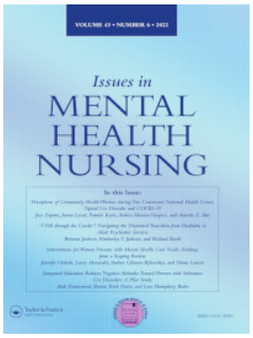

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Working with People Presenting with Symptoms of Borderline Personality Disorder: The Attitudes, Knowledge and Confidence of Mental Health Nurses in Crisis Response Roles in Australia

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ABSTRACT

Many people diagnosed with or presenting with borderline personality disorder (BPD) attend the emergency department (ED) when in crisis, and are often referred to mental health nurses for further assessment, and to arrange appropriate follow-up (MHNs). Little is known about the knowledge, skills, confidence and competence of MHNs working with this group in these specialist roles. This study sought to describe the attitudes of MHNs working in EDs and crisis services towards people who present with symptoms characteristic of BPD and to explore their knowledge of the diagnostic criteria of BPD. A descriptive survey tool comprised of 23 questions was adapted from a previously used survey with clinicians in a mental health service in Australia. Fifty-four nurses who identified as MHNs and were currently employed in EDs or crisis settings completed the survey online. These MHNs were found to hold positive attitudes towards people with BPD including being optimistic about recovery and treatment. The experience and education of MHNs now employed in EDs may have contributed to positive attitudes and self-reported confidence relative to other nurses. Further research ought to focus on how MHNs assist people with a diagnosis of BPD who present in crisis meet immediate needs and facilitate access to effective ongoing care and treatment.

Introduction

The emergency department (ED) is often the first point of contact for a person experiencing a mental health crisis in Australia (Roennfeldt et al., 2021). People with a diagnosis of borderline personality disorder are estimated to present to EDs in disproportionally large numbers relative to other mental health conditions (Lewis et al., 2019). Some suggest that up to 27% of people presenting to the ED in crisis meet the criteria for BPD (Australian BPD Foundation Limited, 2019; Shaikh et al., 2017). Both total numbers of ED presentations and mental health related presentations to ED have steadily increased in Australia over the last decade (Australian Insitute of Health & Welfare, 2022), suggesting an increasing prevalence of people attending with a likely diagnosis of BPD. For many people, the ED is their primary interface with the healthcare system. However, EDs are widely acknowledged as an extremely challenging environment to address presenting problems such as suicidal behaviour and self-harm, and usual post-ED referral pathways such as hospitalisation are largely ineffective in addressing the underpinning problems behind the presenting problem (Koehne & Sands, 2008).

Many individuals with the constellation of symptoms characteristic of BPD report feeling stigmatised, ashamed, invalidated and unsafe when presenting to the ED (Wand et al., 2020). Indeed, the ED is widely acknowledged to be a less than ideal environment for those who present in acute mental distress (Pascoe et al., 2022). People with a mental illness experience longer wait times than their counterparts in an already chaotic and overstimulated environment and are more likely to be subject to coercion and involuntary transportation to the ED via police or ambulance (Roennfeldt et al., 2021). This can potentially increase the individual's level of distress, resulting in re-traumatisation (Rudolph, 2021). EDs also have an acute biomedical orientation to stabilise or address acute problems rather than a recovery-oriented approach promoted if not adopted by mental health services. This can have negative impacts on the individual's recovery and future help seeking behaviour because the broader psychosocial factors which contribute to one's presentation to ED are not addressed (Roennfeldt et al., 2021).

The management of BPD and its associated behaviours has been identified as an area of concern for general nurses

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working within EDs (Jelinek et al., 2013). Generalist ED nurses may not perceive that they have the knowledge and skills required to provide care for those with acute mental distress (Koning et al., 2018). They, like MHNs in inpatient contexts (McCarrick et al., 2022) may feel constrained in their roles and unable to facilitate access to ongoing effective treatment. MHNs in ED can potentially play a role in bridging the ED and mental health systems, including facilitating access to appropriate ongoing care in community settings. Thus their attitudes, knowledge, psychotherapeutic acumen, networking skills and capacity to enact broader roles than generalist ED nurses could potentially assist people with BPD towards recovery rather than just resolution of immediate crisis. This project sought to address this hitherto unexplored area, that is the knowledge, attitudes, opinions and confidence of MHNs in these specialist roles regarding assessment, diagnosis and management of BPD.

Background

In Australia, nurses with mental health skills are employed within the ED and have a role in the assessment, diagnosis and treatment referrals of those who present to the ED in mental health crisis (Campbell et al., 2019). However, what distinguishes MHNs from others in these roles is difficult to determine because mental health nursing is not recognised as a registered speciality in Australia. According to Pascoe et al. (2022) in response to the increase in mental health related ED presentations, mental health liaison nurses were introduced into EDs in Australia in the 2000s. In some cases, these nurses are nurse practitioners with the authority to order diagnostic tests and prescribe some medicines (Nicholls et al., 2011), but this is by no means always the case. Mental health liaison nurses' scope of practice includes providing mental health expertise and help to guide a person's journey through an otherwise chaotic ED (Pascoe et al., 2022). Additional roles of mental health nurses in the ED may include assessment and management of mental health related presentations as well as facilitating any necessary follow up (Nicholls et al., 2011) as well as brief psychotherapeutic interventions and support to ED staff.

Mental health nurses within the ED have been found to have positive impacts on patient outcomes. Sinclair et al. (2006) found that MHNs have the skills and knowledge to undertake appropriate assessments and provide high quality management decisions. Moreover, embedding MHNs into EDs has improved support for consumers who present to the ED with distress as well as a reduce in waiting times in ED (Wand, 2004; Wand et al., 2016). MHNs in the ED can potentially provide support and education to ED staff to enhance their capacity to make management decisions and provide care to client groups such as those diagnosed with BPD who are considered challenging to work with.

The knowledge, attitudes, opinions and confidence of the MHNs in the diagnosis, response to and management of people with BPD can potentially impact on individuals and the care system in profound ways. Historically research on the attitudes of mental health professionals, including MHNs has revealed largely negative attitudes towards people diagnosed with BPD (Black et al., 2011; Bodner et al., 2011; Cleary et al., 2002; Deans & Meocevic, 2006; Markham, 2003; Markham & Trower, 2003; Sansone & Sansone, 2013; Weight & Kendal, 2013). Moreover, MHNs have often found working with people with BPD difficult and challenging in hospital environments and have historically been pessimistic about the likelihood of recovery (Black et al., 2011; Bodner et al., 2011; Cravens, 2016; McAllister et al., 2002; McCarrick et al.) despite the availability of effective psychotherapeutic treatment options (Choi-Kain et al., 2017; Iliakis et al., 2019). However, the ED environment presents additional considerations which could potentially influence existing attitudes. People with BPD have high rates of repeated presentations to the ED (Roennfeldt et al., 2021), which could influence the views held by these nurses concerning recovery. This could be further exacerbated by the knowledge that evidence-based treatment for BPD is lengthy programmes of psychotherapy rarely offered in State mental health services (Oud et al., 2018). Negative attitudes towards people with BPD can result in misdiagnosis and inadequate or harmful treatment being provided (Campbell et al., 2020). The perception that others will view people with a diagnosis of BPD poorly may also result in clinicians not conferring a diagnosis, conferring a diagnosis only related to the presenting problem (e.g., situational crisis), or adjusting their diagnosis and suggested treatment to avoid stigma and subsequent poorer health outcomes (Proctor et al., 2021; Sisti et al., 2016). Knowledge held by MHNs has the ability to influence attitudes towards BPD, but can also influence the level of confidence held by the MHN when making assessment and treatment decisions.

The aims of this study were threefold: Firstly, to explore the knowledge and experience of MHNs regarding the defining symptoms and behaviours that indicate a diagnosis of BPD; Second to identify the attitudes and opinions held by MHNs working in EDs and crisis services towards people who present with behaviour or symptoms associated with BPD; and finally; to identify the confidence held by and the perceived role of the MHN towards the care for people with BPD presenting to the ED.

Methods

Instrument

A survey developed by Cleary et al. (2002) was adapted and deployed on the online survey platform QUALTRICS (2021). The survey tool consisted of 23 questions. Cleary et al. (2002) state this survey was developed to understand health professionals' experience, knowledge, and attitudes regarding the management of people with a diagnosis of BPD to inform ongoing training for MHN staff. The survey appeared to have face validity and had been used by other researchers exploring attitudes towards BPD (Giannouli et al., 2009; Hazelton et al., 2006; James & Cowman, 2007). The adapted questionnaire was sent to a sample of health professionals, and feedback was requested regarding its congruence with

the aims of this study and the construct validity of the items. Adjustments to the clarity of the items were made as per the feedback received, which included making amendments to diagnostic criteria in accord with the DSM-5 (American Psychiatric Association, 2013).

The questions used in the survey tool identify demographic details, past training/education, previous experience caring for someone with BPD, attitudes held by mental health clinicians towards people with a diagnosis of BPD, and knowledge of BPD. Questions to elicit demographic details included gender, age bracket, experience, training, and locality. These questions were included to draw comparisons between responses to the questions aimed at exploring attitudes, knowledge, and confidence of MHNs towards people with BPD. MHN's attitudes towards BPD were explored by providing statements about BPD and asking respondents to respond using a Likert scale rating from strongly agree to disagree. Additional questions explored the confidence and perceived role of MHNs in recognising and providing care to people diagnosed with BPD.

Recruitment and data collection

The study population included qualified registered nurses in Australia who were employed in ED in mental health service roles and identified as MHNs. Emergency and crisis settings included acute care teams, psychiatric emergency centres, psychiatric liaison roles, psychiatric assessment teams, emergency crisis assessment teams, crisis assessment and triage teams, emergency departments, PACER (Police, ambulance, clinical, early response), and mental health assessment teams. These settings were broadly classified because of the array of terminology used to describe nurses in this role in Australia. Convenience sampling was used as we could not determine the number of nurses employed in these environments. The first author initially rang health services but could not confirm the number of MHN's working in these roles. An invitation to complete the anonymous survey was distributed electronically via social media platforms (Twitter and Facebook) and through email invitations, and via nursing distribution lists of the Australian College of Mental Health Nurses. Snowballing (i.e., asking people to forward invitations) was used to increase the sample size. The survey remained open for 12 months. This was necessary because the promotion of the survey coincided with the first wave of COVID-19.

Ethics approval

Ethics approval was sought and granted for this study (Approval number 2020/139).

Data analysis

The completed surveys were imported into a spreadsheet and presented to show observed rates and frequencies. This was consistent with the method used by Cleary et al. (2002). Descriptive statistics were used to describe and synthesise data. Categorical variables were presented as numbers (%). Due to the small sample size, no comparison or correlational tests were performed or inferential statistics were conducted.

Results

Demographic data

Characteristics of respondents

Fifty-four MHNs completed the survey. The majority of respondents were female (65%, n = 35), and were over the age of 50 (50%, n = 27) with over 15 years experience (52%, n = 28). This is broadly representative of nurses who work in mental health. Sixty-seven percent (n = 36) of respondents held postgraduate qualifications. All states and territories were represented in the responses; however, Queensland was where most respondents were located (33%, n = 18). Consistent with the inclusion criteria, respondents were employed in the ED in some capacity (see Table 1).

Participation in specific training

Fifty-two percent (n = 22) of the respondents reported receiving training on BPD within the last 2 years, 31% (n = 13) had received training within the previous 5 years, and 17% (n = 7) had received training more than 5 years ago. The majority of this training was received at a workshop (43%, n = 23), an in-service event (17%, n = 9), a conference (6%, n = 3), or online (4%, n = 2). Nine percent (n = 5) of respondents reported receiving training through other means, including specialist borderline personality services or books (see Table 1).

Contact and management of people with BPD

All respondents reported having contact with someone with BPD at least several times a month, and a majority (69%, n = 37) reported daily contact (see Table 2). Most respondents (83%, n = 45) reported they did not believe people with BPD were adequately managed. Respondents reported this as being primarily related to a shortage of services to treat people with BPD (72%, n = 39). Ten percent (n = 8) of respondents also reported that this may have been due to their lack of training or expertise and 23% (n = 18) of respondents reported that people with BPD are difficult to treat. Respondents were given an option to expand on their reasoning further, and the majority attributed inadequate treatment to negative attitudes and stigma from their peers (67%, n = 12) (see Table 2).

The majority of respondents (70%, n = 38) remained neutral or disagreed with the statement "people with BPD should not be hospitalised." Most respondents (85%, n = 46) agreed that "short-term psychotherapy is useful" to manage crises in people with BPD. The majority of respondents were neutral or disagreed that "antidepressant medication is of no benefit" to treat depression experienced by people with BPD (85% n = 46). All but one

Table 1. Demographic data.

Question	Percentage
Gender	
Male	35 (19)
Female	65 (35)
Age	
<30 years	6 (3)
31–40 years	26 (14)
41–50 years	19 (10)
>50 years	50 (27)
Location	
Northern Territory	2 (1)
Queensland	33 (18)
New South Wales	20 (11)
Australian Capital Territory	6 (3)
Victoria	26 (14)
Tasmania	2 (1)
South Australia	6 (3)
Western Australia	6 (3)
Years in practice	
<2 years	4 (2)
2–5 years	9 (5)
6–10 years	19 (10)
11–15 years	17 (9)
>15 years	52 (28)
Place of work	
Crisis assessment triage team	11 (6)
Psychiatric assessments in the emergency department	37 (20)
Emergency department crisis assessment triage team	13 (7)
Acute care team	20 (11)
Psychiatric liaison	4 (2)
Other:	15 (8)
PACER (Police Ambulance Clinician Emergency Response) MH clinician	
Private low risk	
Academic setting	
Combination of ED assessments and acute crisis work	
Remote Aboriginal Community Clinic	
Acute mental health unit	
Psychiatric assessment and planning unit and overnight telephone triage	
Blended role alternating emergency psych and PACER	
Highest level of education	
Hospital trained	7 (4)
Bachelor's degree	26 (14)
Post graduate certificate/diploma	19 (10)
Master's degree	41 (22)
Higher degree by research (Master's/PhD)	7 (4)

Table 2. Contact and management of BPD.

Question	Percentage
How often do you come into contact with someone with a diagnosis of BPD?	
Daily	69 (37)
1–2 times per week	22 (12)
1–2 times per month	9 (5)
How adequately do you consider people with BPD to be managed?	
Adequately	17 (9)
Inadequately	83 (45)
If you think the management of BPD was inadequate, do you believe this is because: (Multiple responses)	
You lack training and/or expertise	10 (8)
There is a shortage of services to treat this group of people	51 (39)
The people themselves are very difficult to treat	23 (18)
Other:	16 (12)
If you thought the management of people with BPD was adequate, do you believe this is because:	
You have received training and/or have expertise	35 (22)
There is a range of services to treat this group of people	6 (4)
The people themselves are very easy to treat	6 (4)
Other	52 (32)

respondent (98%, n = 53) agreed that "people with BPD can be treated."

Knowledge of BPD diagnostic criteria

Respondents were asked to identify symptoms characteristic of BPD. Unstable interpersonal relationships (52%, n = 28) and a history of trauma (61%, n = 33) were the most common diagnostic criteria identified by respondents (see Table 3). Respondents did not identify transient psychosis and grandiose sense of self-importance as a characteristic of BPD. Only two of the statements, unstable interpersonal relationships and chronic feelings of emptiness, had 100% agreement that they were diagnostic features of BPD (see Table 3).

The majority of respondents disagreed that BPD can progress to schizophrenia (65%, n = 35). Twenty-six percent of respondents (n = 14) believed people with BPD attain stability in their 30s and 40s or that they experienced brief psychotic episodes (n = 14). A further 16% (n = 12) disagreed that people with BPD have a high incidence of depression.

Attitudes

The majority of respondents disagreed that people with BPD were dangerous (93%, n = 50), that they chose to behave the way they do (96%, n = 52), that it is a self-induced disorder (98%, n = 53) or that people with BPD are attention-seeking (85%, n = 46). Respondents were either in agreeance or neutral that people with BPD were manipulative (61%, n = 33) and that they "staff split" (50%, n = 27).

Opinions about working with people with BPD

A small number of respondents (24%, n = 13) felt frustrated when working with people with BPD and 76% (n = 41) did not. The majority of respondents reported enjoying working with people with BPD (81%, n = 44). Eighty-five percent of respondents reported they have empathy for people with BPD (n = 46). Despite this, respondents largely reported that they found working with people with BPD to be moderately difficult (74%, n = 40). However, 61% (n = 36) of respondents reported they found working with people with BPD "equal to" or "no more difficult" than working with people who have other mental health disorders. A third (33%, n = 18) of respondents reported working with people with BPD to be "more difficult" than people with differing diagnoses.

Perceived confidence surrounding care provision for people with BPD

Respondents were asked how knowledgeable and confident they were in relation to the identification, assessment, development of provisional diagnosis, ongoing management, and provision of consumer education for people with BPD. The majority of respondents felt confident and knowledgeable in identifying and developing a provisional diagnosis of BPD. Thirty-nine percent (n = 21) of respondents reported feeling confident and knowledgeable in relation to assessing people with BPD. Eighty-seven percent (n = 47) of respondents reported being knowledgeable and feeling confident in the ongoing management of BPD. Similarly, 85% (n = 46) of respondents reported feeling knowledgeable and confident in providing consumer education to people with BPD (see Table 4).

Role of the MHN in the ED or crisis context

Respondents were asked about their role in relation to the identification, assessment, conferral of a diagnosis, recommending management, and provision of education to people with BPD. Identifying BPD was considered an important element of the MHN's role in this study. Undertaking assessment (98%, n = 53), arriving at a diagnosis (81%, n = 44), recommending management (96%, n = 52), and providing education to people with BPD (93%, n = 50) were also viewed as important elements of the nurse's role.

Discussion

It is well established that many health professionals hold negative attitudes towards people with BPD (Bodner et al., 2015; Hong, 2016; James & Cowman, 2007; McGrath & Dowling, 2012; Proctor et al., 2021; Treloar, 2009). Previous research has established several factors that influence these negative thoughts, including workplace culture, years of experience, and education (Bodner et al., 2011; Hauck, 2013; James & Cowman, 2007; O'Connell & Dowling, 2013; Purves & Sands, 2009). Our study aimed to explore the knowledge,

Table 3. The DSM5 diagnosis of BPD is characterised by:.

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Unstable mood with rapid shifts	33 (18)	50 (27)	7 (4)	6 (3)	4 (2)
Grandiose sense of self-importance	0	17 (9)	28 (15)	31 (17)	24 (13)
Impulsive behaviour particularly self-destructive	39 (21)	56 (30)	0	2 (1)	4 (2)
Frequent attempts to avoid abandonment	41 (22)	46 (25)	7 (4)	4 (2)	2 (1)
Unstable interpersonal relationships	52 (28)	43 (23)	6 (3)	0	0
Unstable/low self-image	33 (18)	41 (22)	7 (4)	2 (1)	0
Intense anger	9 (5)	41 (22)	39 (21)	7 (4)	4 (2)
Chronic feelings of emptiness	39 (21)	50 (27)	11 (6)	0	0
Recurrent suicidal behaviours/ gestures	30 (16)	56 (30)	11 (6)	4 (2)	0
Psychotic phenomena ie hallucinations	0	24 (13)	33 (18)	35 (19)	7 (4)
Transient paranoid thinking	4(2)	43 (23)	44 (24)	7 (4)	2 (1)
History of trauma	61 (33)	22 (12)	11 (6)	6 (3)	0

Table 4. Knowledge and confidence.

	Very	Moderately	Only a little	Not at all
How knowledgeable do you consider yourself in relation to:				
The identification of BPD	33 (18)	59 (32)	7 (4)	0
The development of a provisional diagnosis of BPD	30 (16)	65 (35)	6 (3)	0
The assessment of BPD	39 (21)	54 (29)	7 (4)	0
The management of BPD	20 (11)	67 (36)	13 (7)	0
Providing consumer education on BPD	22 (12)	63 (34)	13 (7)	2 (1)
How confident are you in undertaking the following				
Identification of BPD	37 (20)	57 (31)	6 (3)	0
Provisional diagnosis of BPD	31 (17)	61 (33)	7 (4)	0
Assessment of BPD	41 (22)	50 (27)	9 (5)	0
Ongoing management of BPD	17 (9)	61 (33)	22 (12)	0
Awareness of specialist services of BPD	24 (13)	48 (26)	24 (13)	4 (2)
Referral to specialist services for BPD	26 (14)	44 (24)	26 (14)	4 (2)
Providing consumer education on BPD	30 (16)	54 (29)	15 (8)	2 (1)

attitudes, and confidence of MHNs who work within crisis and emergency settings towards people with BPD. This is important because these nurses have a role in developing an assessment, a provisional diagnosis, and subsequent treatment referrals, which can impact the care and outcomes received by people with a presentation with symptoms characteristic of BPD. Although other research exploring the attitudes of nurses working in the emergency department towards self-harm, this study contributes new knowledge as it is the first study specifically exploring the attitudes, knowledge, confidence and the role of MHNs who work in the ED/crisis settings within the Australian context. Furthermore, it provides knowledge of the current roles, confidence, and knowledge of MHNs, providing a provisional diagnosis of people present to the ED.

The respondents of our survey could be representative of Australia's MHN workforce. The AHIW reports that 70% of nurses employed in the mental health context are female, and 54% are over 45 (Australian Institute of Health & Welfare, 2021). This coincides with the characteristics of our respondents, who were majority female and over the age of 50. With permission from the Australian College of Mental Health Nursing, de-identified data were obtained from the college database, which indicated the role of each member. Each member can voluntarily state their role and qualifications. Of their members, approximately 14% voluntarily disclosed they have a role within emergency departments or crisis settings. Of these, approximately 75% held postgraduate qualifications. While we are unsure what the total number of people who are MHN's is, this sample does seem to be representative based on the data received.

This study explored the attitudes of MHNs in emergency and crisis settings across Australia. In contrast to many studies exploring attitudes of MHNs in the past (Black et al., 2011; Bodner et al., 2015; Dickens et al., 2016; Giannouli et al., 2009; Hauck et al., 2013; James & Cowman, 2007), we found the attitudes towards treatment efficacy and recovery were largely positive. There are several reasons for this finding. Firstly, the majority of respondents in our study were over 50 years of age, had over 15 years of experience working in mental health, and almost all respondents were eligible to be credentialed in Australia. In addition to this, the nature of the role held by these nurses is semi-autonomous and requires confidence and experience to be successful. More exposure and experience in working with people with BPD develops experiential knowledge, and this may better equip MHNs to provide adequate care (Black et al., 2011; Bodner et al., 2011; Hauck, 2013; Ma et al., 2009). Regular contact with someone with BPD at least 1-2 times per month was an important finding in our study because previous researchers have identified the more contact and exposure a clinician has with someone with BPD, the more likely their attitude will be negative towards this group of people (Bodner et al., 2015; Purves & Sands, 2009). Secondly, the vast majority of respondents had a graduate certificate or higher. This coincides with previous researchers who found that highly educated clinicians were more likely to hold more optimistic and positive attitudes (Bodner et al., 2011; Hauck, 2013; James & Cowman, 2007; O'Connell & Dowling, 2013; Purves & Sands, 2009). Finally, we found a shift in optimism surrounding the treatment and recovery for people with BPD. This coincides with the findings of Day et al. (2018), who suggest the positive shift could also be reflected in the increasing awareness of treatments and the ongoing developing mental health system. In addition to MHN's having increased education, experience, and exposure, an expected outcome could be increased knowledge and confidence in working with this consumer group.

Confidence has been identified as important in nursing practice as it is closely linked with knowledge and competence, which can affect care outcomes (Zieber & Sedgewick, 2018). We identified that the majority of respondents perceived their knowledge base and confidence to be adequate when identifying, assessing, providing a provisional diagnosis, and managing people with BPD. This corresponds with existing knowledge whereby perceived self-confidence is thought to be related to education (Purves & Sands, 2009). Despite respondents' confidence and knowledge level, their understanding of DSM-5 criteria was not entirely accurate. Most MHN's identified a history of trauma as the standout diagnostic feature of BPD. A history of trauma is not a diagnostic feature of BPD, according to the DSM-5. Still, it is common in the histories of those with the diagnosis (American Psychiatric Association, 2013) and those with complex PTSD, of which there is some considerable overlap.

However, this finding could be evidence of the shift in the understanding of how BPD is conceptualised and located within a life history characterised by adversity and the recognition that trauma is commonly presented in the aetiology of BPD. In addition, this further supports the contemporary movement to step away from the categorical nature of the DSM and move towards a more dimensional approach whereby the presenting individual's story is considered throughout the assessment and treatment process rather than rigid diagnostic criteria (Campbell et al., 2020). Interestingly, one of the more confronting and easily recognised behaviours commonly associated with BPD, recurrent suicidal behaviours and gestures (Colle et al., 2020), was not one of the top five characteristics identified by respondents as a diagnostic criterion.

People with BPD have higher rates of completed suicide and suicide attempts (Broadbear et al., 2020). The recognition and subsequent management of externalised behaviours often contribute to negative attitudes towards a particular condition (Deans & Meocevic, 2006). Externalised behaviours are often associated with aggressive actions and/or substance use (Eaton et al., 2011). In the case of BPD, one could view externalised behaviours as communicative gestures which commonly take the form of self-injurious behaviour via suicidal gestures or self-harm and emotional instability. Clinicians tend to recognise these types of behaviours more easily than internalised behaviours, which often leads to the formulation of a diagnosis (Winsor & McLean, 2016). Naturally, it is interesting that respondents did not identify these behaviours as prevalent in BPD presentations. This change in association of these behaviours with BPD may well be attributed to the difference in the types of behaviours presenting to the emergency department. Staff in the emergency environment are frequently exposed to violence and aggression (Hyland et al., 2016). Further, rates of aggression in emergency departments are increasing and are becoming a concern for clinicians (Nikathil et al., 2018). The ever-increasing presentations of violence and aggression in the emergency department may well have contributed to the normalisation of suicidal gestures, self-injurious behaviours, and other behaviours associated with emotional dysregulation. Subsequently, the externalised behaviours may not necessarily be considered as challenging and confronting as they have been historically, resulting in less of an impact on attitudes held by MHN's in the ED.

Almost all respondents felt they had a role in identifying, assessing, developing a provisional diagnosis, management, and delivering education for people with BPD. Indeed, this highlights the uniqueness of the MHNs within the emergency or crisis context who are involved in the identification and assessment of BPD and the development of provisional diagnosis, which is usually a privilege designated to the medical profession (Campbell et al., 2019). Despite this, it is clear that the respondents felt the management, treatment, and service availability of people with BPD is still less than desirable. Respondents suggested the current mental health services available within the public sector simply did not have the resources available and are often seen in the emergency department and sent home without treatment. Many respondents identified the need for further services, such as specialist outpatient services, to provide adequate care to achieve the best possible outcomes for people with BPD.

Limitations

This study is not without its limitations. First, the study sample size is small (N = 54). Evidence suggests that surveys are renowned for having very poor response rates, and this study is no exception (Cope, 2014). However, we faced additional challenges as the release of the survey coincided with the first wave of COVID-19 and despite our best efforts to recruit participants, the response rate remained small. Second, the people who completed this survey may be biased as they may be motivated and have a specific interest in people with BPD. It is unclear how representative these respondents were of MHNs working in emergency or crisis settings within Australia. Despite our best efforts, we could not establish the number of MHN's who work in these environments within Australia for several reasons. The exact role description of MHNs who work within emergency or crisis settings changes from service to service, as indicated in the demographic data obtained in our survey. In addition (and possibly due to the varying titles given to these nurses), data is not collected nor reported on for this particular role anywhere in Australia. As such, the population of MHNs in these roles is unknown, impacting the ability to generalise the results. Third, the survey tool could be considered dated and ambiguous. For example, it is unclear what constitutes an attitude, knowledge, or confidence. In addition, although the survey tool was used by other researchers (Cleary et al., 2002; Giannouli et al., 2009; Hazelton et al., 2006; James & Cowman, 2007) it has not been tested for consistency and reliability. Fourth, by the nature of the topic explored and the questions asked, responses may not be entirely accurate. For example, when exploring opinions surrounding negative attitudes, respondents may have responded more favourably than in reality. Finally, there may be bias in the selection of respondents present due to the use of social media platforms and online platforms such as Twitter for recruitment. Respondents recruited by this means may be more educated, more engaged, and actively involved in the upkeep of evidence-based practice than those who were not. Despite these limitations the findings offer important information on the attitudes, knowledge, and confidence of MHNs towards BPD.

Conclusion

We found that MHNs employed in the ED largely have positive attitudes towards people with BPD. This may be due to many of these nurses having over 15 years of experience, being mature in age, and often having additional education at a postgraduate level. However, moving forward, efforts should be afforded to conducting high-quality studies with validated tools to explore the attitudes, knowledge, and

confidence of MHNs in the emergency department towards people with BPD. In addition, future research should also consider assessing patients' perspectives of the care offered by MHNs in emergency settings.

Relevance to clinical practice

The scope, role and impact of MHNs working in EDs is poorly defined and described thus it is difficult to identify professional development opportunities and clearly articulate the impact of these roles. Studies like this which provide important information pertinent to the role and experience of these MHNs can provide insight into their knowledge and perceived confidence and then suggest opportunities for research and education to improve the patient experience. In the case of this study, further research is necessary to determine how MHNs make sense of or formulate presenting problems, what helpful interventions they provide, and how to mobilise this skilled component of the workforce best to ensure that people who present in crisis receive timely and effective ongoing care and treatment.

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References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). American Psychiatric Association.

Australian BPD Foundation Limited. (2019). *The social and economic benefits of improving mental health. Submission prepared by the Australian BPD Foundation for the Productivity Commission into Mental Health April 2019*. https://www.pc.gov.au/__data/assets/pdf_file/0005/240773/sub267-mental-health.pdf

Australian Institute of Health and Welfare. (2021). *Mental Health Services Australia: Nursing workforce*. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce#Nurses

Australian Insitute of Health and Welfare. (2022). *Emergency department mental health services*. Institute of Health & Welfare. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services

Black, D. W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C. S., Phillips, K. A., Robins, C., Siever, L., Silk, K. R., Williams, J. B. W., & Zimmerman, M. (2011). Attitudes toward borderline personality disorder: A survey of 706 mental health clinicians. *CNS Spectrums*, *16*(3), 67–74. https://doi.org/10.1017/S109285291200020X

Bodner, E., Cohen-Fridel, S., & Iancu, I. (2011). Staff attitudes toward patients with borderline personality disorder. *Comprehensive Psychiatry*, *52*(5), 548–555. https://doi.org/10.1016/j.comppsych.2010.10.004

Bodner, E., Cohen-Fridel, S., Mashiah, M., Segal, M., Grinshpoon, A., Fischel, T., & Iancu, I. (2015). The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder. *BMC Psychiatry*, *15*(1), 2. https://doi.org/10.1186/s12888-014-0380-y

Broadbear, J. H., Dwyer, J., Bugeja, L., & Rao, S. (2020). Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder. *Journal of Psychiatric Research*, *129*, 241–249. https://doi.org/10.1016/j.jpsychires.2020.07.007

Campbell, K., Clarke, K. A., Massey, D., & Lakeman, R. (2020). Borderline personality disorder: To diagnose or not to diagnose? That is the question. *International Journal of Mental Health Nursing*, *29*(5), 972–981. https://doi.org/10.1111/inm.12737

Campbell, K., Massey, D., Broadbent, M., & Clarke, K. A. (2019). Factors influencing clinical decision making used by mental health nurses to provide provisional diagnosis: A scoping review. *International Journal of Mental Health Nursing*, *28*(2), 407–424. https://doi.org/10.1111/inm.12553

Choi-Kain, L. W., Finch, E. F., Masland, S. R., Jenkins, J. A., & Unruh, B. T. (2017). What works in the treatment of borderline personality disorder. *Current Behavioral Neuroscience Reports*, *4*(1), 21–30. https://doi.org/10.1007/s40473-017-0103-z

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*(3), 186–191. https://doi.org/10.1046/j.1440-0979.2002.00246.x

Colle, L., Hilviu, D., Rossi, R., Garbarini, F., & Fossataro, C. (2020). Self-harming and sense of agency in patients with borderline personality disorder. *Frontiers in Psychiatry*, *11*, 449–449. https://doi.org/10.3389/fpsyt.2020.00449

Cope, D. G. (2014). Using electronic surveys in nursing research. *Oncology Nursing Forum*, *41*(6), 681–682. https://doi.org/10.1188/14.ONF.681-682

Cravens, S. (2016). Crisis management. *EMS World*, *45*(6), 10–10. http://ezproxy.usc.edu.au:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=115982925&site=ehost-live

Day, N. J. S., Hunt, A., Cortis-Jones, L., & Grenyer, B. F. S. (2018). Clinician attitudes towards borderline personality disorder: A 15-year comparison. *Personality and Mental Health*, *12*(4), 309–320. https://doi.org/10.1002/pmh.1429

Deans, C., & Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. *Contemporary Nurse*, *21*(1), 43–49. https://doi.org/10.5172/conu.2006.21.1.43

Dickens, G. L., Lamont, E., & Gray, S. (2016). Mental health nurses' attitudes, behaviour, experience and knowledge regarding adults with a diagnosis of borderline personality disorder: Systematic, integrative literature review. *Journal of Clinical Nursing*, *25*(13–14), 1848–1875. https://doi.org/10.1111/jocn.13202

Eaton, N. R., Krueger, R. F., Keyes, K. M., Skodol, A. E., Markon, K. E., Grant, B. F., & Hasin, D. S. (2011). Borderline personality disorder co-morbidity: Relationship to the internalizing-externalizing structure of common mental disorders. *Psychological Medicine*, *41*(5), 1041–1050. https://doi.org/10.1017/S0033291710001662

Giannouli, H., Perogamvros, L., Berk, A., Svigos, A., & Vaslamatzis, G. (2009). Attitudes, knowledge and experience of nurses working in psychiatric hospitals in Greece, regarding borderline personality disorder: A comparative study. *Journal of Psychiatric and Mental Health Nursing*, *16*(5), 481–487. https://doi.org/10.1111/j.1365-2850.2009.01406.x

Hauck, J. (2013). Psychiatric nurses' attitudes and persons with borderline personality disorder: Focus on clinical practice, education,

and best practices–A follow-up. *Journal of the American Psychiatric Nurses Association*, *19*(1), 33-33.

Hauck, J. L., Harrison, B. E., & Montecalvo, A. L. (2013). Psychiatric nurses' attitudes toward patients with borderline personality disorder experiencing deliberate self-harm. *Journal of Psychosocial Nursing and Mental Health Services*, *51*(1), 20–29. https://doi.org/10.3928/02793695-20121204-02

Hazelton, M., Rossiter, R., & Milner, J. (2006). Managing the 'unmanageable': Training staff in the use of dialectical behaviour therapy for borderline personality disorder. *Contemporary Nurse*, *21*(1), 120–130. http://ezproxy.acu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=16594889&site=ehost-live&scope=site

Hong, V. (2016). Borderline personality disorder in the emergency department: Good psychiatric management. *Harvard Review of Psychiatry*, *24*(5), 357–366. https://doi.org/10.1097/HRP.0000000000000112

Hyland, S., Watts, J., & Fry, M. (2016). Rates of workplace aggression in the emergency department and nurses' perceptions of this challenging behaviour: A multimethod study. *Australasian Emergency Nursing Journal: AENJ*, *19*(3), 143–148. https://doi.org/10.1016/j.aenj.2016.05.002

Iliakis, E. A., Sonley, A. K. I., Ilagan, G. S., & Choi-Kain, L. W. (2019). Treatment of borderline personality disorder: Is supply adequate to meet public health needs? *Psychiatric Services (Washington, D.C.)*, *70*(9), 772–781. https://doi.org/10.1176/appi.ps.201900073

James, P. D., & Cowman, S. (2007). Psychiatric nurses' knowledge, experience and attitudes towards clients with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, *14*(7), 670–678. https://doi.org/10.1111/j.1365-2850.2007.01157.x

Jelinek, G., Weiland, T., Mackinlay, C., Gerdtz, M., & Hill, N. (2013). Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: Findings from a national qualitative study. *International Journal of Emergency Medicine*, *6*(1), 2–7. https://doi.org/10.1186/1865-1380-6-2

Koehne, K., & Sands, N. (2008). Borderline personality disorder—An overview for emergency clinicians. *Australasian Emergency Nursing Journal*, *11*(4), 173–177. https://doi.org/10.1016/j.aenj.2008.07.003

Koning, K., McNaught, A., & Tuffin, K. (2018). Emergency department staff beliefs about self-harm: A thematic framework analysis. *Community Mental Health Journal*, *54*(6), 814–822. https://doi.org/10.1007/s10597-017-0178-8

Lewis, K. L., Fanaian, M., Kotze, B., & Grenyer, B. F. S. (2019). Mental health presentations to acute psychiatric services: 3-year study of prevalence and readmission risk for personality disorders compared with psychotic, affective, substance or other disorders. *BJPsych Open*, *5*(1), e1–e1. https://doi.org/10.1192/bjo.2018.72

Ma, W., Shih, F., Hsiao, S., Shih, S., & Hayter, M. (2009). 'Caring Across Thorns'-Different care outcomes for borderline personality disorder patients in Taiwan. *Journal of Clinical Nursing*, *18*(3), 440–450. https://doi.org/10.1111/j.1365-2702.2008.02557.x

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health*, *12*(6), 595–612. http://ezproxy.usc.edu.au:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=106751378&site=ehost-live https://doi.org/10.1080/09638230310001627955

Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *The British Journal of Clinical Psychology*, *42*(Pt 3), 243–256. https://doi.org/10.1348/01446650360703366

McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing*, *40*(5), 578–586. https://doi.org/10.1046/j.1365-2648.2002.02412.x

McCarrick, C., Irving, K., & Lakeman, R. (2022). Nursing people diagnosed with borderline personality disorder: 'We all need to be on the same hymn sheet'. *International Journal of Mental Health Nursing*, *31*(1), 83–90. https://doi.org/10.1111/inm.12935

McGrath, B., & Dowling, M. (2012). Exploring registered psychiatric nurses responses towards service users with a diagnosis of borderline personality disorder. *Nursing Research and Practice*, *2012*, 601918. https://doi.org/10.1155/2012/601918

Nicholls, D., Gaynor, N., Shafiei, T., Bosanac, P., & Farrell, G. (2011). Mental health nursing in emergency departments: The case for a nurse practitioner role: Mental health nursing in emergency departments. *Journal of Clinical Nursing*, *20*(3-4), 530–536. https://doi.org/10.1111/j.1365-2702.2010.03504.x

Nikathil, S., Olaussen, A., Symons, E., Gocentas, R., O'Reilly, G., & Mitra, B. (2018). Increasing workplace violence in an Australian adult emergency department. *Emergency Medicine Australasia*, *30*(2), 181–186. https://doi.org/10.1111/1742-6723.12872

O'Connell, B., & Dowling, M. (2013). Community psychiatric nurses' experiences of caring for clients with borderline personality disorder. *Mental Health Practice*, *17*(4), 27–33. http://ezproxy.acu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c-cm&AN=104170566&site=ehost-live&scope=site

Oud, M., Arntz, A., Hermens, M. L. M., Verhoef, R., & Kendall, T. (2018). Specialized psychotherapies for adults with borderline personality disorder: A systematic review and meta-analysis. *The Australian and New Zealand Journal of Psychiatry*, *52*(10), 949–961. https://doi.org/10.1177/0004867418791257

Pascoe, S. E., Aggar, C., & Penman, O. (2022). Wait times in an Australian emergency department: A comparison of mental health and non-mental health patients in a regional emergency department. *International Journal of Mental Health Nursing*, *31*(3), 544–552. https://doi.org/10.1111/inm.12970

Proctor, J. M., Lawn, S., & McMahon, J. (2021). Consumer perspective from people with a diagnosis of borderline personality disorder (BPD) on BPD management-How are the Australian NHMRC BPD guidelines faring in practice? *Journal of Psychiatric and Mental Health Nursing*, *28*(4), 670–681. https://doi.org/10.1111/jpm.12714

Purves, D., & Sands, N. (2009). Crisis and triage clinicians' attitudes toward working with people with personality disorder. *Perspectives in Psychiatric Care*, *45*(3), 208–215. https://doi.org/10.1111/j.1744-6163.2009.00223.x

QUALTRICS. (2021). *Provo*. Retrieved from https://www.qualtrics.com

Roennfeldt, H., Wyder, M., Byrne, L., Hill, N., Randall, R., & Hamilton, B. (2021). Subjective experiences of mental health crisis care in emergency departments: A narrative review of the qualitative literature. *International Journal of Environmental Research and Public Health*, *18*(18), 9650. https://doi.org/10.3390/ijerph18189650

Rudolph, K. (2021). Ethical considerations in trauma-informed care. *The Psychiatric Clinics of North America*, *44*(4), 521–535. https://doi.org/10.1016/j.psc.2021.07.001

Sansone, R. A., & Sansone, L. A. (2013). Responses of mental health clinicians to patients with borderline personality disorder. *Innovations in Clinical Neuroscience*, *10*(5–6), 39–43.

Shaikh, U., Qamar, I., Jafry, F., Hassan, M., Shagufta, S., Odhejo, Y., & Ahmed, S. (2017). Patients with borderline personality disorder in emergency departments. *Frontiers in Psychiatry*, *8*, 136. https://doi.org/10.3389/fpsyt.2017.00136

Sinclair, L., Hunter, R., Hagen, S., Nelson, D., & Hunt, J. (2006). How effective are mental health nurses in A&E departments? *Emergency Medicine Journal: EMJ*, *23*(9), 687–692. https://doi.org/10.1136/emj.2005.033175

Sisti, D., Segal, A. G., Siegel, A. M., Johnson, R., & Gunderson, J. (2016). Diagnosing, disclosing, and documenting borderline personality disorder: A survey of psychiatrists' practices. *Journal of Personality Disorders*, *30*(6), 848–856. https://doi.org/10.1521/pedi_2015_29_228

Treloar, A. J. C. (2009). A qualitative investigation of the clinician experience of working with borderline personality disorder. *New Zealand Journal of Psychology*, *38*(2), 30.

Wand, T. (2004). Mental health liaison nursing in the emergency department: On-site expertise and enhanced coordination of care. *Australian Journal of Advanced Nursing*, *22*(2), 25–31.

Wand, T., Collett, G., Cutten, A., Buchanan, Hagen, S., Stack, A., & White, K. (2020). Patient and clinician experiences with an emergency department-based mental health liaison nurse service in a metropolitan setting . *International Journal of Mental Health Nursing*, *29*(6), 1202–1217. https://doi.org/10.1111/inm.12760

Wand, T., D'Abrew, N., Acret, L., & White, K. (2016). Evaluating a new model of nurse-led emergency department mental health care in Australia; Perspectives of key informants. *International Emergency Nursing*, *24*, 16–21. https://doi.org/10.1016/j.ienj.2015.05.003

Weight, E. J., & Kendal, S. (2013). Staff attitudes towards inpatients with borderline personality disorder. *Mental Health Practice*, *17*(3), 34–38. http://ezproxy.usc.edu.au:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=104159922&site=ehost-live https://doi.org/10.7748/mhp2013.11.17.3.34.e827

Winsor, T., & McLean, S. (2016). Residential group care workers' recognition of depression: Assessment of mental health literacy using clinical vignettes. *Children and Youth Services Review*, *68*, 132–138. https://doi.org/10.1016/j.childyouth.2016.06.028

Zieber, M., & Sedgewick, M. (2018). Competence, confidence and knowledge retention in undergraduate nursing students – A mixed method study. *Nurse Education Today*, *62*, 16–21. https://doi.org/10.1016/j.nedt.2017.12.008