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Priorities for service improvement in personality disorder in Australia: Perspectives of consumers, carers and clinicians

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ABSTRACT

Background – *Improvements to service provision for personality disorder has been predominately explored through the perspectives of clinicians, with limited understanding of the views of consumers and carers. The aim of the present study was to understand the priorities for service improvement through multiple perspectives.*

Method – *Twelve roundtables, with a total of 53 consumers, clinicians and carers, discussed how organizations could improve service provision for people with personality disorder and completed a questionnaire on current and optimal service provision. Inductive thematic analysis was used to identify the priorities for service improvement, and we aimed to identify differences between what participants currently receive and what they believe to be optimal.*

Results – *Four priorities were identified: (1) increasing consumer, carer and peer involvement in care, (2) re-orienting approaches to service provision, (3) improving access and accessibility of treatment and (4) building the capacity of services. Participants were more likely to receive individual or group treatment alone, yet believed combined individual and group treatment to be optimal. Significantly, more participants believed that long-term treatment was optimal.*

Conclusion – *A shift in focus from establishing a consistent approach to servicing, to focusing on holistic care that involves consumers and carers in care, is required.*

Introduction

Personality disorder is a complex mental health issue, experienced by 7.8% of the global population,[1] and represents approximately 20.5% of all inpatient mental health admissions,[2] despite community-based treatment being recommended by clinical guidance.[3] Given high costs associated with hospital admission and the negative effects on general health,[4] life expectancy[5] and quality of life,[6] there needs to be a focus on improving treatment and services for people with personality disorder.[7]

Evidence-based practice for personality disorders has attracted increased attention through the introduction of clinical practice guidelines,[3,8] policy[9] and advocacy from individuals and organizations.[10,11] At the core of international clinical practice guidelines is the provision of community-based interventions. Yet there are limited community-based services that are available to meet the complex needs of people with personality disorder and support recovery. For example, in England, 16% of mental health trusts had no dedicated services for people with personality disorder,[12] despite evidence for the effectiveness of treatment[13] and subsequent cost-effectiveness.[14]

Recommendations for a shift towards an integrative whole-of-service approach to providing care to people with personality disorder have been cited in the literature and clinical practice guidelines.[3,15,16] This integrated approach describes a step-down model of care[16] and includes opportunities to improve clinicians' knowledge and awareness through training and greater access to supervision. Clear communication and active involvement of people with lived experience and their family and carers is encouraged and aligns with international recognition for person-centred care in mental health care.[17,18] Training clinicians using a structured approach to personality disorders has been identified to improve understanding, reduce countertransference and improve perceived capability.[19]

Service provision for personality disorder in Australia is predominately serviced within the public mental health system and provided as part of universal healthcare. Initiatives, such as the Better Access to Mental Health Scheme, subsidize 10 sessions with a psychologist in one calendar year, which has been identified to be insufficient in meeting the needs of people with personality disorder.[7] Additionally, local mental health services may provide brief intervention services and interventions of a longer nature;[20] however, access to services remains to be difficult. Understanding methods of improving service provision for personality disorder has predominately been explored through the perspectives of mental health clinicians. In a Canadian study of 291 clinicians, Ogrodniczuk *et al.*[21] identified discrepancies between what clinicians provided and what was perceived to be optimum. Case management and dialectical behavioural therapy (DBT) were the most commonly provided treatment, where nearly 50% of clinicians indicated that DBT was the optimal treatment. Differences between the treatment length and format were identified, such that combined group and individual therapy was perceived to be optimum, yet more clinicians provided individual therapy.[21] In Australia, the gap between service provision and perception of optimum care was also examined in a sample of 60 mental health clinicians, through adapting the questionnaire used in Ogrodniczuk *et al.*'s [21] and McCarthy *et al.*'s study.[22] Clinicians were identified as providing crisis and case management, cognitive behavioural therapy and supportive psychotherapy; however, clinicians believed that DBT was the optimum treatment. Approximately, a third of clinicians provided individual therapy; however, the majority of clinicians did not believe this was optimal. Combined individual and group therapy was identified to be optimum by 91% of the sample.[22] Significantly, more clinicians (62.1%) believed that long-term treatment was optimum, yet a lower proportion (43.3%) provided care on a long-term basis. These findings are important in guiding improvements to service provision identified as important to clinicians.

There is a scarcity of studies investigating improvements to service provision through the perspectives of people with lived experience, as well as their family and carers. It is important that these voices be heard in order to provide a balanced and comprehensive approach to improvement of service provision. Therefore, the current study aimed to follow-up on the perspectives on service provision for personality disorder in Australia and to extend the understanding to include the perspectives of consumers, family members, carers as well as clinicians.

Method

Participants

A convenience sample of 59 individuals attending a lived experience forum (as part of a clinical and scientific conference for personality disorders) were invited to take part in the roundtable consultation. The forum was publicly advertised online and in newsletters through mental health organizations. There were no restrictions on who could attend the forum and was attended by a mixture of consumers, clinicians and carers. Following a detailed overview of the study, 54 individuals provided written consent to take part in the consultation, as per Institutional Review Board approval. Responses of one individual were excluded due to non-completion of the survey; therefore, the responses of 53 individuals were included in the analysis.

Procedure

The procedure used was adapted from a previous study;[15,22] however, the focus of the current roundtable consultation was broader to include the views of people with lived experience and carers, in addition to clinicians. Twelve concurrent roundtables were held with four to nine individuals at each table. Participants were initially provided with a brief outline on the current state of the research literature into service improvement in personality disorder services, then all roundtables discussed the same question ‘How could organisations improve how they provide services for people with personality disorder? Brainstorm priorities for change.’ Participants had 45 min to discuss their views and were provided with resources to record their perspectives. Each roundtable was facilitated by a self-appointed participant or an experienced researcher with expertise in clinical psychology or social psychiatry. This decision was made by the participants at the table. The facilitators role was to maintain discussion and to ensure all individuals had an opportunity to contribute. Participants were randomly assigned to the 12 roundtables, therefore, roundtables could consist of a mixture of consumers, clinicians or carers. Each roundtable was given a choice as to whether their discussion was recorded, such that discussions were not recorded if one participant in the roundtable declined. Roundtables that consented to the recording were provided with an audio-recorder, whilst the roundtables who declined recorded were provided with paper to record the key discussion points. Of the 12 roundtables, six were audio recorded, and the remaining six declined to be audio recorded, and their data were recorded on paper.

Following the roundtable discussion, participants were given the opportunity to review all responses from the other roundtables and vote for the five most important priorities for change. Participants also completed a survey that focused on treatments received or provided and perspectives on optimal and current levels of care for personality disorder. This survey was adapted from previously published work.[15,21,22]

Given the increasing number of evidence-based interventions available for the treatment of personality disorder, the current survey extended the selection of treatment options to maximize responses from participants. Options for skills-based treatments included DBT, cognitive behaviour therapy, interpersonal therapy, acceptance and commitment therapy, mindfulness skills, and family therapy. Relationally or supportive-based treatments included crisis management, case management and supportive therapy, mentalization-based therapy, transference-focused psychotherapy, schema-focused psychotherapy, dynamic interpersonal therapy, psychodynamic therapy, conversation model, cognitive analytic therapy or psychoanalysis.

Data analysis

Frequencies and proportions from the data in the survey were calculated to understand participant responses. Proportions were compared through using z-statistics to understand the differences between characteristics of the main treatment received and what participants perceived to be optimal. Participants’ perceptions of current care were also analysed.

An inductive thematic analysis approach was used to understand the perspectives of individuals attending the roundtable. Qualitative data recorded by participants from the roundtable discussions were analysed using a six-phase approach.[23] Firstly, data recorded on paper during the roundtable were entered verbatim into NVivo 11, then researchers familiarized themselves with individual responses. Two analysts (F N. and M T.) then independently tagged participant responses with representative codes. Codes of a similar nature were collated into potential themes. Potential themes were reviewed by the wider analyst team to check that themes were representative of the participant views and were consistent with the codes identified. Disagreements were resolved via consensus. The wider analyst team consisted of five analysts with expertise in social psychiatry and clinical psychology. One analyst also had lived experience of mental health concerns, which enhanced the analysis and interpretation of the findings.

Results

Participant characteristics

The characteristics of the 53 participants are shown in Table 1. Significant age differences were identified between participants ($F = 6.6$, $p < 0.01$), where family members or carers were significantly older than consumers and providers. Family members, carers and clinicians responded in accordance to a person that they care for. Clinicians were defined as participants in a paid role within the public or private mental health service in Australia.

Treatment received

Table 2 provides comparisons between what participants receive or provide, and what they believe to be optimal in terms of treatment type, format and length. The majority of participants ($n = 42$, 79.4%) indicated that they or the person they cared for had previous experiences of treatment for personality disorder. Five family members or carers and six clinicians indicated that the person they cared for had no treatment experiences. Skills-based treatment was the main treatment received or provided ($n = 24$, 61.5%), and the majority of individuals indicated receiving or providing individual or group-based interventions ($n = 27$, 58.7%). The majority of individuals also

Table 1: Participant characteristics

Characteristic	Overall (*N* = 53) *n* (%) or M (SD)	Consumers (*n* = 14) *n* (%) or M (SD)	Family and carers (*n* = 22) *n* (%) or M (SD)	Clinicians (*n* = 17) *n* (%) or M (SD)
Age (years)	47.63 (13.76) *R* = 25–72[a]	40.93 (12.98) *R* = 25–65	55.35 (12.05) *R* = 31–72	44.06 (12.43) *R* = 26–64
Gender				
Female	38 (71.7)	12 (85.7)	15 (68.2)	11 (64.7)
Male	15 (28.3)	2 (15.4)	7 (31.8)	6 (35.3)
Highest level of education				
School (to age 16)	1 (1.9)	2 (14.3)	1 (4.5)	0 (0)
School (to age 18)	4 (7.5)	0 (0)	2 (9.1)	0 (0)
College/Technical/Trade	12 (22.6)	2 (14.3)	5 (22.7)	5 (29.4)
University	37 (67.9)	10 (71.4)	14 (63.6)	12 (70.6)
Work or study status				
Full or part time work or study	39 (73.6)	7 (50)	15 (68.2)	17 (100)
Casual/temporary work	1 (1.8)	1 (7.1)	0 (0)	0 (0)
Volunteer work	4 (7.5)	2 (14.3)	2 (9.1)	0 (0)
Unemployed	7 (13.2)	4 (28.6)	3 (13.6)	0 (0)
None of the above	2 (3.8)	0 (0)	2 (9.1)	0 (0)
Relationship status				
Single or widowed	14 (26.4)	5 (35.7)	5 (22.7)	4 (23.6)
In a relationship	7 (13.2)	5 (35.7)	1 (4.5)	1 (5.9)
Married or *defacto*	21 (39.6)	1 (7.1)	13 (59.1)	7 (41.2)
Separated or divorced	6 (11.3)	2 (14.3)	2 (9.1)	2 (11.8)
Missing data or none of the above	5 (9.4)	1 (7.1)	1 (4.5)	3 (17.6)

[a] R = range.

Table 2: Comparison of the main treatment type, format and length received or provided and what is believed to be optimum for the treatment of personality disorder

Characteristic	*N*	*n*	People receiving or providing (%)	*N*	*n*	People believe optimal (%)	*z*	*p*
Main treatment type[a]	39			27				
Skills based		24	61.5		18	66.7	−0.43	0.67
Relational/supportive		15	38.5		9	33.3	0.43	0.67
Treatment format[a]	46			53				
Individual/group		27	58.7		14	26.4	3.25	0.001**
Combined individual and group		19	41.3		39	73.6	−3.25	0.001**
Treatment length[a]	41			35				
Short (<40 sessions)		16	39.0		1	2.9	3.77	0.0002**
Long-term (>40 sessions)		25	61.0		34	97.1	−3.77	0.0002**

[a] Some participant responses were missing and therefore removed from the analysis.
**p<0.01

identified that the main treatment that they received or provided was longer term (more than 40 sessions) (n = 25, 61%).

Optimal treatment

More individuals indicated that skills-based treatment was perceived to be optimal in the treatment of personality disorder (66.7%), compared with relational or supportive treatment options. More individuals also indicated that combined individual and group-based treatment was optimal (73.6%), and long-term treatment was also perceived to be optimal, compared with short-term treatment.

Comparison between characteristics of main treatment received and optimal treatment

There were no significant differences between the main treatment type participants received or what was perceived to be optimal. More individuals received or provided individual or group-based therapy, whilst less individuals perceived this to be optimum (z = 3.25, p = 0.001). Conversely, less individuals received or provided combined individual and group therapy, yet a significantly greater proportion of individuals perceived this to be optimal (z = −3.25, p = 0.001).

The majority of individuals received treatment of a longer duration, which aligned with the belief that longer-term treatment was optimal (z = −3.77, p < 0.01). Whilst some individuals received or provided short-term treatment (1–40 sessions), only one individual believed this to be optimum (z = 3.77, p < 0.01).

Perception of current care and barriers to treatment

The availability of treatment for personality disorder was described as poor (66%) or fair (34%), with the majority of participants reporting a lack of confidence with the treatment provided. Consumers, family and carers, and clinicians did not significantly differ in the levels of confidence. Approximately, a third of participants indicated that there was more than one barrier to treatment, with a proportion indicating a lack of resources (Table 3). The majority of participants (n = 52, 98.1%) recognized the need for more training of clinicians in working with people with personality disorder and recommended that personality disorder be made a mental health priority area (n = 51, 96.2%).

Qualitative findings

A total of 140 individual statements were recorded on paper by participants across the 12 focus groups. Responses from participants represented four overarching themes: (1) increasing consumer, carer and peer worker involvement in care, (2) re-orienting approaches to service provision, (3) improving access and availability of treatment and (4) building capacity of services to provide

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Table 3: Perceptions of current care and barriers to treatment

Perception	*n* (%)
Availability of treatment (N = 53)	
Excellent	0
Good	0
Fair	18 (34.0)
Poor	53 (66.0)
Barriers to care (N = 53)	
Lack of resources	12 (22.6)
Lack of policy/guidelines	1 (1.9)
Lack of clinician confidence	5 (9.4)
Stigma	8 (15.1)
Lack of education and support for clinicians	9 (17.0)
Multiple barriers	18 (34.0)
Level of confidence in treatment provision (N = 52)	
Very confident	2 (3.8)
Quiet confident	9 (17.3)
Somewhat confident	24 (46.2)
Not at all confident	17 (32.7)

treatment. The proportion of roundtables reporting themes, sub-themes and the number of theme endorsements voted by participants are summarized in Table 4.

Increasing consumer, carer and peer worker involvement in care

Consumer involvement. Re-conceptualizing the role of consumers to being a source of knowledge and incorporating their views to guide service design and provision were recommended by participants. 'Consumer involvement at every level of service' (Group F), 'Buddy up with consumers to guide practice' (Group G). Recommendations included improving communication 'more open dialogue from consumers' (Group G) and the development of peer support services, to see the incorporation of 'peer workers or someone with lived experience in the treatment team' (Group E). Benefits of working with consumers

Table 4: Themes and subthemes identified

Theme	Number of roundtables identifying theme (*N* = 12)	Number of individual endorsements for each theme (*N* = 241)[a]
Increasing consumer, carer, and peer worker involvement in care	**9 (75%)**	**101(41.9%)**
Consumer involvement	9 (75%)	93 (38.5%)
Carer involvement	4 (33.3%)	23 (9.5%)
Peer worker involvement	3 (25%)	16 (6.6%)
Re-orienting approaches to service provision	**12 (100%)**	**118 (49.0%)**
Alternative approaches	6 (50%)	23 (9.5%)
Individualized care	9 (75%)	34 (14.1%)
Addressing stigma	9 (75%)	17 (7.1%)
Improving access and availability of treatment	**11 (91.7%)**	**56 (23.2%)**
Availability of treatment or services	11 (91.7%)	56 (23.2%)
Early intervention	5 (41.7%)	22 (9.1%)
Transitional care	1 (8.3%)	9 (3.7%)
Long-term treatment	7 (58.3%)	20 (8.3%)
Removing barriers to treatment	6 (50%)	10 (4.1%)
Knowledge and information regarding treatment options	4 (25%)	0 (0%)
Building capacity of services to provide treatment	**11 (91.7%)**	**55 (22.8%)**
Greater resources	6 (50%)	14 (5.8%)
Treatment and support needs of clinicians	11 (91.7%)	40 (16.6%)

[a] Following reviewing all responses from the roundtables, participants voted for their five most important priorities. Participants were able to vote more than once for a particular theme.

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as this may 'encourage returning to services' (Group L), which may reduce rates of treatment dropout.

Carer involvement. Supporting family and carers in their role in caring for people with personality disorder was identified by four groups. Specific areas to focus on included increasing knowledge through providing 'psychoeducation for and dual support for carers' (Group K), and shifting the role of carers because 'they have knowledge, observations and perspectives' (Group A), which may extend beyond the views of clinicians and consumers.

Peer worker involvement. Peer workers were viewed to be able to contribute significantly to improving the services that are provided to people with personality disorder and their carers. Experiential knowledge was viewed to be beneficial such that participants suggested 'include peer workers or someone with a lived experience in the DBT team, someone trained as a peer worker who has done treatment and training themselves' (Group E).

Re-orienting approaches to service provision

Individualized care focused on the need for services and clinicians to adopt a flexible framework to provide an 'opportunity to make choices about care' (Group F) and for service coordination. Participants noted that this would allow for 'services which are easier to navigate and access' (Group F) and options for the 'ongoing access to psychotherapy' (Group B). Additionally, a shift away from viewing consumers through the lens of diagnosis was needed, such that 'we want clinicians to see us as an individual person and facilitate us to formulate individual goals not just see us as our diagnosis and treat that from a manual' (Group E).

The development of alternative approaches in mainstream services was reported by six focus groups, in recognition that 'not one size fits all' (Group J) and that 'clinicians should accept when some of the activities are not suitable for everyone and be willing to change or alter them' (Group E). Suggestions of alternative approaches included 'art therapy or having therapy outside or pets should be more central to treatment' (Group E) or 'safe places people can go to or phone service offerings' (Group L). Five focus groups highlighted the need to reduce stigma, through improving attitudes in services, as 'some organisations send you away' (Group B) and there is a 'lack of awareness in the community' (Group H).

Improving access and availability of treatment and services

Access and availability of services was identified by 11 groups, with 'ongoing access to psychotherapy' (Group B) and early intervention seen as a priority. The need for early intervention through greater 'provision of information and resources on personality disorders' (Group C) to schools, universities, and child and adolescent mental health teams were also reported to be important in order to improve 'recognition of early indicators of personality disorders and to not misdiagnose' (Group C). One focus group also highlighted that there was a 'sharp drop in support going from inpatient to outpatient' (Group H), indicating that transitional care may be an area for development. The barriers to treatment identified included access, namely in the prohibitive cost, limited subsidy of treatment and extensive wait list, as 'there are long wait times to get into DBT through community mental health services unless you want to pay money and go private' (Group H); however, private 'services are expensive for consumers' (Group D). One group identified that treatment costs 'create artificial barriers for carers and consumers to get access to integrated services or programs' (Group K). Four focus groups also identified the importance of promoting knowledge surrounding 'what services are around' (Group F) and where to 'access information on practical issues' (Group D).

Building capacity of services

The issue of gaps in resources and funding affecting access to services was also identified. One group expressed the need to 'organise for purpose-built buildings for mental health needs'

(Group I). Yet it was recognized that more clinicians with training in treatment delivery for people with personality disorder are required.

The capacity of services to provide treatment was recognized to be heavily influenced by the practical needs of clinicians. Some clinicians expressed feelings of stress when working with people with lived experience of personality disorder. The needs of clinicians were summarized by a comment indicating that 'I find it very exasperating and feel I need more help, training, education and support in caring for people engaging in extreme self-harm that I see in the hospital' (Group E). In order to promote non-judgemental and compassionate communication from clinicians to consumers, opportunities for debriefing and supervision were recognized. A strong emphasis was placed on the education and training needs of staff who are not only with the health service but 'all staff in organisations including schools, medical services, GPs, emergency departments, ambulance officers, Centrelink, community services, to be trained in mental health knowledge and recognise BPD and how to deal with and respond' (Group K).

Specific training about evidence-based treatment options, diagnosing personality disorder and comorbidity with other disorders was recommended and reinforced the need for a collaborative approach to improving services. Specific need for specialist skills in certain treatment modalities, in particular DBT, were also identified. However, the focus was predominately on providing clinicians with a 'positive education about personality disorder' (Group L). The implications of training was also noted such that it may lead to 'better recognition of early indicators for personality disorders and (reduce) misdiagnosis' (Group C) with the potential to improve outcomes.

Discussion

The present paper sought to understand the perspectives of consumers, family members, carers and clinicians on service provision for personality disorder in Australia and to identify recommendations for service improvement. To achieve this, roundtable discussion using a mixed methods approach was utilized. Analysis of responses from the roundtable discussion identified four overarching themes: (1) increasing consumer, carer and peer worker involvement in care; (2) re-orienting approaches to service provision; (3) improving access and availability of treatment of services and (4) building capacity of services. The participants had the opportunity to select priorities for change from both the overarching four themes as well as the subthemes. The top priorities overall were first re-orienting approaches to service provision; second, increasing consumer, carer and peer worker involvement in care; third, increasing consumer involvement in their care and fourth, increasing access and availability of services and treatment.

The majority of the sample had received or provided skills-based treatment, in an individual or group-based format, over a long-term period (more than 40 sessions). Significant differences between what individuals received and what they perceived to be optimum in relation to treatment length and format were identified. Contrasting to existing findings, no differences between treatment type received/provided and what was perceived to be optimum were identified,[21,22] whereas DBT was previously identified as the most commonly provided and optimal treatment. This shift may be reflective of changes to public and clinician knowledge, acknowledging the effectiveness of a range of treatments for personality disorder. The effectiveness of all specialist interventions for BPD, despite differences in theoretical orientation, has also been supported by a systematic review,[13] identifying that specialist treatments feature a number of overlapping, common factors. The perception that combined individual and group format treatment aligns with the beliefs of clinicians interviewed in 2012.[22] Despite this, individuals indicated low levels of confidence in the Australian mental health system in the treatment of personality disorder. Furthermore, 66% described the availability of treatment for personality disorder as poor. A shift in focus from the type of treatment provided to reorienting the manner in which services are provided to emphasize the inclusion of consumers, carers and peer workers in care is required. This is further supported by the finding that over 40% of individuals

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identify the lack of education and support for clinicians as a barrier, indicating the importance of clinicians receiving appropriate levels of clinical training and ongoing support of a team, supervisor or trusted colleague in the provision of treatment. Additionally, this represents a progression in focus, where prior studies have identified the need for a consistent approach to servicing, compared with the current focus on holistic care. A consistent approach to servicing involves one treatment approach that is provided to all consumers, regardless of their individual differences or preferences. In contrast, a holistic approach to treatment identifies the individual differences, circumstances and preferences. Holistic care approaches are recommended internationally for individuals with personality disorder.[3,9] Policies that emphasize holistic care outline the importance of individualized psychological formulations and systems level approaches.[24]

Participant responses indicate the value of using formulation-based rather than diagnosis-based approaches, offering non-verbal therapies, addressing stigma, recognizing that some interventions do not work for everyone and providing choice to consumers regarding their treatment. These findings point to the importance of a holistic, integrative whole-of-service approach that emphasizes that treatment is not to be a one-size-fits-all approach but an individualized approach that considers the consumers experiences and preferences.

The belief that long-term treatment was optimum is supported by previous research examining service provision in personality disorder[22,25] and international best practice guidelines for borderline personality disorder. These guidelines recommend that treatment for BPD occurs weekly over at least a 1-year period.[3] Yet qualitative responses report difficulties accessing services for personality disorder, suggesting that accessing services is a barrier to initiating a trajectory towards recovery. This coincides with the identification that the availability of treatment for personality disorder is poor or fair in Australia, where accessing services are known to be difficult,[26] with current mental health schemes offered in Australia considered as insufficient to support the recovery of individuals.[7] The capacity of services may contribute to these findings, such that improving resources, clinician confidence and education and support may improve services and outcomes of people with personality disorder. This view has remained consistent since the last survey of clinicians in Australia.[15]

A holistic approach to care for individuals with personality disorder is a priority for reform and policy change. In particular, this requires clinicians recognizing that individuals with personality disorder engaged in treatment are unique human beings with a vast range of experiences and differing goals,[27] rather than viewing all phenomena through the lens of diagnosis and personality disorder symptomatology. The current findings support and inform calls for an integrative whole-of-service approach to care for personality disorder[16] that provides the right care at the right time based on people's needs. Stepped care requires a number of treatment steps that people can be referred to. Both consumers and clinicians point out that there are missing steps in the options for care, and particularly if they need longer-term treatment, it is often not available. The current findings also extend this integrative approach by placing greater emphasis on the involvement of individuals with lived experience, carers, with health and other human services.

The major strength of the present paper is its inclusive and comprehensive approach in seeking the viewpoints of consumers, carers and clinicians, yet certain limitations must be acknowledged. This sample has a high education level, which may affect the generalization of the findings. Some of the participants had experience providing treatment for or lived experience of BPD, therefore findings may be less generalizable to other personality disorders. The 12 focus groups comprised combinations of consumers, carers and clinicians, so it is difficult to differentiate these perspectives in terms of arising themes. Future studies may wish to include designs that allow for cross comparison between groups, understand the perspectives of individuals who may hold dual clinical and lived experience identities, and differences experienced through seeking help via the public and private mental health system. Despite international recognition of the need to focus on prevention and early intervention in BPD,[28] these was not a central finding within the current paper. This may be explained by the average age of participants (47.6 years) and the convenience sample used. A further limitation of the study is that many participants may have experienced only one or two evidence-based treatment models, therefore may have influenced their experiences. Whilst the sample size was adequate for qualitative research, it is worth noting that it was composed of a significantly greater number of carers. For this reason, the current findings may be particularly of relevance to improving service provision for carers of people with personality disorder. However, it is known that carers of individuals with personality disorder experience higher levels of distress and expressed emotion,[29] therefore survey responses may be skewed.

The aim of the present study was to understand the priorities for service improvement through multiple perspectives including consumers, clinicians and carers. The findings suggest a shift in focus from establishing a consistent approach to servicing, to focusing on holistic care that involves consumers and carers is required.

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Conflicts of interest

All authors have no conflicts of interest to declare.

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