinician's interactions and treatments at every point of contact. Using a stepped-care approach, they can be used flexibly according to the current needs of the person with BPD. Accessing ongoing supervision and support further augments the core competency skills and knowledge.

### 1.5.3. Quality of the BPD Core Competency Workshop

Based on the evaluation results provided in Progress Report 1, the BPD Core Competency Workshops including our trainers and associated training resources has shown to be of superior quality. Word of mouth has made the workshop attractive to other clinicians as they are confident they will be provided with a positive and valuable learning experience.

Over 90% of participants were "highly" to "very highly" satisfied in the training overall, the resources and learning activities provided, the trainers' knowledge in the content, the trainers' responsiveness

to their needs and the administration arrangements of the workshop. Participants of the workshop found its interactive nature including the opportunities to ask questions, having open discussions, the demonstration of skills through role plays and taking part in activities as some of the most useful aspects of the workshop. They really appreciated the trainer's knowledge and expertise in the field of BPD, particularly their practice wisdom. They liked the participant handbook as a source of reference post the workshop. Organising the content into core competencies and having one case study themed across the whole workshop was also found to be useful as it allowed the content to be more comprehensible.

The evaluation of the BPD Core Competency Workshop has also shown an increase in participant's knowledge and skills in working with people with BPD and the attitudes towards them.

As shown in Figures 4 and 5, the confidence and knowledge of participants in our workshops increased as a result of attending the workshop both subjectively and objectively. It was impressive to see that their average scores in the knowledge assessment increased from 57% to 77%. Also encouraging is that participants had a more positive attitude towards people with BPD post the workshop.

*Figure 3 Subjective level of willingness, knowledge and confidence*

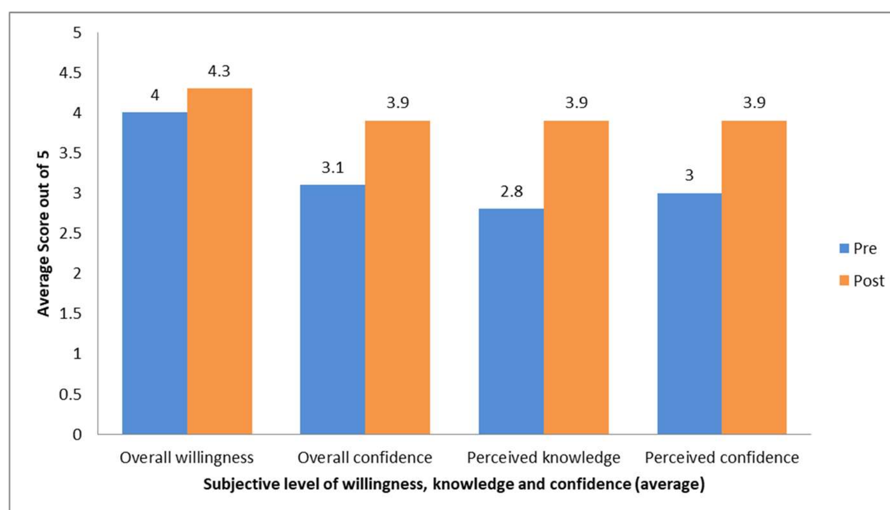



*Figure 4 Objective level of attitude and knowledge*

## 1.6. Alignment of the National BPD Awareness and Training Strategy with the recommendations of the Productivity Commission Inquiry into Mental Health

### 1.6.1 - A Person-Centred Mental Health System

Finding 4.1 states:

> *"A person centred mental health system would comprise the full spectrum of community support and clinical services people may need to recover from mental ill health and live healthy, productive lives. Consumers and carers should be able to access the services they need when they need them ........Services should be delivered by a skilled workforce."* [13]

[13] Productivity Commission Inquiry Report into Mental Health: Actions and Finding No 95, 30 June 20202 p4

Many consumers and carers find the diagnosis of BPD difficult to understand and many say that the diagnosis has never been explained to them. They have negative experiences of receiving services and often describe this as a lack of understanding, knowledge and skills demonstrated by health professionals in a range of settings.

When refused care or derided for 'needlessly taking up valuable resources', they are further traumatised. These experiences perpetuate high levels of anxiety for many with BPD and a disinclination for some to continue searching for helpful services.

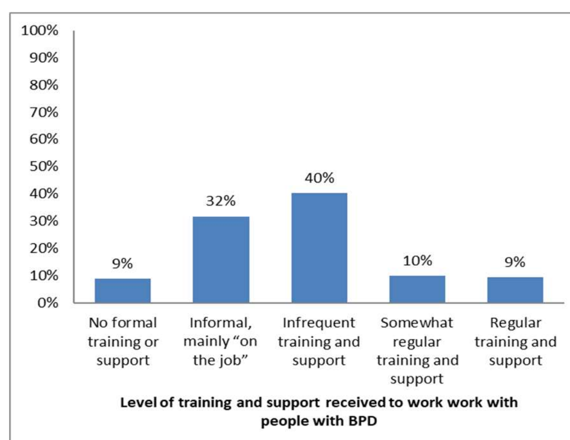
The families, friends and carers are also deeply affected by the same issues. For both people with BPD and their carers, a lack of access to skilled clinicians who are responsive and have the capacity to support people experiencing chronic risk during a crisis and who have the skills to provide compassionate, collaborative, inclusive, validating, and effective treatment and care in an accepting and respectful environment are a major concern and highlight the significant gaps within mental health services.

This was further highlighted by a recent paper[14] which states '*those living with the disorder [BPD], and those who care for them, still struggle to be taken seriously, let alone respectfully. This is especially the case among health professionals, where harmful attitudes, beliefs and practices are most common and stubbornly persist, impervious to a substantial body of scientific evidence about the aetiology, reliability, validity, severity and treatability of BPD'.*

Unfortunately the foundation is regularly told by callers that they are being denied access to services with the statement ….."we don't treat BPD" and we have had contact with a number of the Gateway / Directory services which highlight the lack of knowledge about BPD (some still perceive that BPD is bipolar disorder).

In a study investigating the confidence of psychiatry trainees in diagnosing, supporting, and treating borderline personality disorder found that the respondent's confidence scores with respect to BPD were overall considerably lower in comparison to schizophrenia. The biggest difference was found in delivering treatment, as well as developing a management plan, assessment and management of suicide risk and working therapeutically with the person. The study also found that trainees want to learn the skills required to treat BPD however, due to the lack of training they feel unable to offer little beyond crisis management and a sense of therapeutic nihilism pervaded.[15]

In addition, the lack of clinician training in BPD was evident in the first cohort of health professionals who undertook the Training provided in Stage 3 of our Strategy. Figure 2. Level of prior training in BPD.




[14] Chanen AM. Bigotry and borderline personality disorder. Australasian Psychiatry. October 2021. doi:10.1177/10398562211045151

[15] Nithianandan M, Heidari P, Broadbear J, Rao S. Confidence of psychiatry trainees in meeting the needs of borderline personality disorder in comparison with schizophrenia. Australasian Psychiatry. 2021;29(6):690-694. doi:10.1177/1039856221992650

Only 9% of participants had received regular training and support in BPD. Most participants in the workshop of Stage 3 of the National Training Strategy had received either informal on the job training or infrequent training and support

For further information from the Stage 3 Evaluation please refer to the report on our website.

There are calls substantiated by research to make further training of the mental health workforce a priority.[16] Similarly, there is mounting evidence that effective training needs to be evidence based[17], employ the principle of adult education[18] and utilise post training support mechanisms[19] to ensure knowledge transfer occurs.

Similarly, A literature review conducted to inform the development of the National Mental Health Workforce Strategy states that "Workforce training is a key part of ensuring a quality workforce and an effective service system that responds to the needs of consumers. The endorsement and application of evidence-based approaches by staff is predicted by knowledge, attitudes and skills, thus making training programs for staff a key means of ensuring an effective mental health service system[20] Training can increase positive attitudes towards and deployment of evidence-based approaches." (REF pg 40

**The prosed extension to the National Training Strategy will assist in the provision of a person-centred mental health system for people with BPD by upskilling and giving clinicians the confidence and capacity to offer person-centred care for people with BPD. It will do this by the provision of training is a variety of formats (webinars, eLearning program and face to face training including supervision and support) for metropolitan, rural and regional mental health clinicians from a variety of disciplines.**

## 1.6.2 - Social inclusion and stigma reduction

**Finding 8.1 — Social Exclusion and Disadvantage are Strongly associated with Mental Ill-Health &**
**Action 8.1 – National Stigma Reduction Strategy**
**Action 16.6 — Targeting stigma among health professionals**
"The Strategy should

- rely on the leadership and direction of people with lived experience……
- focus on the experiences of people with mental illness that are poorly understood by the community, including those with schizophrenia and borderline personality disorder…….
- actively target stigma and discrimination directed towards people with mental illness by health professionals, including by developing contact interventions that involve interactions between health professionals and mental health consumers, on an equal footing outside of a clinical

[16] McCarthy, K. L., Carter, P. E., & Grenyer, B. F. S. (2013). Challenges to getting evidence into practice: Expert clinician perspectives on psychotherapy for personality disorders. Journal of Mental Health, 22(6), 482-491.
[17] Beidas RS, Kendall PC. Training Therapists in Evidence-Based Practice: A Critical Review of Studies From a Systems-Contextual Perspective. Clin Psychol (New York). 2010;17 (1):1-30.
[18] H. Patrick McNeil, H. Patrick McNeil, Chris S. Hughes, Susan M. Toohey & S. Bruce Dowton (2006) An innovative outcomes-based medical education program built on adult learning principles, Medical Teacher, 28:6, 527-534,
[19] Sanne Peters, Geraldine Clarebout, Marc van Nuland, Bert Aertgeerts and Ann Roex, A Qualitative Exploration of Multiple Perspectives on Transfer of Learning Between Classroom and Clinical Workplace, Teaching and Learning in Medicine, 30, 1, (22), (2018)

[20] Hoge, Michael A.,et al. "Behavioral Health Workforce Development in the United States." *Workforce Development Theory and Practice in the Mental Health Sector*, edited by Mark Smith and Angela F. Jury, IGI Global, 2017, pp. 37-59. https://doi.org/10.4018/978-1-5225-1874-7.ch002 p40

setting. Stigma reduction programs should initially be included in training programs for mental health nurses, with the aim of developing evidence as to their effectiveness."

A report commissioned by the National mental Health Commission in 2018 concluded that *'The current Australian mental health system is not designed to best meet the needs of people living with BPD which remains highly stigmatised and misunderstood.'*[21]

In his witness statement to the Productivity Commission the Commission quotes A. Fornarino as saying "*Some mental health professionals do not have the time, tolerance, resilience and ability to listen to those experiencing the symptoms [of borderline personality disorder] … Some continue to deny the disorder is a mental illness and label the disorder as purely 'behavioural'. [Borderline personality disorder] may be described by some professionals as a nuisance in the mental health care system.*[22]

Action 8.1 reinforces numerous studies which show that '*Stigma towards persons with BPD being greater than that towards persons with a mental illness more generally'*.[23] Stigma against people with BPD also exists across all facets of health care in Australia. For example, it has been identified as a major barrier from within the mental health system to access treatment and recovery, as well as in the general health system to quality physical care. The stigma associated with BPD can have an impact on health providers themselves and negatively mediates their work environment [24,25,26]. People with BPD often feel blamed and judged for their difficulties and especially those who engage in self-harm or attempt suicide are often perceived as being manipulative and/or attention seeking when they seek help.[27] Many people diagnosed with BPD say that they are ignored and blamed for their illness and are often told that their problems are not 'real' or represent a 'serious' mental illness and that their state of distress or disability is not sufficiently severe to warrant access to treatment from mental health services.

In addition, people diagnosed with BPD experience frequently experience prejudice and discrimination within general health services, among other professional groups eg law, and in some parts of the general community. These groups often compare the behaviours of people with BPD with other mental illnesses and perceive the person to be attention seeking and or 'manipulative' – this is incorrect and in fact perpetuating the stigma.

Action 16.6 recommends that "*Mental health stigma reduction programs should be incorporated in the initial training and continuing professional development requirements of all health professionals, subject to periodic evaluation as to their appropriateness and effectiveness*."

Just raising awareness, without a corresponding increase in the accessibility of services can promote the feeling of stigma and discrimination. The aim of awareness campaigns is to encourage people to

---

[21] Carrotte E, Hartup M, Blanchard M. "It's very hard for me to say anything positive": A qualitative investigation into borderline personality disorder treatment experiences in the Australian context. Aust Psychol. 2019;1–10. https://doi.org/10.1111/ap.1240010

[22] Productivity Commission into Mental Health Inquiry Report 2020 "Box 16.6 (Aaron Fornarino, sub. 17, p. 2) https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf p743

[23] Stigma towards borderline personality disorder: effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design. Knaak et al. Borderline Personality Disorder & Emotion Dysregulation (2015) 2:9 DOI 10.1186/s40479-015-0030-0

[24] Exploring General Practitioners' Views and Experiences of Providing Care to People with Borderline Personality Disorder in Primary Care: A Qualitative Study in Australia. *Int. J. Environ. Res. Public Health* **2018**, *15*(12), 2763; https://doi.org/10.3390/ijerph15122763e

[25] Daniel Ring & Sharon Lawn (2019) Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder, Journal of Mental Health, DOI: 10.1080/09638237.2019.1581337

[26] Clinician attitudes towards borderline personality disorder: A 15-year comparison Day, N. J. S., Hunt, A., Cortis-Jones, L., and Grenyer, B. F. S. (2018) Clinician attitudes towards borderline personality disorder: A 15-year comparison. Personality and Mental Health, 12: 309– 320. https://doi.org/10.1002/pmh.1429.

[27] S Veysey (2014) People with a borderline personality disorder diagnosis describe discriminatory experiences, Kotuitui: New Zealand Journal of Social Sciences Online, 9:1, 20-35, DOI: 10.1080/1177083X.2013.871303

seek support and access therapy. However, without a corresponding increase in the overall accessibility of services ie number of clinicians, financial and location, people will once again that they are too complex and feel let down and by the system – compounding the stigma and discrimination. For this reason, to date, our campaigns have provided information to help people with BPD target self-stigma, self-shame and worthlessness.

**The prosed extension to the National Training Strategy will allow the Australian BPD Foundation to expand its current Awareness campaign [BPD Awareness Week (1-7 October to be professionally run throughout the year to keep BPD in the forefront of people's minds. It is envisaged that the campaigns will continue to be codesigned and co-produced with lived experience (those with BPD and carers)**

## 1.6.3 - Approach to suicide prevention

**Action 9.3:**

> *"Australia's approach to suicide prevention holds promise, but there are opportunities for improvement. Governments should make changes to ensure a cross-portfolio approach to suicide prevention in Australia."*

The impact of BPD on the wellbeing of consumers and carers is severe.[28] People with BPD frequently live with constant and intrusive suicidal thoughts. They often find deliberate self–harm or Non Suicidal Self Injury (NSSI) to be the most effective way to manage their emotional distress, pain and sense of self-hatred and shame. NSSI brings short–term relief: unfortunately, it frequently has real and severe consequences both for their mental health, physical well–being and impacts upon their relationships with families, carers and healthcare providers. Inadvertent fatal outcomes are a reality.

Many people with BPD feel unsafe, most, if not all of the time. Carers also live with constant anxiety, lack of support and information to appropriately support their family member or friend's suicidality/ NSSI and manage the impact on their own physical and mental health.[29] Psycho-educational training and support for carers/families is an essential aspect of wholistic support for the person with BPD and leads to better outcomes for all.

BPD is often associated with high risk-taking behaviours and lifestyle factors, including chronic suicidal ideation, self–harm and suicide, significant burden of co–existing mental health conditions. It is also associated with eating disorders and alcohol and drug dependency.

In a recent study undertaken by Spectrum Personality Disorder Service and the Victorian Coroners Court using the Victorian Suicide Registry (2009-2013), there were a total of 253 deaths where there was a diagnosis of, or symptoms consistent with, a diagnosis of BPD. This is 10% of all suicides in Victoria; 99% of these had contact with a mental health service within one year prior and 88% within 6 weeks prior to their death.[30] This cohort is reaching out for help and not receiving appropriate evidence-based and/or affordable care. No suicide prevention research funding is specifically allocated for researching suicidality in people with personality disorders despite the Royal College of Psychiatrists (UK) stating:

---

[28] Lawn, S., &, & McMahon, J. (2015). Experiences of family carers of people diagnosed with borderline personality disorder. Journal of Psychiatric & Mental Health Nursing, 22(4), 234-243.
[29] Bailey, R. C., & Grenyer, B. F. S. (2013). Burden and support needs of carers of persons with borderline personality disorder: A systematic review. Harvard Review of Psychiatry, 21(5), 248-258.
[30] Jillian H. Broadbear, Jeremy Dwyer, Lyndal Bugeja, Sathya Rao, Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder, Journal of Psychiatric Research, Volume 129, 2020, Pages 241-249, https://doi.org/10.1016/j.jpsychires.2020.07.007.

*"Among people who die by suicide, more than half are likely to have suffered from a diagnosed personality disorder (Cheng et al, 2000) and in prisons approximately 60–70% are estimated to satisfy the diagnostic criteria for personality disorder (Singleton et al, 1998)."*[31]

**The best suicide prevention strategy for BPD is to offer appropriate therapy.**

**The proposed extension to the National Training Strategy will upskill clinicians to be more confident in working with and supporting those living with BPD. It also upskills clinicians in strategies support those experiencing chronic risk and as a result to become less reactive to crisis driven interventions which are appropriate for those experiencing acute risk.**

**The Awareness component of this proposal will educate people living with BPD, their carers, the general public, health care professionals and other key stakeholders to see the person, and the distress that lies behind the diagnosis. The campaigns also encourage people with BPD and their carers to move towards a strengths-based thinking which celebrates their strengths.**

**Increasing clinicians' knowledge of the power of language to hurt and disempower will go a long way to diminish the impact of self-stigma experienced by those with BPD.**

## 1.6.4 - Improve emergency mental health service experiences

Action 13.1:

> *"Hospitals and crisis response services should be able to support a person's recovery in a safe environment that meets their needs. In particular, public and private hospitals should take steps to improve the emergency department experience they provide for people with mental illness."*

Emergency Departments (EDs) are often the only option available for people experiencing thoughts of suicide and many consumers and carers. Many say that the busy-ness of ED, waiting times that frequently exceed the four-hour target and a lack of compassionate, empathetic care in fact, increases their distress and is unfortunately regarded by many as iatrogenic.

The reality is that many clinicians do not understand supporting people experiencing chronic risk and are responding in inappropriate ways. By increasing clinicians' knowledge and skills for working with people experiencing a chronic (and often high) level of risk will allow them to respond in a more supportive way and lead to a decrease in presentations to Emergency Departments.

Whilst not specifically part of the National Training Strategy many emergency department staff have attended the training to date and emergency department staff will be encouraged to attend any extension to the project.

It is important for medical and mental; health practitioners to understand that effective treatment for people with BPD is based on core therapeutic treatment principles that can be used by **any** clinician with the required skill set as taught in the National Training Strategy.

## 1.6.5 - Improving care for people with concurrent mental illness and physical health conditions

**Action 14.1**

> *"Ensuring workers in the mental health sector have access to the training and support they need to provide person-centred, effective and coordinated care to people with comorbidities".*

[31] Royal College of Psychiatrists (UK) Position Statement, *Services for people diagnosable with personality disorder*, January 2020, p 24.

The percentage of people with BPD who experience concurrent mental illnesses, chronic physical health conditions, are immunocompromised or experience neuro and gender diversity is high. As mentioned in the Productivity Commission Report "The poorer physical health status of those with [borderline personality disorder] lead[s] to more utilisation of general medical services, pharmaceutical services and to longevity less than a comparable age cohort."[32]

A frequent comment made to the Foundation is that when a person with mental health issues presents to ED in emotional distress their physical health is minimised and vice versa eg repeated presentations to an ED over many months for chest pains is dismissed as being 'attention seeking' and the person repeatedly sent home again. In fact, this was finally diagnosed as a significant health issue.[33]

> By upskilling mental health clinicians to be cognisant of the frequent co-morbidities experienced by people with BPD this will improve the level of appropriate person-centred care received by person leading to improved health outcomes and an improved quality of life. The core competency workshop includes a module focussing on co-existing mental and physical health issues.

## 1.6.6 - Improved mental health training for medical practitioners

Action 16.3

> *"Medical practitioners' training on medications and non-pharmacological interventions requires improvement."*

There are no evidence-based biological treatments for BPD. Unfortunately, biological treatments such as medications are commonly and often inappropriately prescribed for people with BPD often with unintended negative consequences including death from intentional and/or accidental overdoses.

Whilst not specifically part of the National Training Strategy many medical practitioners have attended the training to date and will be encouraged to attend any extension to the project.

> It is important for medical practitioners to understand that effective treatment for people with BPD is based on core therapeutic treatment principles that can be used by **any** clinician with the required skill set as taught in the National Training Strategy.

## 1.6.7 - Family and carer-inclusive practices

Action 18.1

> *"Family and carer-inclusive practices require mental health services to consider family members' and carers' needs, and their role in contributing to the recovery of individuals with mental illness. This includes young children where a parent or other family member has a diagnosis of BPD."*

> **In recognition of the increasing recognition of the important role of 'carers' supporting a person with BPD the current National Training Strategy includes a key competency on '*Partnering with Family, Partners and Carers'* which, to date has been valued highly by participants. In line with both the Productivity Commission and the Royal Commission into Mental Health (Victoria) recommendations this competency has been informed by the lived experience of carers and written by a carer. Participants have highly valued the competency and endorsed that it will encourage them to offer support and information to carers.**

[32] Productivity Commission Inquiry Report Mental Health Volume 1 p626

[33] Personal communication

## 1.7. Alignment of the National BPD Awareness, Training & Professional Development Strategy with the recommendations of the National Mental Health and Suicide Prevention Plan 2021

**The proposed extension to the National BPD Awareness, Training & Professional Development Strategy also aligns with 5 Pillars outlined in the National Mental Health and Suicide Prevention Plan**

For all Australians impacted by BPD (consumers and carers) to receive the support they need, when they need it, the plan has developed 5 pillars reflecting the key themes emerging from the findings of the PC Report and NSPA Advice. These are:

1. **Prevention and early intervention** – there is a clear correlation between children and young people up to the age of 24 years with a record of a neurodevelopmental or mental disorder or self-harm before the age of 24 years were more likely to miss school than those without a record.[34] Upskilling clinicians to more appropriately support young people with BPD +/- NSSI/suicidal ideation +/- neurodevelopmental disorders will hopefully assist to reverse this trend and assist the young person to continue with their schooling and future employment.

2. **Suicide prevention** – as noted above in the Productivity Commission's recommendations 9.3 'The best suicide prevention strategy for BPD is to offer appropriate therapy.'

3. **Treatment** – The National Training Strategy will upskill clinicians working with people with BPD and their families. It is important for *all* medical practitioners to understand that effective treatment for people with BPD is based on core therapeutic treatment principles that can be used by any clinician with the required skill set as taught in the National Training Strategy.

4. **Supporting the vulnerable** - as noted above in the Productivity Commission's Action 14.1 — Improving care for people with concurrent mental illness and physical health conditions. People with BPD experience high levels of disadvantage – concurrent physical, mental health conditions, homelessness, frequent experiences of trauma, domestic violence, high engagement with child protection and the forensic system etc

5. **Workforce and governance** – as above – the National Training Strategy will upskill the workforce and via the Train the Trainer component this process will continue beyond the life of this project.

## 1.8. Outline of submission

We propose that each component of the National BPD Awareness, Training and Professional Development Strategy, is delivered concurrently and embedded within an awareness campaign. For ease each component is separated into the following "Parts":

- Part 1: BPD Awareness Campaign (Appendix A)
- Part 2: Webinars and Virtual Resource Library (Appendix B)

[34] Ann John; Yasmin Friedmann; Marcos DelPozo-Banos; Aura Frizzati; Tamsin Ford; Anita Thapar. Association of school absence and exclusion with recorded neurodevelopmental disorders, mental disorders, or self-harm: a nationwide, retrospective, electronic cohort study of children and young people in Wales, UK. The Lancet Psychiatry Volume 9, Issue 1, P23-34, January 01, 2022 DOI:https://doi.org/10.1016/S2215-0366(21)00367-9

- Part 3: Online Self-Directed E-Learning Modules (Appendix C)
- Part 4: BPD Core Competency Workshop & Train the Trainer Program PLUS Post Training Support (Appendix D)

Included are projected budgets and timelines for the above 4 Parts for a 3 year extension of the existing National Training Strategy with the inclusion of an awareness campaign to target the stigma and discrimination experienced by those living with BPD.

Outcomes and budgets are summarised in Table 1. Detailed budgets are available by contacting the author, Rita Brown, on rbrown@bpdfoundation.org.au

As noted in each part the Australian BPD wishes to continue the current collaborations with Spectrum Personality Disorder Service and Project Air Strategy to ensure the proposal reflects the latest research and best practice..

**Spectrum** is a state-wide specialist service specialising in the treatment of personality disorders and complex trauma in Victoria. It also contributes to both international and national research and provides workforce development training nationally in the field of BPD and other personality disorders/complex trauma where high levels of functional impairment bring the consumer to the attention of specialist mental health services. Spectrum supports primary and public sector mental health services responding to referrals from General Practitioners, mental health services and other services across Victoria and interstate. Spectrum works with people aged 16-64 years and has treated people with BPD in Victoria for the past 20+ years. Spectrum works with state justice systems to deliver assessment and treatment services to individuals with BPD who are, or are at risk of, being incarcerated.

The **Project Air Strategy for Personality Disorders** is an internationally recognised leader in research, education and treatment. Project Air is a Personality Disorders Strategy that aims to enhance treatment options for people with Personality Disorder and their families and carers. It partners with health, justice, communities, schools, families and individuals to bring new scientific discoveries to promote recovery. The Project Air Strategy endorses an integrative collaborative relational approach and thereby promotes a personality disorders-inclusive health service.

Project Air Strategy has demonstrated expertise both in knowledge of BPD, training and research and has the necessary technological expertise and equipment to develop the web-based e-learning modules.

## 1.9. Proposal Budget and Timeline

**Part 1:** Nation-wide Campaign Strategy
- Engage consultant and evaluate needs (2022/23)
- Roll-out campaign (2023/24 – 2024/25)

**Part 2:** Webinars and Virtual Resource Library
- Provide 10 Professional Development Webinars (2022/23 – 2024/25)
- Update and Maintain Virtual Resource Library for Practitioners (2022/23 – 2024/25)

**Part 3:** Online Self-Directed eLearning Modules
- Extension of eLearning Modules (2022/23)
- Update of eLearning Modules (2022/23)
- Updated of eLearning Modules (2023/24 – 2024/25)

**Part 4:** BPD Core Competency Workshops and Train the Trainer Workshops & Post Training Support
- 48 x BPD Core Competency Workshops & 24 x online peer support sessions for participants (2022/23 – 2024/25)
- 6 x Train the Trainer Workshops & 18 x peer support sessions & 3 professional development sessions for new trainers (2022/23 – 2024/25)

| | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|
| Part 1 | $135,700 | $160,425 | $177,730 | Total Part 1 = $473,855 |
| Part 2 | $83,033 | $96,933 | $98,871 | Total Part 2 = $278,837 |
| Part 3 | $54,967 | $3,566 | $3,566 | Total Part 3 = $62,099 |
| Part 4 | $406,254 | $426,567 | $447,894 | Total Part 4 = $1,280,715 |
| **TOTAL Funding** | **$679,954** | **$687,491** | **$728,061** | **$2,095,506** |

# 2. APPENDIX A – PART 1

## National BPD Awareness Campaign

Prepared by:

---

## 2.1. BPD awareness in Australia

Advocacy by consumers, carers and clinicians led to the Australian Senate proclaiming in 2011 the 5th October as the National Borderline Personality Disorder (BPD) Awareness Day. Following further advocacy, the Australian Senate formalised the first week of October in each year as BPD Awareness Week to focus a dedicated annual spotlight on this serious mental illness in Australia

In 2016 a group of individuals and organisations collaborated to create a website as an enduring platform for the Australian BPD community. That group has grown from 3 to over 60 in 2021. The group includes key stakeholders in the BPD community who have joined together to raise awareness about this distressing and debilitating mental illness via the National BPD Awareness Week. Unfortunately, the capacity of many to engage, especially during the last two years, has been low.

In 2017 the Foundation officially took over the role of coordinating the collaboration group to promote awareness and the work towards decreasing some of the stigma and discrimination that surrounds BPD. We believe we are the only country to actively run a national themed campaign in relation to BPD awareness.

To date we have run 5 themed campaigns:

- 2017 - From Stigma to Strength
- 2018 - Know BPD. NO Stigma campaign was run with the support of a grant from the NMHC.
- 2019 - Best Practice Deserved – also supported by a grant from the NMHC. The reports presented to the NMHC are available from our website.
- 2020 - Flipping the Script: Changing the Narrative of BPD
- 2021 - Discover Creative Wellbeing

Each campaign has built on the previous year's campaign and aim to be inclusive of the diversity of stakeholders. They are designed to educate and demystify BPD, to replace negative dominant clinical narratives with evidence-based expert information and encourage understanding and empathy through learning and listening.

In 2018 the foundation developed a 'Nation-wide Campaign Strategy to Decrease Stigma and Discrimination Towards People Living with Borderline Personality Disorder (BPD), their Carers, Community and Clinicians' which has informed our campaigns since.

Using co-design frameworks of practice, we conducted open surveys from people with lived experience, those who support and care for them and those who work with them clinically. We asked about their experiences of stigma and discrimination and the barriers they faced from the BPD label. All three groups agreed that stigma existed within the mental health systems itself and led to access difficulties. We also surveyed what participants felt needed to change and be put in place to combat the stigma and discrimination against BPD and what they felt the campaign needed to focus on. We received over 200 responses. The importance of education and awareness was the dominant theme. Participants were seeking more information into the realities of BPD – including its diagnostic criteria, symptoms and evidence-based specialist treatments. This information needed to be told clearly and simply and allow the voices of experts – both those who have a lived experience and those who are academically qualified – to be finally heard.

Our target audience is diverse and complex and includes:

- Australians living with BPD
- People experiencing "emerging" BPD
- Families, friends, employers and colleagues of Australians with BPD
- Federal Politicians
- State Politicians
- General Practitioners
- Psychiatrists, psychologists and other clinicians working in the mental health sector
- Mental health funding influencers and decision makers
- Front line responders (e.g. paramedics)
- Hospital emergency department workers
- Mental Health Organisations
- Health Agencies
- Social Service Organisations eg Centrelink, Domestic Violence and Homeless Services
- Forensic and Justice systems
- Education system (Child Care, Early Childhood to Tertiary)

Given the breadth of these audiences, the campaign will need to be broad and comprehensive to ensure each target group is included. Potential media targets include:

- The Australian
- Metropolitan daily newspapers
- Suburban newspapers
- Regional newspapers
- Online news sites
- Metropolitan radio news
- Regional radio news
- Radio current affairs/talkback programs
- Television news
- Television current affairs programs
- Other relevant programs such as The Project

## 2.2. STRATEGY for BPD AWARENESS:

### 2.2.1. Reduce stigma and discrimination by:

- Demystifying common misconceptions around BPD

- Challenging language used to define BPD and People living with BPD
- Educating people about the cause and reasons BPD occurs
- Promoting recovery for people living with BPD
- Promoting hope and optimism about recovery from BPD

#### 2.2.2. Increase appropriate responses to People living with BPD by:

- Advocating for people living with BPD
- Advocating for carers of people living with BPD
- Providing engaging content to encourage compassion for People living with BPD
- Promoting evidence-based effective treatment programs and strategies
- Highlighting recovery-orientated practice in treating BPD

To date our key strategies have focused on:
**BPD Awareness Week/Day Events**
**Anti-Stigma Campaign**
**Collateral**
A range of postcards, posters, stickers printed and made available at the various events to engage awareness, education, solidarity, and promotion. These were designed to grab people's attention and graphically represented information, facts, and quotes. Please refer to the BPD Awareness Website. This is a purpose built website to house all the resources developed. The graphics can be freely downloaded.

## 2.3. Vision

To date a small team of 4 people (2 people living with BPD and 2 carers) have done the bulk of the work for BPD Awareness Week largely on a voluntary basis whilst balancing demanding work schedules.

We are aware that we have made a difference however feel we lack the expertise and the time to make the campaigns as extensive and targeted as needed and really change many of the prevailing stigmatising attitudes.

We also have not had the capacity to fully evaluate the campaigns. Anecdotal evidence from the trainers for the current Stage 3 of the National Training Strategy have indicated that they frequently share the graphics prepared for the 2020 campaign with participants and for many this has been a defining moment.

Given the teams limited experience with the media we have not been able to get any real meaningful and lasting engagement with the media.

To be able to really target the stigma and discrimination (and the resultant costs for the person, their family and the health system from inappropriate care) experienced by people living with BPD we have a vision to expand the campaign to be professionally run throughout the year and keep BPD in the forefront of people's minds via the media and social media.

To do this we wish to:

- Develop a fully funded Nation-wide Campaign Strategy to Decrease Stigma and Discrimination Towards People Living with Borderline Personality Disorder (BPD), their Carers, Community

and Clinicians co-designed, co-produced, co-led and co-evaluated by people impacted by BPD at all stages

- In conjunction with the Training components of this proposal to build resources and capacity to maintain momentum
  - decrease the stigma and discrimination (both self-stigma and the external stigma) experienced by people living with BPD (and their carers)
  - Increase clinicians and services willingness and capacity to treat BPD
  - Improves outcomes for people with BPD
  - Decrease the personal, social and economic costs
  - Decrease the number of suicides related to a diagnosis of BPD

## 2.4. Budget and Timeline

# 3. APPENDIX B - PART 2

# Webinars & Virtual Library

**Australian BPD Foundation**

**Spectrum Personality Disorder Service**

## 3.1. Introduction

In 2017, the Australian BPD Foundation had partnered with Spectrum Personality Disorder Service and Mental Health Professionals' Network to deliver **Stage 1** of the National BPD Training and Professional Development Strategy (National Training Strategy)[35] to improve the capacity of clinicians to recognise, respond to and treat people with BPD and be inclusive of families. This stage included the delivery of 6 x online professional development webinars and the establishment and promotion of a virtual resource library for practitioners

This stage was completed in 2019 and the final report was provided in March 2019.

The purpose of this project proposal is to outline the need for further funding to deliver additional professional development webinars and maintain the virtual resource library for practitioners.

## 3.2. Professional Development Webinar Series

### 3.2.1. Delivery of 10 x online professional development webinars

The current Six 75-minute webinars were delivered between October 2017 and November 2018. The webinars have since been hosted on the Australian BPD Foundation website as part of the Virtual Resource Library. Since 2017 there have been over 10,000 views of the webinars, providing an ongoing resource for health professionals for working with people with BPD.

Overall, each of the BPD webinars were attended, on average, by over 1,700 health professionals at the time of the live webinars. Evaluations indicated that the webinars were well received with over 95% of respondents indicating that their learning objectives were entirely or partially met, relevant to their workplace and that the webinars will help them improve their work practice. The key messages of hope, need for validation, ways to keep people with BPD engaged and using appropriate language were well received by attendees and they indicated that they were more confident to improve clinical practice when working with people with BPD. The inclusion of a lived experience and/or carer perspective in the webinars was highly valued by the audience.

These webinars provide a fairly superficial overview of working with people with BPD. However, there is a huge need for content that provides more in-depth training on various topics for working effectively *with* people with BPD. The topics proposed align with the content of the ten core competencies that clinicians require to enable them to effectively work with people with BPD (as developed in Stage 3 of the current National Training Strategy).

Instead of having a variety of expert panelists advising attendees how to work effectively with people with BPD, there will be a clinical trainer and a person with lived experience (person living with BPD and/or a 'carer' demonstrating to attendees how to work effectively with people with BPD via pre-recorded role play videos. We envisage that the content will also continue to build on the current content of the webinars from Stage 1 and rather than, for example, just outlining the

[35] National BPD Training and Professional Development Strategy (National Training Strategy)

need to support carers/family the planned webinars would do a deep dive and explore *how to engage* with carers.

The planned format for the 10 x 90minute webinars is:

- A discussion of a therapeutic principle
- Role play video, based on a case study demonstrating the therapeutic principle
- A discussion on the role play as to what is or isn't working
- Question and answer session with the presenters responding to questions via the "Question and Answer" function of the webinar platform.

### 3.2.2. Advantages of Webinars

The benefits of webinars as a platform for educating health professionals to improve the capacity of clinicians to recognise, respond to and treat people with BPD and be inclusive of families are as follows:

- accessible to a variety of professionals and settings at a convenient time
- provide an ongoing resource for health professionals
- the short format of the webinars provides a quick way for time poor and hesitant professionals to access and preview how to work with people with BPD and hopefully stimulate the need for further professional development in the field.
- recently the appreciation of online presentations has increased especially as a way to reach those living in rural and remote areas.

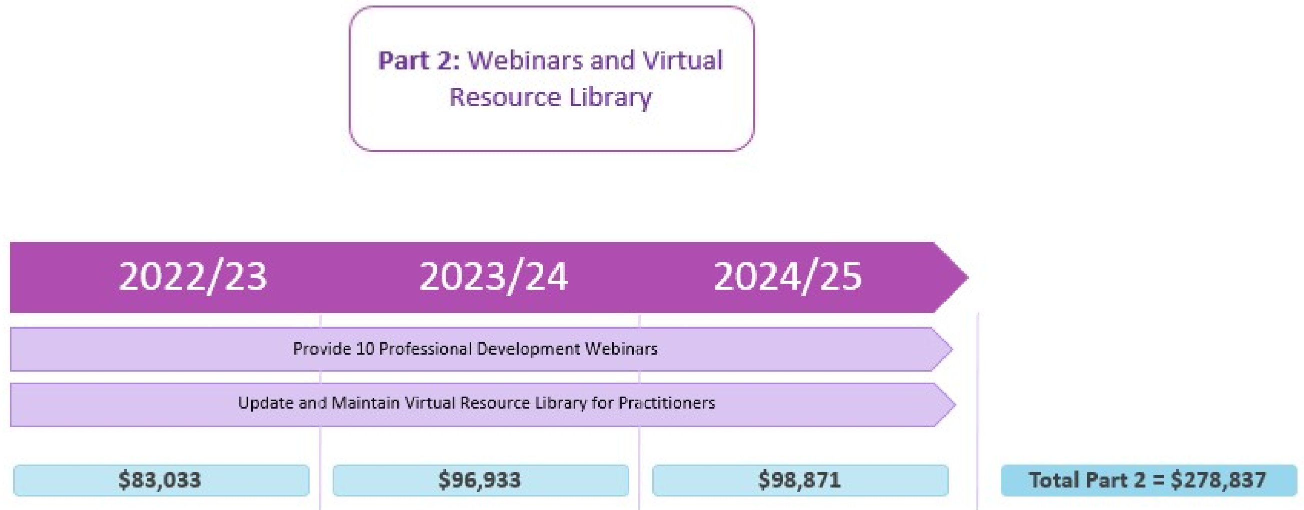
## 3.3. Virtual Resource Library for Practitioners

A Virtual Resource Library was developed Spectrum Personality Disorder Service and was launched on the 30th October 2017. It is currently housed on the Mental Health Professionals Network page https://mhpn.org.au/Webinars and the Australian BPD Foundation website, https://bpdfoundation.org.au/virtual-library.php which additionally provides resources related to the topics addressed by the National Training Strategy Webinar Series. In order to ensure credibility of material published or referred to in the Virtual Resource Library, all material included was vetted by subject experts at Spectrum.

Since the completion of the project the Australian BPD Foundation has maintained the resource however, we are aware that many of the resources require updating and/or refreshing as the current knowledge base expands.

Additional funding will allow us to continue to develop and provide a Virtual Resource Library that is readily accessible to health professionals across the country that provides relevant, current evidence-based resources and research related to BPD.

## 3.4. Budget and Timeline




# 4. APPENDIX C – PART 3

# eLearning Modules

Prepared by:

**Australian BPD Foundation**

**Project Air Strategy for Personality Disorders**

---

## 4.1. Introduction

In 2018, the Australian BPD Foundation partnered with Project Air Strategy for Personality Disorders to deliver **Stage 2** of the National BPD Training and Professional Development Strategy

(National Training Strategy)[36] to improve the capacity of clinicians to recognise, respond to and treat people with BPD and be inclusive of families.

Stage 2 was completed in 2021 and the final report was provided to the National Mental Health Commission in June 2021. The final report is available for download.

The e-learning program is publicly available on both the Australian BPD Foundation's website https://bpdfoundation.org.au/learning-modules.php and via Project Air's website https://www.uow.edu.au/project-air/health-professional/e-learning/#d.en.123129.

As of 30 April 2021, approximately 1,121 health professionals had completed the eLearning program titled "Effective psychological treatment for borderline personality disorder: An e-learning training program for mental health workers and service providers". Training evaluations from those participants were analysed and are summarised in the report provided to the NMHC.

## 4.2. Scope for Ongoing delivery eLearning Modules

The purpose of this project proposal is to outline the need for further funding to allow the Australian BPD Foundation to extend the availability of the e-learning program by continuing to commission Project Air to continue to host the e-learning modules, as well as the provision of professional development recognition to health workers and service providers who complete the program.

Part 3 will continue to be primarily directed to clinicians working in the public and private mental health sectors, and for service providers working in the community managed sector.

This learning can be undertaken opportunistically by clinicians and service providers in their own time and undertaken at their own pace. A certification process provides participants with evidence that they have satisfactorily completed the program.

Whilst the value of providing a learning resource that can be completed by time poor health professionals in the own time when convenient some of the feedback received noted '"*Face-to-face training, clinical supervision and on-going experience is required to further move trainees from having good knowledge and skills from the e-learning resource, to having practical applied experience in the workplace.*" The eLearning modules should be seen in this context i.e., as one part of the broader National Training Strategy building on and complementing the webinars (Part 2) and Part 4 where the face to face training, supervision and the embedding of learning into practice can occur.

To keep the program going and ensure it continues to meet world class standard and reflects current best practice we believe it is important that recommendations from the final review of Stage 2 of the modules are reviewed and implemented as appropriate.

Based on the feedback and developments in the field since we developed the program, we believe there is an opportunity for e-learning enhancements:

- **Lived Experience Enhancement**. Develop stronger resources for enhanced lived experience voices throughout the training.
- **Peer Workforce Enhancement**. There is an increased attention on using a peer workforce and models applied to BPD could be included. This would be new content.

[36] National BPD Training and Professional Development Strategy (National Training Strategy)

- **Working with families**. There was also feedback about better reaching out and working alongside family members and carers as a priority. This would also lead to new resources.
- Finally, **demonstration videos** around assessment and key intervention skills would enhance the learning points and again represent new material that would respond to suggestions for improvement.

Ongoing funding will:

- ensure sustained and secure accessibility to the e-learning program. Provision of professional development recognition to health workers and service providers who complete the program.
- provide an online eLearning program that is readily accessible to health professionals across the country that provides relevant, current evidence-based resources and research related to BPD.

## 4.3. Project Budget and Timeline

# 4. APPENDIX D - PART 4

# BPD Core Competency Workshops Train The Trainer Program Including Post-Training Support

## 4.1. Introduction

The Australian BPD Foundation has partnered with Spectrum Personality Disorder Service to deliver **Stage 3** and **Stage 4** of the National BPD Training and Professional Development Strategy (National Training Strategy)[37] to improve the capacity of clinicians to recognise, respond to and treat people with BPD and be inclusive of families.

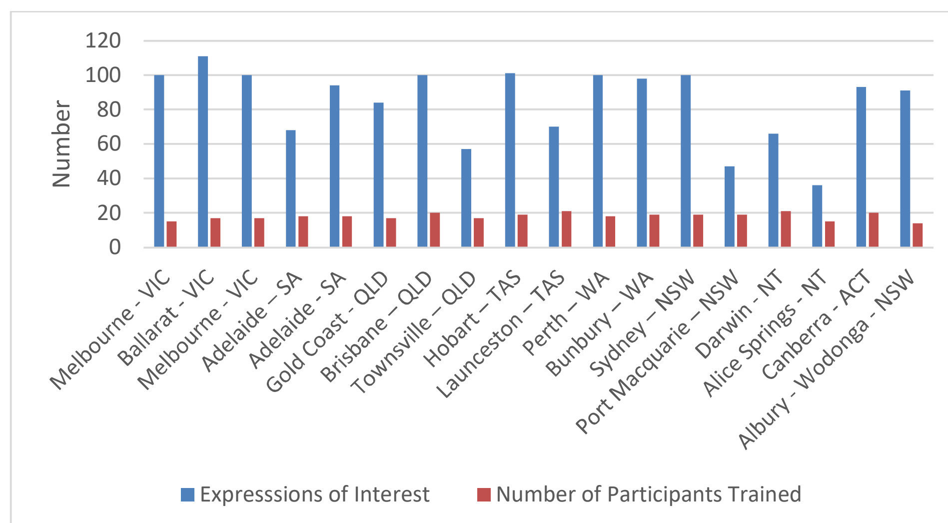
[37] National BPD Training and Professional Development Strategy (National Training Strategy)

As outlined above *"Face-to-face training, clinical supervision and on-going experience is required to further move trainees from having good knowledge and skills from the e-learning resource, to having practical applied experience in the workplace."* To balance online versus face to face learning this component of the Strategy is delivered face to face (unless pandemic restrictions are enforced). This part builds on, and complements, the webinars (Part 2) and the eLearning modules (Part3) by offering face to face training, supervision and supporting the embedding of learning into practice can occur.

As of October 2021, all Stage 3 activities (core competency workshops and train the trainer components) have been completed and we are currently undertaking Stage 4 activity (ongoing post-training support and supervision) which is planned for completion by 30th June 2022.

The popularity of the workshops throughout the country has been unprecedented with workshop Expressions of Interest (EOIs) received up to 100 in most capital cities. To meet the overall demand of these EOIs we would need to have delivered 101 x 2-day workshops in total (15 participants per workshop) in total. Please refer to Figure 5.

*Figure 5 EOIs and number of participants trained*




## 4.1.1 Future Scope

The purpose of this project proposal is to outline the need for further funding to deliver additional BPD Core Competency Workshops and Train the Trainer Workshops and to ensure the ongoing coordination and maintenance of the Train the Trainer Program for an extended period. It will also outline the extension of the post-training support. This aspect of our proposal is referred to as Part 4.

The demand for the BPD Core Competency Workshops has been due to a number of reasons as follows:

- The current lack of skills and knowledge of clinicians to work with people with BPD and their families – refer p
- BPD Core Competencies are based on the Common Factors approach -
- Quality of the BPD Core Competency Workshop

### 4.1.2. Deliverables

- a minimum of 720 clinicians, from across Australia, Metropolitan, regional and rural, will complete the BPD Core Competency Workshops to improve their skills and knowledge to work with and engage with the families of people with BPD. Approximately 15 – 20 participants per workshop. Workshops to be delivered face to face wherever possible
- a minimum of 90 clinicians will become National BPD Core Competency Endorsed Trainers who have the confidence and knowledge to deliver the BPD Core Competency Workshops across the country (minimum of 15 participants per workshop). Workshops to be delivered face to face wherever possible
- evaluation to ensure the quality improvement of the workshops and provide the necessary feedback when it is time to review the curriculum and
- assess the long-term impact and influence of the BPD Core Competency Workshops on clinicians.
- ensure BPD Core Competency Curriculum training materials have incorporated the latest evidence and expert clinical, research and training advice as well as the voices of those with lived experience.
- ensure participants remain current in their practice to provide effective supports for people with BPD and also obtain peer support when working with more complex clients by the provision of post training support, access to training resource and admin support, discussion group and supervision.

## 4.2. Relevance and Quality of the BPD Core Competency Workshop

Based on the evaluation results provided in Progress Report 1, the BPD Core Competency Workshops including our trainers and associated training resources has shown to be of superior quality. Word of mouth has made the workshop attractive to other clinicians as they are confident they will be provided with a positive and valuable learning experience.

Over 90% of participants were “highly” to “very highly” satisfied in the training overall, the resources and learning activities provided, the trainers’ knowledge in the content, the trainers’ responsiveness to their needs and the administration arrangements of the workshop. Participants of the workshop found its interactive nature including the opportunities to ask questions, having open discussions, the demonstration of skills through role plays and taking part in activities as some of the most useful aspects of the workshop. They really appreciated the trainer’s knowledge and expertise in the field of BPD, particularly their practice wisdom. They liked the participant handbook as a source of reference post the workshop. Organising the content into core competencies and having one case study themed across the whole workshop was also found to be useful as it allowed the content to be more comprehensible.

The evaluation of the BPD Core Competency Workshop run to date has also shown an increase in participant’s knowledge and skills in working with people with BPD and the attitudes towards them.

As shown in Figures 4 and 5, the confidence and knowledge of participants in our workshops increased as a result of attending the workshop both subjectively and objectively. It was impressive to see that their average scores in the knowledge assessment increased from 57% to 77%. Also encouraging is that participants had a more positive attitude towards people with BPD post the workshop.

*Figure 6 Subjective level of willingness, knowledge and confidence*

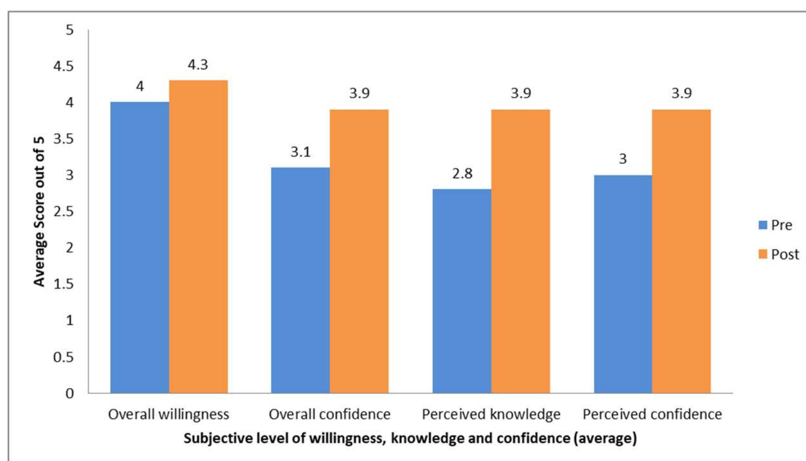
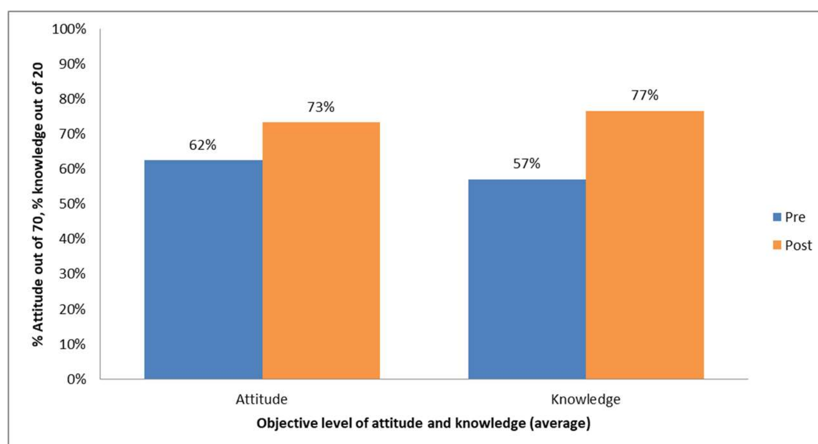



*Figure 7 Objective level of attitude and knowledge*




## 4.3. Train the Trainer Program

The overall aim of the Train the Trainer workshop is to ensure that participants have the **confidence and knowledge** to deliver the BPD Core Competency Workshops to mental health professionals working with people with BPD and their families. The Train the Trainer Program will assist with the ongoing sustainability of the delivery of workshops to meet the demand and reach a larger audience. Most of the endorsed trainers, to date, have indicated that they will deliver the workshop within their own services and some trainers have the capacity to provide contracted training to other services if funding is available. However, this is limited and ad hoc and many expressed a need for further mentorship and the option of presenting the training with an experienced trainer.

Those that complete the program become endorsed National BPD Training Strategy Trainers by the Australian BPD Foundation to deliver the BPD Core Competency Workshop across Australia.

This program has the potential to multiply the results from a relatively small initial investment several times over.

#### 4.3.1. Future Scope

Thus, to deliver the best outcome possible the program requires additional funding to ensure a more coordinated approach and to support the endorsed trainers to deliver the workshop in their own area. Funding is also required to maintain the current training materials and the post training support after the current project ends in June 2022. It is important that we capitalise on the resources utilised so far to develop and deliver the current program and ensure we keep the current momentum and enthusiasm of our new trainers to deliver the workshops around Australia. Our experienced Spectrum trainers will be able to co-deliver the additional BPD Core Competency Workshops with the new trainers where required.

## 4.4. Post Training Support

There are considerable challenges to the effective transfer of knowledge from the training environment to the work setting. Whilst it is recognised that education and training is one of the essential components to transfer of information and techniques, education and training outcomes are much improved with the provision of post training supports.

Post training supports are seen as an essential adjunct to any comprehensive training program. In addition, the NMHRC Clinical Guidelines (2012)1 recommends that clinicians working with BPD receive adequate supervision according to their level of experience and the type of work they are doing. The supervision / support offered by this proposal supports new graduates as they start to practice new skills and allow services time to develop their own supervision supports.

The post training support is provided cost effectively via new web based technologies that can be delivered in real time. They are provided over secure networks and incorporate a combination of retraining, over-learning, supervision and mentoring.

#### 4.4.1 Future Scope

Much of the benefits from the training will be negated without the provision of ongoing support and supervision. Ongoing funding will allow the extension to include new graduates.

## 4.5. Budget and Timeline

# 5. CONCLUSION

This proposal offers a comprehensive awareness and training strategy to change the current negative culture and denial of service that surrounds the diagnosis of borderline personality disorder.

This complex disorder is characterised by a pervasive and persistent instability of sense of self, difficulty in regulating emotions, extreme sensitivity to perceived criticism, volatile interpersonal relationships, and impulsive and often self-harming behaviours. BPD often co-exists with other mental and physical health concerns. These conditions are often compounded by unemployment and homelessness resulting in people with BPD having multiple complex needs.

- Many health professionals feel inadequately prepared to diagnose and work with people living with BPD. This may lead to a reluctance to diagnose BPD in the first instance,[20] resulting in either no treatment or inappropriate treatment being offered.
- Unlike other mental illnesses, no drug has been approved (to date) for the treatment of BPD. The best available evidence suggests that long-term, BPD-appropriate psychotherapy is the most efficacious treatment for BPD.
- Inadequate and inappropriate mental and physical health system responses lead to poorer health and life outcomes for people with BPD, including premature death.
- The life expectancy for people living with BPD is estimated to be nearly 20 years less than other Australians.
- A recent study of Victorian Coronial Records over a 5-year period (2009-2013) showed that 10% of all suicides in Victoria had a diagnosis of BPD, or symptoms consistent with it.
- People with BPD often experience lower levels of physical, sexual, and reproductive health[26] and higher rates of unemployment.
- Current research shows that a focus on treating BPD improves both the symptoms of BPD and most co-morbid symptoms, yet services often focus on treating the co-morbidities (e.g., depression) whilst ignoring the BPD - or only see the diagnosis of BPD and dismiss other health concerns (e.g., sarcoidosis).

This situation can no longer be tolerated in Australia. Action must be taken, and this gross injustice addressed.

The benefits of investment in better services and training will be tangible, not just for those with lived experience of BPD, but also for those who work in emergency departments, mental health services, emergency services, child protection, justice and coroners' departments.

Prepared by Rita Brown (President Australian BPD Foundation)

January 2022