Recovery and Borderline Personality Disorder: A Description of the Innovative Open Borders Program

Sheila Mortimer-Jones, RN, PhD and Paul Morrison, RN, PhD

Murdoch University, School of Health Professions, Murdoch, Perth, Australia

Ahmed Munib, PhD

Armadale Kelmscott Memorial Hospital, Mental Health Service, Armadale, Australia

Francesco Paolucci, PhD

Murdoch University, Sir Walter Murdoch School of Public Policy and International Affairs, Murdoch, Perth, Australia

Sonia Neale

Perth, Australia

Amanda Bostwick, RN

Fremantle Hospital and Health Service, Fremantle, Australia

Catherine Hungerford, RN, PhD

Charles Sturt University, School of Nursing, Midwifery and Indigenous Health, Wagga Wagga, New South Wales, Australia

ABSTRACT

Although Recovery-oriented approaches to delivering mental health services are now promoted in health services across the globe, there is an ongoing need to adapt these approaches to meet the unique needs of consumers with a diagnosis of borderline personality disorder. The lived experience of borderline personality disorder includes emotional dysregulation, intense and unstable relationships, self-harming behaviours, fear of abandonment, and a limited capacity to cope with stress. These experiences present a range of challenges for those who deliver Recovery-oriented services and advocate the principles of empowerment and self-determination. This paper describes a novel crisis intervention program, "Open Borders," which has been established to meet the unique needs of people with a borderline personality disorder diagnosis. Open Borders is a Recovery-oriented model that is run at a public, state-wide residential facility for mental health consumers in Western Australia, and offers alternative pathways to achieving mental health Recovery, including self-referral and short-term admission to a residential facility. The aims of the program are to break the cycle of hospital admission, reduce rates of self-harm, and support the complex Recovery journey of consumers with a diagnosis of borderline personality disorder. Open Borders provides an exemplar for other health service organisations seeking to establish Recovery-oriented crisis intervention alternatives.

INTRODUCTION

Recovery-oriented approaches to delivering mental health services are now promoted in the policy and care guidelines of health services worldwide (Hungerford, 2014). Evaluations of these Recovery-oriented approaches suggest a range of benefits for consumers, including empowerment, together with the opportunity to self-determine and develop more collaborative relationships with health service organisations (Hungerford, Hungerford, Fox, & Cleary, 2016; van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012). There is a dearth of research, however, on how Recovery-

oriented services have been developed to meet the unique needs of consumers with a diagnosis of borderline personality disorder (BPD).

This paper describes a novel crisis intervention program that has been established to support consumers with a diagnosis of BPD in their Recovery journey. “Open Borders,” located in Western Australia, is a Recovery-oriented model that operates as part of the universal health system that operates in Australia. The program was developed as an alternative pathway for supporting the complex nature of the Recovery journey of consumers with a diagnosis of BPD, and provides an exemplar for other health service providers who seek to overcome the challenges involved.

THE PROBLEM

There is an increasing body of research on the implementation and evaluation of Recovery-oriented mental health services worldwide (Hungerford et al., 2016; Piat & Lal, 2012; Williams et al., 2015). Analysis of this research, however, suggests few, if any, studies relate specifically to the effectiveness of Recovery-oriented services when used to support people with a diagnosis of borderline personality disorder (BPD).

For example, a search of the databases CINAHL, MEDLINE, PsycINFO, and Health Source: Nursing/Academic Edition, using the search words “borderline personality disorder” AND “recovery approach in mental health” OR “recovery oriented care” detected no research journal articles. A search of the same databases using the search words “borderline personality disorder” AND “recovery approach” found one journal article; however, this article identified no more than “promising leads” (Hasler, Hopwood, Jacob, Brändle, & Schulte-Vels, 2014, p. 263) to the improvement of Recovery-oriented functional and social outcomes for people with BPD. Another search using the terms “borderline personality disorder” AND “recovery model” located a study undertaken in Melbourne, Australia that identified a number of operational barriers to Recovery-oriented mentalization-based interventions implemented in a community mental health service setting (Bosanac et al., 2015). An important focus of that article, however, was the operational barriers to providing innovative mental

health services, rather than the effects of delivering Recovery-oriented services to people with a diagnosis of BPD.

The issues generated by operational and also systemic barriers have been previously identified by Hungerford (2014). In the process of evaluating Recovery-oriented services delivered by a publicly-funded clinical health service in south-eastern Australia, she identified the challenges faced when consumer-centred approaches are incorporated into organisations that tend to prioritise biomedical imperatives and strategies aimed at minimising risk. For example, enabling consumers to make their own health choices can lead to risk-taking by consumers, with this risk-taking standing at odds with conventional medical or hospital-based treatments crystallised within a rather coercive culture (National Mental Health Commission, 2014). Such issues are particularly problematic for health professionals who provide care to people with complex conditions such as BPD, with self-harming behaviours a part of the symptomology.

BPD and Hospital Admission

BPD is a mental health condition characterised by intense and unstable relationships, emotional instability, self-harming, and parasuicide behaviours, fear of abandonment or rejection, and inability to cope with stress (American Psychiatric Association, 2013). This disorder affects 1–2% of the general population, and around 20% of the inpatient population (Swartz, Blazer, George, & Winfield, 1990; Torgersen, Kringlen, & Cramer, 2001).

Consumers-in-crisis who have BPD frequently present to already stretched emergency departments (EDs) of hospitals following an episode of self-harm, suicidal ideation, or suicide attempt (Pascual et al., 2007). In addition to potentially adding to the wait times in these EDs, the consumer with BPD may have to endure being interviewed by numerous people, and still find that they are unable to gain admission to a hospital bed. This can result in increasing feelings of rejection, which may lead to further deterioration in the person's mental state (McMahon & Lawn, 2011).

While hospital admission is generally considered an appropriate course of action for a person experiencing suicidal ideation in the context of a psychotic or severe depressive episode, this response

is not so clear-cut for consumers diagnosed with BPD (Borschmann & Moran, 2011). Specifically, the parasuicidal and self-harming behaviours of people with BPD may have a very different motivation than for people with psychosis or depression; also, the parasuicidal and self-harming behaviours are often chronic in nature and therefore unlikely to resolve quickly, regardless of whether the consumer is admitted to hospital or not (Paris, 2002). Additionally, hospital admission comes with a number of risks and potential adverse consequences for consumers with BPD (Sansone, 2004). For example, the consumers with BPD have comparatively more management issues than consumers with other diagnoses, including incidents of self-harm, episodes of restraint and/or the *statum* (i.e., immediate) administration of medications to chemically de-escalate inappropriate behaviours (Leontieva & Gregory, 2013). Such management issues add to the cost of the hospitalisation and may also lead to increases in staff burnout and turnover.

BPD and Hospital Staff Burnout

High levels of staff burnout and turnover are almost characteristic of health professionals who deliver healthcare to people with BPD. For example, Cleary, Siegfried, and Walter (2002) surveyed the attitudes of mental health professionals to people with a diagnosis of BPD. A total of 80% of those interviewed found this consumer group very difficult to deal with; 66% felt that management of this consumer group was inadequate, with 29% of these reporting a lack of training and/or expertise in the area as the reason for these feelings. In addition, nurses have been found to have less empathy towards patients with BPD (Fraser & Gallop, 1993) and a higher negative cognitive attitude toward patients with BPD than psychologists and social workers (Bodner, Cohen-Fridel, & Iancu, 2011), while Betan, Kegley Heim, Zittel Conklin, and Westen (2005) identified countertransference dimensions, such as being overwhelmed/disorganised and helpless/inadequate, that can impact on this consumer group. These findings suggest the need for inpatient services with a difference, to support, not only the consumers with BPD, but also the staff who provide the health care.

BPD and Alternative Treatments

While issues related to the hospitalisation of consumers with BPD are numerous, alternative treatments or services are limited. Perhaps the most effective therapeutic intervention thus far is long-term outpatient-based psychotherapeutic interventions such as dialectical behavioural therapy (DBT) (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). For example, in Australia, the hospital admission rate of a group of women who participated in a DBT project located in the community was found to decrease after six months (Carter, Willcox, Lewin, Conrad, & Bendit, 2010). Such specialised, ongoing treatment of BPD is effective because it leads to decreases in suicidal ideation, self-harming behaviours, hopelessness, impulsivity, and depression (Brown, Newman, Charlesworth, Crits-Christoph, & Beck, 2004; Clarkin et al., 2001; Comtois, Elwood, Holdcraft, Smith, & Simpson, 2007; Cottraux et al., 2009). There are, however, limitations with this intervention. Specifically, people diagnosed with BPD may not meet the criteria for entry into DBT programs; or they may not be willing to engage with long-term specialised therapy.

Adaptations of Hospitalisation-Based Interventions

To address the complex issues involved, a number of researchers and clinicians have developed diverse programs with varying aims, including reduced levels of hospitalisation. Findings of the evaluation of these programs suggests that the effectiveness of these programs is mixed.

For example, Chiesa, Fonagy, Holmes, and Drahorad (2004) compared the effects of a step-down facility, comprising 6 months hospital admission followed by 12–18 months outpatient psychotherapy and 6–9 months outreach nursing, with a 12 month specialist psychotherapy admission program. They found that the step-down facility significantly improved consumer outcomes overall, whilst the long-term admission program improved symptom severity, social adaptation, and global functioning. However, no improvement was observed in self-harming behaviours.

Another useful approach is partial hospitalisation. A initial study by Bateman and Fonagy (1999) found that partial hospitalisation with mentalization based treatment (described by Bateman & Fonagy, 2010 as the process by which people make sense of themselves and one another, both implicitly and explicitly, subjectively and objectively) significantly reduced the length of inpatient

episodes. In a later study, it was found that this benefit was maintained 5 years post-treatment, with an overall reduction in the use of services and suicide attempts, compared with the treatment-as-usual group (Bateman & Fonagy, 2008).

In addition to partial hospitalisation there are programs that support the brief hospital admission of people with BPD. For example, in a systematic review of the literature describing various models of brief hospitalisation, Helleman, Goossens, Kaasenbrood, and Achterberg (2014) found that brief admissions to hospital for people diagnosed with BPD in crisis could be useful. Silk et al. (1994) also described such a program, with the bulk of admissions coming via the emergency room where the consumers sign a pre-admission contract which included attending DBT-oriented groups. Once in hospital, a specific behavioural treatment plan is developed that includes a discharge date set within the next 1–2 weeks. Silk et al. found that on subsequent admissions, consumers tended to set their own early discharge date. An important anecdotal finding was that the program led to empowerment of the staff and a greater willingness to engage with the consumers.

A different model involved the availability of 8 crisis beds within the psychiatric emergency service for 2–3 day admissions (Breslow, Klinger, & Erickson, 1993, 1995). After studying 51 admissions, it was found that this model was more suited to consumers with personality disorders in general, than other psychiatric disorders (Breslow et al., 1993). Using an alternate perspective, mental health clinicians were interviewed in relation to brief hospital treatment plans (Nehls, 1994). Although the clinicians believed that the consumers were empowered by their involvement in the brief admission treatment plans, including their ability to control their own admission to hospital, the nature of hospitalisation tends to negate this empowerment. The clinicians in the study also understood that these brief admissions were sought by the consumers for supportive respite from their daily difficulties; however, they also felt that this support was not necessarily freely given.

Ash and Galletly (1997) evaluated a dedicated crisis unit that provided brief hospital stays. Most of the consumers admitted to the crisis unit during the 3 month evaluation period had a diagnosis of adjustment disorder or personality disorder, with 17% of consumers diagnosed with BPD. The average length of stay was 3 days. As most of those comprising the study-group were not re-admitted

during the following 6 months of follow up, the study supports the suggestion that a model comprising brief admissions provides a means of diverting consumers with BPD away from general psychiatric hospitalization.

Koekkoek, van der Snoek, Oosterwijk, and van Meijel (2010) also developed a program of planned brief hospital admissions. Although service use was not significantly reduced, Koekkoek et al. gained valuable positive consumer feedback of their brief admission program. For example, consumers reported improved ability to cope outside of hospital post-discharge. Similarly, Berrino et al. (2011) found that crisis intervention consisting of approximately 5 days at a general hospital reduced incidents of self-harm and psychiatric hospitalisation during the 3 month follow-up period, compared with the treatment-as-usual group. These studies are important as they indicate that it is the brief admission itself that is effective, rather than the environment.

Until recently, the Haven in England had a unique crisis service available for consumers diagnosed with BPD that involved 24-hour telephone contact, a centre that consumers could attend for several hours at any time, and a four-bedded crisis house for brief respite admissions, for up to 3 weeks (Haigh, 2007). Between 2004 and 2014, the Haven Project was a self-referring, user driven Recovery-oriented, therapeutic-community residential service for people diagnosed with BPD as a short stay alternative to hospital admission. Respite beds could be planned in advance and taxi vouchers were provided for crisis response. The service offered a variety of groups including DBT skills groups. The aim of the project was to create a secure base where consumers could dip in and out as needed, where a sense of safety and trust was created in a tangible way (Castillo, 2015). Castillo (as cited in Haigh, 2007) described The Haven Project as having strict behavioural standards in which self-harm behaviour and substance misuse was not tolerated. “Acceptable behaviour” policies were made by the community and there were stepped consequences for “transgressions.” A committee of consumers made decisions on consequences, which included exclusion for a period of time or permanently with facility for redress. Consumers also had full access to their records as there was an open notes policy.

This program has some similarities with the Open Borders program developed in 2013 in Western Australia, identified at the commencement of this paper. This program is now described at length.

OPEN BORDERS

he Open Borders program is one of several programs run at a public mental health service in Western Australia. This service provides a ten-bedded short stay, residential facility, staffed 24 hours a day by nurses, with no medical practitioners on site, and is consistent with the move away from the medical model (Western Australian Mental Health Commission, 2015, p. 12). The Open Borders program fills an unmet need by offering consumers with BPD who have been identified as heavy users of inpatient mental health services, a ready alternative to hospital admission. To meet the criteria for admission into the program, the consumer must be engaged with adult mental health services, carry a diagnosis of BPD, and have a history of unstable behaviour evidenced by a minimum of 5 hospital admissions and/or presentations to ED or triage with emotional instability, self-harming behaviours, or suicidal ideation over a 12-month period. Those consumers with illicit drug or alcohol dependence (but not use), and those with organic brain disorder or mental impairment are excluded from the program.

The consumers are initially referred to the service, and once accepted into this program, the threshold for admission to the residential facility is lowered. Importantly, consumers are able to arrange their own admission rather than going through the usual channels of assessment that are required to access a hospital admission. Consumers may arrange their own admission to the facility without having to demonstrate that they are a serious risk to themselves or others; the aim of this strategy is to help ease some of the escalating behaviours associated with trying to gain admission to hospital. The length of stay will generally be brief (1 week) and a discharge date is set soon after admission. Case management remains with the outpatient team.

Consumers who are accepted into the program are allocated a key worker from the residential facility, with the key worker meeting with the consumer and their case manager to create a management plan intended to meet their needs. This may include frequent short term respite admissions to the facility with the ability to gain access at short notice when in crisis. Individuals on the Open Borders program work from a specific individual workbook that includes skills-based exercises and approaches using a DBT framework. Interventions using these approaches occur on a one-to-one basis with a key worker and during informal group work in the house. Educational DVD's, books, and relevant articles are also

made available for consumers to access during their stay. Staff use a modified DBT approach with the expectation that it will facilitate consumers in gaining the stability necessary to eventually engage with outpatient therapy programs, and thereby provide a supportive environment as consumers reintegrate into the community.

A clinical psychologist from the local mental health hospital, specialising in DBT, visits the facility once a month for a 1-hour staff training session. This session is focussed on increasing staff skills in the management of patients with BPD, improving and reinforcing the use of DBT skills, and offering an opportunity for nursing care of specific consumers to be discussed in a group setting. This professional support is offered in addition to the usual opportunities open to all staff of the Health Service, including specific DBT and BPD training in the form of regular lunchtime forums, as well as more lengthy multi-day DBT training courses. With the main focus remaining on the individual, consumers become familiar with an overall view of DBT approaches, common language, and expectations during the therapeutic process giving them a “taster” before embarking on enrolment in a formal DBT program. Consumers on the program who are not resident at the facility are offered supportive telephone coaching 24-hours a day.

In addition to the Open Borders program, the facility provides the following services for all public mental health consumers regardless of diagnosis: admission diversion and respite programs as well as a stepdown service for mental health consumers who are in hospital and are not quite ready to go home, but who no longer require hospital level care (see Figure 1).

All consumers at the facility are expected to take responsibility for themselves while staying at the house. This means, for example, attending to their own grocery shopping, meal preparation and cooking, as well as all laundry needs. Consumers are also responsible for bringing their own medication and collecting prescriptions. Although consumers are managed by a medical treating team, staff encourage alternatives to medication. In addition, in times of high emotion or risk-taking behaviours, staff work with the individual to develop skills and strategies to aid in their recovery. Nursing staff support and work closely with individuals to look at developing self-responsibility and self-empowerment, with a view to them taking control of their own health interventions, rather than

being a passive recipient of medical treatment. At the same time, however, hospital admissions are facilitated if deemed necessary.

CLINICAL IMPLICATIONS

Open Borders is a unique program that offers a service specifically for individuals with BPD who are heavy users of the publicly-funded mental health system in Western Australia. The Open Borders program combines aspects of the models that utilise brief admissions to manage the consumers-in-crisis with the models that use DBT. In the process, both consumers and health professionals are supported. Within the framework provided by Recovery, the Open Borders program has the following goals for consumers:

- To enable consumers to self-determine, by providing those who have been identified as heavy users of inpatient mental health services with a greater range of options, including the option to self-refer.
- To empower consumers to self-manage their symptoms by providing practical strategies for de-escalating behaviours that often lead to hospital admission, including a supportive coaching telephone service available 24-hours a day.
- To enable consumers to self-determine by arranging their own admission to the residential facility, with the threshold for admission through the Open Borders program lower than that required for hospital admission, thereby reducing the risk of escalating self-harm behaviours.
- To provide a welcoming environment in a residential setting.
- To support consumers to foster hope and optimism through skills-based exercises and approaches that use a DBT framework, with a focus on developing distress tolerance, emotional regulation, and interpersonal effectiveness.
- To support consumers to move towards readiness, in their Recovery journey, for participation in a formal DBT program.

The Open Borders program aims to support health professionals and health services to meet a range of clinical and workforce indicators. These include reductions in presentations to EDs and subsequent hospital admissions, and also reductions in levels of staff burnout and increases in staff satisfaction. These intended outcomes are expected to result from:

- Improved management of the challenging behaviours of consumers, which is a function of the Open Borders program.
- Additional and ongoing training of staff, to provide them with the advanced skills required to support consumers with a diagnosis of BPD.
- Ongoing supervision of staff, to reduce countertransference dimensions that can impact on this consumer group.
- Ensuring clear and transparent communication between services, with community case management remaining with the outpatient team during each short admission.
- Enabling the mutually supportive and collaborative management of consumers with challenging behaviours, with community case workers and Open Borders staff working together to support the consumer's Recovery journey.

Research is underway to study the effectiveness of the Open Borders program through analysis of quantitative data obtained from the Borderline Evaluation of Severity over Time (Pfohl et al., 2009 self-rated assessment tool, analysis of service usage, and semi-structured interviews of staff and consumers.

CONCLUSION

For people with a diagnosis of BPD who engage in psychotherapeutic programs, the prognosis is good. Many of these programs, however, have a long-term focus and do not always meet the needs of the consumer-in-crisis. In addition, while brief hospital admission has been shown to be successful for some consumers with a diagnosis of BPD, there is a need to move away from the medical model to

more fully reflect the Recovery-oriented approach. The residential care offered through the Open Borders program is a positive step to support the Recovery journey of consumers-in-crisis. The current research project that will evaluate the effectiveness of Open Borders is highly significant as it will enhance our understanding of alternative models of care, while building on some of the successful foundations highlighted in earlier studies. Well-conducted research that measures the efficacy of such a program will undoubtedly be of interest to mental health practitioners nationally and internationally, and will inform decisions regarding service provision in the mental health sector. The findings will also be of great interest to consumers looking for professional care that is fully commensurate with their health care needs.

ACKNOWLEDGMENTS

We would like to thank Rhys Jones, RN and Clive Batchelor, RN for the design and implementation of the Open Borders program, and Dr. Douglas Fletcher for his statistical advice and encouragement.

Declaration of interest: The authors report no conflict of interest. The authors are solely responsible for the content and writing of this paper.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, DC: American Psychiatric Association

Ash, D., & Galletly, C. (1997). Crisis beds: The interface between the hospital and the community. *International Journal of Social Psychiatry*, *43*(3), 193–198.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry*, *156*(10), 1563–1569

Bateman, A., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry*, *165*(5), 631–638.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry*, *9*(1), 11–15.

Berrino, A., Ohlendorf, P., Duriaux, S., Burnand, Y., Lorillard, S., & Andreoli, A. (2011). Crisis intervention at the general hospital: An appropriate treatment choice for acutely suicidal borderline patients. *Psychiatry Research*, *186*(2–3), 287–292.

Betan, E., Kegley Heim, A., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, *162*(5), 890–898

Bodner, E., Cohen-Fridel, S., & Iancu, I. (2011). Staff attitudes toward patients with borderline personality disorder. *Comprehensive Psychiatry*, *52*, 548–555.

Borschmann, R., & Moran, P. (2011). Crisis management in borderline personality disorder. *International Journal of Social Psychiatry*, *57*(1), 18–20.

Bosanac, P., Hamilton, B., Beatson, J., Trett, R., Rao, S., Mancuso, S., & Castle, D. (2015). Mentalization-based intervention to recurrent acute presentations and self-harm in a community mental health service setting. *Australasian Psychiatry*, *23*(3), 277–281.

Breslow, R. E., Klinger, B. I., & Erickson, B. J. (1993). Crisis hospitalization on a psychiatric emergency service. *General Hospital Psychiatry*, *15*(5), 307–315.

Breslow, R. E., Klinger, B. I., & Erickson, B. J. (1995). Crisis hospitalization in a psychiatric emergency service. *New Directions for Mental Health Services*, *1965*(67), 5–12

Brown, G. K., Newman, C. F., Charlesworth, S. E., Crits-Christoph, P., & Beck, A. T. (2004). An open clinical trail of cognitive therapy for borderline personality disorder. *Journal of Personality Disorders*, *18*(3), 257–271.

Carter, G. L., Willcox, C. H., Lewin, T. J., Conrad, A. M., & Bendit, N.(2010). Hunter DBT project: Randomized controlled trial of dialectical behaviour therapy in women wth borderline personality disorder. *Australian & New Zealand Journal of Psychiatry*, *44*(2), 162–173.

Castillo, H. (2015). *The reality of recovery in personality disorder.* London, UK: Jessica Kingsley Publishers.

Chiesa, M., Fonagy, P., Holmes, J., & Drahorad, C. (2004). Residential versus community treatment of personality disorders: A comparative study of three treatment programs. *American Journal of Psychiatry*, *161*(8), 1463–1470.

Clarkin, J. F., Foelsch, P. A., Levy, K. N., Hull, J. W., Delaney, J. C., & Kernberg, O. F. (2001). The developemnt of psychodynamic treatment for patients with borderline personality disorder: A preliminary study of behavioral change. *Journal of Personality Disorders*, *15*(6), 487–495.

Cleary, M., Siegfried, N., & Walter, G. (2002). Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing*, *11*, 186– 191.

Comtois, K. A., Elwood, L., Holdcraft, L. C., Smith, W. R., & Simpson, T. L. (2007). Effectiveness of dialectical behavior therapy in a community mental health center. *Cognitive and Behavioral Practice*, *14*, 406–414.

Cottraux, J., Note, I. D., Boutitie, F., Milliery, M., Genouihlac, V., Yao, S. N., … Gueyffier, F. (2009). Cognitive therapy versus rogerian supportive therapy in borderline personality disorder. *Psychotherapy and Psychosomatics*, *78*(5), 307–316.

Fraser, K., & Gallop, R. (1993). Nurses' confirming/disconfirming responses to patients diagnosed with borderline personality disorder. *Archives of Psychiatric Nursing*, *7*(6), 336–341.

Haigh, R. (2007). The 16 personality disorder pilot projects. *The Mental Health Review*, *12*(4), 29–39.

Hasler, G., Hopwood, C. J., Jacob, G. A., Brändle, L. S., & Schulte-Vels, T. (2014). Patient-reported outcomes in borderline personality disorder. *Dialogues in Clinical Neuroscience*, *16*(2), 255–266.

Helleman, M., Goossens, P. J., Kaasenbrood, A., & Achterberg, T.(2014). Evidence base and components of brief admission as an intervention for patients with borderline personality disorder: A review of the literature. *Perspectives in Psychiatric Care*, *50*(1), 65–75.

Hungerford, C. (2014). Recovery as a model of care? Insights from an Australian case study. *Issues in Mental Health Nursing*, *35*(3), 156–164

Hungerford, C., Hungerford, A., Fox, C., & Cleary, M. (2016). Recovery, non-profit organisations and mental health services: "Hit and miss" or "dump and run"? *International Journal of Social Psychiatry*, *62*, 350–360.

Koekkoek, B. R., van der Snoek, R., Oosterwijk, K., & van Meijel, B.(2010). Preventive psychiatric admission for patients with borderline personality disorder: A pilot study. *Perspectives in Psychiatric Care*, *46*(2), 127–134.

Koons, C. R., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzalez, A. M., Morse, J. Q., … Bastian, L. A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy*, *32*, 371–390.

Leontieva, L., & Gregory, R. (2013). Characteristics of patients with borderline personality disorder in a state psychiatric hospital. *Journal of Personality Disorders*, *27*(2), 222–232.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L.(1991). Cognitive behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *48*(12), 1060–1064.

McMahon, J., & Lawn, S. (2011). Foundation for change: Part 1- CONSUMERS: Experiences of CONSUMERS with the diagnosis of borderline personality disorder (BPD*). Private Mental Health Consumer Carer Network (Australia)*. Retrieved from http://dspace.flinders.edu. au/dspace

National Mental Health Commission. (2014). National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney, Australia: NMHC.

Nehls, N. (1994). Brief hospital treatment plans for persons with borderline personality disorder: Perspectives of inpatient psychiatric nurses and community mental health center clinicians. *Archives of Psychiatric Nursing*, *8*, 303–311.

Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder. *Psychiatric Services*, *53*(6), 738–742.

Pascual, J. C., Corcoles, D., Castano, J., Gines, J. M., Gurrea, A., Martin-Santos, R., …Bulbena, A. (2007). Hospitalization and pharmacotherapy for borderline personality disorder in a psychiatric emergency service. *Psychiatric Services, 58*(9), 1199–1204. doi: 10.1176/appi.ps.58.9.1199

Pfohl, B., Blum, N., St. John, D., McCormick, B., Allen, J., & Black, D. W.(2009). Reliability and validity of the borderline evaluation of severity over time (BEST): A self-rated scale to measure severity and change in persons with borderline personality disorder. *Journal of Personality Disorders*, *23*(3), 281–293.

Piat, M., & Lal, S. (2012). Service providers' experiences and perspectives on recovery-oriented mental health system reform. *Psychiatric Rehabilation Journal*, *35*(4), 289–296.

Sansone, R. A. (2004). Chronic suicidality and borderline personality. *Journal of Personality Disorders*, *18*(3), 215–225.

Silk, K. R., Eisner, W., Allport, C., DeMars, C., Miller, C., Justice, R., & Lewis, M. (1994). Focused time-limited inpatient treatment of borderline personality disorder. *Journal of Personality Disorders*, *8*(4), 268–278.

Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the prevalence of borderline personality disorder in the community. *Journal of Personality Disorders*, *4*(3), 257–272.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry*, *58*(6), 590–596.

van Gestel-Timmermans, H. P., Brouwers, E. P. M. P., van Assen, M. A. L. M. P., & van Nieuwenhuizen, C. P. (2012). Effects of a peer-run course on recovery from serious mental illness: A randomized controlled trial. *Psychiatric Services*, *63*(1), 54–60.

Western Australian Mental Health Commission. (2015). *Better choices. Better lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*. Perth, Australia: Government of Western Australia.

Williams, J., Leamy, M., Bird, V., Le Boutillier, C., Norton, S., Pesola, F., & Slade, M. (2015). Development and evaluation of the INSPIRE measure of staff support for personal recovery. *Social Psychiatry and Psychiatric Epidemiology*, *50*(5), 777–786.

Figure 1. Functions of the Residential Mental Health Service in Western Australia.