Abstract

Purpose: To evaluate the impact of Knowledge and Understanding Framework (KUF) awareness level training with mental health staff in a UK NHS Mental Health Trust

Design/Methodology: 181 mental health professionals completed 3 day KUF awareness level training to promote understanding and positive attitudes in working with personality disorder. Attitudes to personality disorder were evaluated using the Personality Disorder – Knowledge and Skills Questionnaire (PD-KASQ, Bolton et al, 2010) at pre and post training and at 3 and 6 months follow up. Quantitative data was analysed and descriptive statistics were obtained. Qualitative methods were also used to evaluate the integration of learning into work based practice with 5 participants.

Findings: Participants reported a favourable reaction to the training. Understanding and positive emotions about working with personality disorder increased significantly post-training (gains maintained at 3 and 6 months follow-up). Capability in working with personality disorder was increased post training and at 3, but not 6 months. Qualitative analysis suggests clinical practice was positively impacted upon 3 months following training.

Research Limitations/Implications: This research suggests awareness level KUF training can have a positive impact on the attitudes, understanding and clinical practice of mental health practitioners towards people with a personality disorder. It confirms earlier research on a decrease in capability post training, and explores strategies to further develop capability with this client group.

Originality/Value: Despite the promotion of KUF awareness level training by the Department of Health there is limited evaluation of the approach with mental health professionals in practice. This study reports on an evaluation of KUF training within a large mental health trust with 3 and 6 month follow up data. Qualitative evaluation 3 months after course completion indicates application of course principles when working with individuals with personality disorder.

Key Words
Personality disorder, Training, Mental health, Attitudes, Knowledge and Understanding Framework, co-production

Paper type Research paper

Introduction

The negative effects of a psychiatric label include being judged and stereotyped by others, being denied access to treatment, mistreatment, and being treated in a way which lacks understanding and support (Hamilton et al, 2014). High levels of stigma have been found to be linked to labels such as Personality Disorder (PD) and Borderline Personality Disorder (BPD) within samples of both laypeople and mental health practitioners (Aviram, Brodsky & Stanley 2006). Indeed the diagnostic label of BPD has resulted in both the stigmatisation and marginalisation of individuals (Nehls 1998), and these labels may be attached to individuals without adequate assessment (Wright & Jones 2012). Nursing staff may respond more negatively to people with BPD than other disorders, e.g. schizophrenia and depression (Markham & Trower, 2003; Forsyth 2007; Westwood & Baker, 2010), and may also be less optimistic about the potential of people with BPD to recover (Markham & Trower 2003), viewing them as more difficult to care for compared to other service users (James & Cowman, 2007; Howes, Weaver, & Tyrer, 2008).

Woollaston & Hixenbaugh, 2008 found that some nursing staff felt they lacked the necessary skills to work with people with BPD, but wanted to improve their practice with this service user group. A need to develop skills in working with BPD was also a theme evident within the literature reviewed by Westwood & Baker (2010). Despite emerging evidence toward efficacy of specific treatments (NICE, 2009), negative attitudes and skill deficits are likely to impact in a detrimental way on clinical practice, leading some advocates to call for additional training for mental health staff in both the diagnosis of BPD and also in communicating with service users with the diagnosis (Weight & Kendal 2013). Developing optimistic, trusting relationships which foster choice and autonomy are important factors (NICE 2009), and are likely to underpin the success of specific treatments offered by mental health services.

Impact of training for staff working with service users with Personality Disorder.

Although some positive outcomes have been identified from brief awareness level training for PD, differences in the content, duration and evaluation methods used makes it difficult to compare studies. Two-day training with mental health and substance misuse staff was found to be linked to significant improvements in participants' perceptions of their theoretical knowledge, clinical skills, and attitudes (optimism, enthusiasm, confidence and willingness to work with people with BPD) pre to post training and at 6 month follow-up (Krawitz, 2004). Positive effects on attitude towards personality disorder (not specifically BPD) were also found pre to post training and at 2 month follow up from a 2 hour awareness workshop with prison officers (Maltman & Hamilton, 2011). Other research has compared different types of education programme (cognitive behavioural and psychodynamic), on mental health and emergency medicine clinicians' attitudes to deliberate self harm (Commons Treloar, 2009). Participants in CBT and psychodynamic programmes showed significant improvements in attitudes post training compared to a control group. However, only the psychoanalytic education group maintained significant changes in attitude at 6 month follow up which the authors suggest may be linked to greater understanding of the complexity of the issues involved. A study evaluating service user and clinician co-facilitated two day training with mostly mental health nurses noted that service user input was highly valued by participants and the training seen as relevant to their work (Krawitz & Jackson, 2007). The authors suggest service user input helped participants become more understanding of service users' perspectives, and more positive about treating people with a diagnosis of BPD.

The impact of negative attitudes towards people with a PD alongside lack of skills & knowledge of their needs within staff working with this client group has been recognised (NIMHE, 2003a). Training which fosters positive attitudes in enabling people with PD to work towards recovery therefore has been seen as critical to improving service provision (NIMHE, 2003b, NICE, 2009). Despite this, relatively little research has investigated ways of promoting more positive attitudes among staff within mental health services. Without such caring and empathic attitudes service users with these diagnoses will continue to receive sub optimal standards of care (Westwood & Baker 2010)

Personality Disorder Knowledge and Understanding Framework (KUF)

In 2007 the Department of Health (DH) and Ministry of Justice in the UK commissioned the Personality Disorder Knowledge and Understanding Framework (KUF). The 'Raising Awareness' level training is recommended by the DH (2009) to develop the capacity of the local workforce. It was co-produced by the Institute of Mental Health in Nottingham and Emergence (a user led BPD organization). The training fits with core underpinning competencies for work with all personality disorders (e.g. knowledge of presenting and diagnostic issues) and generic therapeutic competencies (e.g. the ability to foster and maintain a good therapeutic alliance (Roth & Pilling, 2013). The KUF Awareness Level Program uses a computer based Virtual Learning Environment (VLE) package of materials providing knowledge & understanding to enable more effective work with service users with personality disorders, with specific focus on BPD. The module descriptors are shown in Table 1:

Module No	Title and Descriptor
1	What is PD: Explores key factors in understanding the development of personality disorder within a biopsychosocial model of personality development
2	Labelling, myths and beliefs about PD: Examines diagnosis and the impact of stigma
3	Recognising PD, Different Perspectives: Examines how childhood experience is linked to the development of schemas which influence behavioural responses in the present
4	Equipping the organisation to work with PD: Explores how teams can learn to understand and manage the emotional impact of working with PD
5	Understanding different perspectives about PD: Explores how people develop different perspectives about PD based on their experience
6	Positive outcomes: Highlights the importance of reflective practice and support for teams to be able to work effectively with PD

Table 1: KUF Module Descriptors

Structure of KUF Awareness Training

Three structured facilitated training days enable staff to engage with the VLE material, and to reflect upon the implications of their learning for working practice. Training days are co-facilitated by a professional and an expert by experience, a central principle of the training model (National Institute of Mental Health, 2013). Experts by experience are people with lived experience of the diagnosis of PD or of supporting and caring for a person with the diagnosis (expert by occupation).

One evaluation of KUF training demonstrated significant improvements in understanding and positive emotions, and in a sense of capability in working with the client group pre to post training on the KUF recommended questionnaire PD Knowledge Attitudes and Skills Questionnaire (PD KASQ, Bolton, et al, 2010) with 162 mental health practitioner participants (Davies et al 2014). Understanding and positive emotional reactions remained significantly improved 3 months post training, however capability had decreased back to pre-training levels. A further evaluation with 136 professionals from across a range of organisations indicated gains in understanding, capabilities and emotional reactions however, gains reduced in all domains at 3 month follow up (Lamph et al,2014)

Aims of the current evaluation

Appropriate training is needed to ensure clinical professionals have the necessary attitudes and values to provide recovery focused, effective care for people with PD. With this in mind KUF training was implemented within a large mental health trust in the UK. The current study aimed to evaluate training effectiveness in changing attitudes, the duration of any gains from a larger training cohort over a longer time period than previous studies (3 and 6 months) and to assess the impact of training on clinical practice, again complementing previous studies.

Hypotheses

1. Training would be associated with high levels of satisfaction among participants
2. Attitudes towards PD would be impacted upon positively immediately post training with changes maintained at 3 and 6 months following training.
3. Knowledge from training would be applied within clinical practice.

Method

Design

This evaluation study used Kirkpatrick's (2006) model of evaluation of training programmes. According to the model there are 4 levels of evaluation including 1) Reactions, for example participants' levels of satisfaction with the course; 2) Learning, or what participants actually learned on the course in terms of new knowledge and skills; 3) Behaviours, or whether participants have utilised new knowledge and skills learned by implementing them in practice, and 4) Results, the impact of the training in terms of costs, service user experience, access to services etc. Table 2 shows the evaluation strategy with respect to the model:

Level of Evaluation	Evaluation Strategy
Reactions	Training Evaluation Forms
Learning	Personality Knowledge and Skills Questionnaire
Behaviour	Critical Incident Analysis
Results	N/A

Table 2 Evaluation strategy utilising Kirkpatrick's Model of Evaluation

Participants were 196 mental health service staff (mental health nurses and occupational therapists working in inpatient and community settings) enrolled on 11 cohorts of training. 181 (92.3%) of staff completed the course. Participants completed measures pre-training, post training as well as at 3 and 6 months following the course. Resources were only available to

gather follow up data on a limited number of training cohorts. Qualitative data was also collected from a small sample of the participants from cohort two (n=5, 4 mental health nurses, 1 occupational therapist) who accepted an invitation to participate in this aspect of the evaluation. Semi-structured interviews informed by critical incident analysis, a tool which has been viewed as a helpful in fostering reflective learning and assessment of learning in nursing (e.g. Perry, 1997) and medical education (e.g. Branch, 2005), were used to collect participant accounts of how the training had impacted on their professional behaviour with service users with BPD. Within critical incident analysis the participant is invited to explore a recent event(s) that involved working with a service user with BPD, and a semi structured interview approach based upon a reflective model (Gibbs 1988) was used to evaluate changes in behaviour as a result of attending the course. Within this approach the participant is guided through the reflective cycle by focusing upon the critical incident. The use of such an approach provides the opportunity to collect self reported observations of behaviours (Perry 1997), and to enable the participant to redefine their understanding of professional knowledge and evaluate the appropriateness of actions (Marks–Maran & Rose 2002).

Measures

The Personality Disorder – Knowledge and Skills Questionnaire (PD-KASQ, Bolton et al, 2010) 18 item self-reported questionnaire was used to assess self-reported learning. This assessed participant's agreement with different statements on a 5-point Likert scale, ranging from 'strongly disagree' to 'strongly agree'. A total score was calculated, responses can also be assessed in relation to the following 3 factors: Understanding, Capability and Emotions. This questionnaire was used as part of the national directive underpinning delivery and evaluation of the KUF training. The measure was completed pre-training, post-training and 3 and 6 months following training.

Participants completed training evaluation forms (adapted versions of a standard within service training evaluation form) at the end of each training day to capture participants' reactions to the training. Participants rated their agreement with a number of statements about their overall satisfaction with the training on a 5 point likert scale (ranging from 'agree strongly' to 'disagree strongly'). Participants rated specific learning activities within each day and delivery, using a six-point scale ranging from 'excellent' to 'very poor'. There was also a space for participants to provide comments.

Semi-structured interviews were conducted 3 months following training completion encouraging participants to reflect on their learning. Interviews began with questions about key learning points from the training and impact on perspectives about PD. Critical incident analysis questions asked participants to focus on a recent time working with a person with PD. They were then asked to focus on how they made sense of the situation, whether they felt they would have understood it differently prior to training, how they felt and responded in the situation and their confidence at being able to help the person at the time. They were asked to reflect on how effective their response had been in the situation and ways in which they might change their behaviour based on their reflections.

Procedure

At the beginning of Day 1 participants completed the pre-training PD-KASQ. Training evaluation forms were completed at the end of each training day. At the end of Day 3

(completion of the course) the PD-KASQ was also re-administered to assess learning immediately post-training. The PD-KASQ was then re-administered 3 and 6 months post training. Interviews lasted between 30 and 40 minutes and were conducted by a trainee psychologist, independent from the training and the service. Interviewees were self selected volunteers from a cohort of participants.

Data Analysis

Descriptive statistics were obtained from the qualitative data and one-way within subjects ANOVAs were conducted to look for statistically significant change in self-reported learning over time. Bonferroni post-hoc tests show where significant differences occur.

Participant analysis was undertaken for the each critical incident interview which was audio recorded and transcribed verbatim to aid accuracy of the thematic analysis. Thematic analysis of interviews was conducted using a deductive approach (Braun & Clarke, 2006). Identification of themes was influenced by the research question which aimed to explore changes in clinical practice, shift in knowledge, attitude and feelings. Themes were systematically identified through key concepts that seemed pertinent within the interviews. Once themes had been derived, these were ordered in to overarching super-ordinate themes and subordinate themes, where the number of participants that agreed on any given theme was identified. This process led to some reorganization of themes, some themes that were only identified within one data set were discarded, and others divided into further subordinate themes.

Ethical Considerations

The project was approved by the trust research and development department as a service evaluation. Ethical approval was not required for this study as it was a service evaluation for staff attending a series of training events. Ethical principles related to consent confidentiality, anonymity, participant autonomy and respect were observed whilst undertaking the study. This ensured that participants exercise choice to complete the evaluation questionnaires used and that they were completed anonymously. In addition for the semi structured interviews all transcripts were anonymised and kept securely and written consent was obtained.

Results

1. **Training would be associated with high levels of satisfaction among participants**

In order to identify any differences between the cohorts pre training a one-way between-subjects ANOVA was carried out. This confirmed that there were no statistically significant differences between the cohorts ($F_{(9,119)} = 1.293$, $p=0.248$), therefore the cohorts were combined for further analyses. Table 3 shows the data that was available from each cohort at each data collection point.

Stage of Evaluation	Pre training (n=181)	Post training (n= 165)	3 months post training (n=61)	6 months post training (n=48)
Satisfaction with	100%	91.1%	N/A	N/A

Training Form				
PD Knowledge Attitudes & Skills Questionnaire (PD KASQ)	100%	91.1%	33.7%	26.5%
Critical Incident Analysis	N/A	N/A	2.8%	N/A

Table 3: Participant data available at each time point

Participants overall impression of the day and ratings of content, delivery and usefulness of training are presented in table 4. These aspects included questions about the presentations being clear and the course being helpful in developing job related skills.

Satisfaction with specific elements of training content
Ratings of 'good', 'very good' or 'excellent' were given by the following percentages of participants in response to specific elements of the training e.g. specific training exercises, or presentations, and are also shown on table 4

	Training Day		
	Day 1	Day 2	Day 3
Overall Participant satisfaction	94%	97%	95%
Participant satisfaction with specific elements of training ie presentations and exercises	96.5%	94%	91.5%

Table 4: Satisfaction with facilitated training days

Participant Reactions

Participant responses were obtained from evaluation forms and were grouped according to context, example quotes are provided. Overall participants' responses largely corroborated the above results.

Increased confidence to work with personality disorder
'Really interesting today it has made me think about how I deal with patients and I feel confident to challenge staff who talk in negative ways about PD thank you' (Day2)

New learning about personality disorder
'Thank you for this opportunity, the whole course has given me some new perspectives and I have gained new understandings that I can continue to build upon. I enjoyed the perspectives of the participating service user. Very refreshing. I cannot recommend any changes- all good!' (Day 3)

2. **Attitudes towards PD would be impacted upon positively immediately post training with changes maintained at 3 and 6 months following training.**

Table 5 shows the mean scores for the total and each of the 3 factor scores (understanding, capability and emotions) on the PD KASQ pre training, post training, at 3 months and at 6 months post training. Significant change was evident on total PD KASQ scores pre to post training, at 3 and 6 month follow up. A significant change was shown on understanding and emotional reactions pre to post training, and at 3 and 6 months. A significant change was shown on the capabilities factor pre to post training and at 3 months, but not 6 months.

PD KASQ (mean scores)	Pre training	Post training	3 months post training	6 months post training
Understanding	22.6	28.8**	28.8**	27.8**
Capability	18.7	21.7*	21.5*	21.0
Emotions	14.7	18.9**	16.9**	16.7**
Total	64.8	80.6**	77.4**	77.9*
*Significance on one way within subjects ANOVA's $p<0.001$ ** $p<0.003$**				

Table 5: Mean scores and significance levels for the PD KASQ pre training, post training, at 3 months and at 6 months post training.

A significant improvement in PD KASQ scores pre to post training suggests participants self-reported understanding, capabilities and emotional reactions regarding personality disorder had improved. Improvements were all maintained at 3 months following training and with understanding and emotional reactions at 6 months.

3. Knowledge from training would be applied within clinical practice.

The qualitative analysis obtained from the critical incidents examined participant self reported changes in clinical practice following KUF training. Key themes identified from the semi-structured interviews included: validation, limit setting and formulation. These are now explored further.

Validation: is a concept illustrated on the course and related to the development of an empathic communication style to facilitate collaboration and is noted within the theory of Dialectical Behaviour Therapy (Linehan 1993) which suggests that emotional instability may be intensified in invalidating environments, for example where there is a failure to convey attention, respect, and understanding. One example from a participant for the theme of validation:

'following one of the sessions I did give her that validation, ' I hear what you are saying', and it did help break down that barrier so that she felt listened to and helped us move forward from there. So I'd definitely say that's impacted on my practice'.

Limit setting: is related to psychodynamic theory (Kernberg et al 1989) and involves the mental health professional setting realistic and appropriate limits with the client in order to provide containment of powerful feelings and the reduction of acting out behaviours and is an important strategy in the management of people with personality disorder. The importance of limit setting was a factor that impacted positively on staff practice:

'… I think this girl overdosed in one week three times, and we never readmitted her… I was saying no, we need to be working with it, 'cos (sic) if we keep admitting her we're just deskilling her, she'll become dependent on the ward…'

Formulation: Staff also seemed to have a greater understanding of service user's behaviour, and feelings without becoming overwhelmed by them, and were able to reflect on their own reactions to the person:
'…being able to identify that like the frustration and the emotion that was directed to [me]… was actually my own frustration and my awareness of my own feelings reflected off her so now I'm more aware of that and how emotional working with that client group can be and how to deal with it more effectively'

Interviewees also identified lack of training, organisational culture and team resistance as some of the barriers to implementing learning in practice. Support from supervision, particularly helping normalise emotional responses to working with the client group were identified as important enablers. Increased confidence in interactions and decisions was evident. There was also a theme of increased empathy within the majority of the sample which participants linked to having a better understanding of the person's behaviour.

Discussion

Guidance suggests staff should be trained to the required level for their role in order to feel confident, skilled and supported to deliver evidence-based treatment and to help individuals with a PD diagnosis make positive changes in their lives (NIMHE, 2003b). Training packages need to focus on specific competencies to address skill deficits within the varying roles in mental health services. Awareness level KUF provides a package of training aimed at developing core underpinning competencies for work with personality disorder (e.g. knowledge of presenting and diagnostic issues), and generic therapeutic competencies (e.g. the ability to foster and maintain a good therapeutic alliance, and to understand and respond to the service users emotions and world view) thought to be essential in the provision of high quality services (Roth and Pilling, 2013).

The majority of training participants were satisfied with the content, delivery and perceived utility of the training. Improvements in the capabilities factor were not maintained at 6 months post training. Training appears to have impacted positively on staff understanding and attitudes; however other factors will affect this e.g. team culture and supervision. Other research has also found a significant change on the capability factor pre to post training reduced at 3 month follow up (Davies et al 2014) with mental health practitioners. Participants working in more varied environments and without a core professional training were found to lose gains related to dealing with strong emotional reactions and challenging behaviours at 3 month follow up compared to those with a core professional training (Lamph et al, 2014). This indicates the need for ongoing support and supervision, and opportunity to put new learning into practice. Decline in the capability factor may also suggest greater understanding of skills needed to support people with personality disorder effectively. The qualitative analysis suggests that learning impacted on behaviour through participants self report of increasing the ability to validate service user's feelings, to take more positive risks and to seek support. There was also some indication of perceived improvement in service user - clinician relationships. Comments from this study indicated that participants felt they would have benefited from more specific skills helpful in working with people with personality disorder from the training; this could be a major factor in perception of capability.

Results show that at 6 months the participants maintained progress with understanding and containing their own emotions but that their attribution of capability had reduced. Whilst the KUF awareness course was not designed to specifically provide key interventions but a reflective framework to better understand service users with personality disorder, it may be that this reflective framework has enabled participants to identify further learning needs to support the management of service users with personality disorder. Increased understanding of service users and reflective practice are factors which may help to maintain gains from training and promote healthy responses to the challenges of working with personality disorder (Moore, 2012).

There may be a number of workplace barriers to implementing learning and sharing learning with colleagues (Barnes et al 2006). Ferlie and Shortell (2002) argue there are 4 core essential properties necessary to support effective quality improvements in healthcare. These include effective leadership at all levels, cultures that support learning, an emphasis on team development, and greater use of information technology. Attrition of gains from training when viewed against this model may also have been due to returning to unsupportive teams/cultures, lack of positive leadership within teams, lack of a critical mass of practitioners trained in the KUF model, lack of ongoing supervision and support for integrating learning in practice, or of opportunity to utilise learning. Awareness level training on its own may not be sufficient in changing staff practice; it needs to be supported by continued evaluation, supervision and good leadership (Campbell, 2007). Ongoing supervision is also necessary to enable integration and consolidation of skills, as well as to support continued reflection to encourage collaborative care (NIHCE, 2009, Westwood & Baker, 2010, Roth & Pilling, 2013). Team based training focused has been shown to lead to more gains from training (Brooker & Brabban 2004). Again these are key factors requiring further research.

Limitations and Future Research

This evaluation suggests KUF training was effectively implemented within a mental health organisation, which endorses earlier findings. However there were several limitation to the study. Firstly this was a pragmatic evaluation of KUF training delivered within a large UK mental health trust with a significant reduction in measures being completed at both 3 and 6 month follow-up periods which may have been due to work pressures, staff sickness or change in jobs of participants. More rigorous follow-up of participants would have enhanced the overall quality of the study. Similarly due to resources and time constraints the qualitative aspect of the study focussing upon participant behaviours and the impact of training involved a small number of participants, increasing this and repeating at 6 month follow up may have provided richer data and greater understanding into the factors affecting capability at 6 months follow-up.

Further research would be strengthened by use of a control group and/ or double baseline, and use of measures to objectively demonstrate learning transfer over time (such as a test of participant knowledge). Measurement of confounding variables would be helpful, (e.g. participant information clinical experience, peer support, caseload). Interviews are a useful method in examining opinions in more depth as they are more likely to elicit diverse views compared to questionnaires (Goodwin et al 1998). A larger interview sample would also help to gain understanding around the behaviour level, and help to ameliorate response bias from the self selecting sample available. Finally, interviewing service users with regard to

perceived attitudes of clinicians would provide valuable data and link with the fourth level of Kirkpatrick's (2006) model relating to impact of the training on results.

The Personality Disorder KUF requires considerable resources in terms of clinician and service user trainer time and time from service provision for attendance of participants. It is therefore important to assess which are the critical factors in creating the changes identified, and the relative importance for example of the VLE learning, facilitated training days, and co-facilitation by a professional and expert by experience. Comments from participants consistently indicated the value of the expert by experience co-facilitator within the training. Barnes et al (2006) suggest integral involvement of experts by experience in the commissioning, design, delivery and evaluation of training for post qualification interprofessional mental health training programmes can help challenge both attitudes and power differentials within traditional mental health care. Mental health services that endorse recovery as one of their central principles need to match this by developing co-production models to ensure that service user experience are at the centre of educational programmes (Willis 2015) as well as service redesign (NHS England 2014) to ensure services meet local needs. The model of co-production within the KUF awareness programme should be promoted in other mental health focused courses to further improve understanding and reduce negative attitudes.

Key Points

- It is important that clinical staff working with people with personality disorders have positive, recovery focused attitudes to be able to support the implementation of effective evidence-based care.
- The current evaluation suggests awareness level Personality Disorder KUF training can be effective in positively enhancing attitudes, knowledge and capabilities of clinical staff and this may impact positively upon behaviour in clinical practice.
- The findings support further investment in training aimed at enabling attitudinal change, although the key factors within the KUF linked to attitudinal change are not clear (e.g. VLE learning, facilitated training days or expert by experience co-facilitation) and need further investigation.
- The evaluation also indicates that standardised Personality Disorder training can be delivered effectively by a number of trainers.
- Improvements in capabilities were not maintained at 6 months, this may relate to factors such as supervision, organizational culture and support, factors it will be important to research further.

Acknowledgement
No declaration of interest. We would like to acknowledge the KUF Central Team, the experts by experience working with Emergence, and the professionals within Northumberland Tyne and Wear Foundation Trust who worked together to make the training possible.

References

Aviram, R. B., Brodsky, B. S, and Stanley, B. (2006). Borderline Personality Disorder, Stigma, and Treatment Implications. *Harvard Review of Psychiatry*, 14 (5) 249-256 (doi:10.1080/10673220600975121)

Barnes, D., Carpenter, J., Dickinson, C. (2006) The outcomes of partnerships with mental health service users in interprofessional education: a case study. *Health & Social Care In The Community,* **14** (5) 426-435

Bolton, W., Feigenbaum, J., Jones, A., and Woodward, C. (2010). *Development of the PD-KASQ (Personality Disorder – Knowledge, Attitudes and Skills Questionnaire)*

Branch, W. T (2005). Use of Critical Incident Reports in Medical Education. *Journal of General Internal Medicine*, **20** (11) 1063 - 1067

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* **3** (1) 77 – 101.

Brooker, C. & Brabban, A. (2004) *Measured success: A scoping review of Evaluated Psychosocial Interventions Training for Work with People with Serious Mental Health Problems.* Trent NIMHE/Trent WDC

Campbell, M. (2007). Staff training and challenging behaviour : Who needs it? *Journal of Intellectual Disabilities,* **11** (2) 143-156.

Commons Treloar, A, J. (2009). Effectiveness of Education Programs in Changing Clinicians Attitudes Toward Treating Borderline Personality Disorder. *Psychiatric Services*. **60** (8) 1128 - 1131

Department of Health (2009). *Recognising Complexity; Commissioning Guidance for PD Services*

Davies, J, Sampson, M, Beesley, F, Smith, D and Baldwin, V. (2014). An evaluation of Knowledge and Understanding Framework personality disorder awareness training: Can a co-production model be effective in a local NHS mental health Trust? *Personality and Mental Health* **8** (2) 161-168

Ferlie, EB & Shortfell, SM (2001) Improving the Quality of Health Care in the United Kingdom and the United States: A Framework for Change. The Milbank Quarterly, Vol. 79, No. 2, 2001

Forsyth, A,S (2007) The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing,* Vol **14** (1) 33-40.

Gibbs, G. Learning by Doing: A Guide to Teaching and Learning Methods.(1988) London: Further Education Unit,

Goodwin, I., Holmes, G., Newnes, C., and Waltho, D. (1998). A qualitative analysis of the views of in-patient mental health service users. *Journal of Mental Health***.** **8** (1) 43-54.

Hamilton.S; Lewis-Holmes,E; Pinfold,V, Henderson,C; Rose,D; Thornicroft, G (2014) Discrimination against people with a mental health diagnosis: qualitative analysis of reported experiences. Journal of Mental Health, 23(2) pp88-93

Institute of Mental Health (2013) The National Personality Disorder Knowledge and Understanding Framework: Prospectus, People, Work and Pictures, Nottingham

James P.D. and 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.

Kernberg, O. F., Selzer, M. A., Koenigsberg, H. W., Carr, A. C., and Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients*. New York: Basic Books.

Kirkpatrick, D. L., and Kirkpatarick, J. D. (2006) *Evaluating Training Programmes: The Four Levels (3rd Edition)*. San Fransisco: Berrett-Koehler Publishers inc

Krawitz, R. (2004). Borderline personality disorder: attitudinal change following training. *Australian and New Zealand Journal of Psychiatry*, **38** (7) 554–559.

Krawitz, R. and Jackson, W (2007). Consumer-Clinician co-taught borderline personality disorder training: A pilot evaluation. *International Journal of Mental Health Nursing,* **16** (5) 360 – 364

Lamph, G; Latham,C; Smith,D; Brown,A; Doyle,J and Sampson,M (2014) Evaluating the impact of a nationally recognised training programme that aims to raise the awareness and challenge attitudes of personality disorder in multi-agency partners. *Journal of Mental Health Training, Education and Practice*. **9** (2) 89-100.

Linehan, M.M. (1993a). *Cognitive behavioral therapy for Borderline Personality Disorder*. New York: Guilford Press.

Maltman, L and Hamilton, L. (2011). Preliminary evaluation of personality disorder awareness workshops for prison staff, *British Journal of Forensic Practice*, **13** (4) 244 - 256

Markham D. and Trower P. (2003). The effects of the psychiatric label 'Borderline Personality Disorder' on nursing staff's perceptions and casual attributions for challenging behaviours. *British Journal of ClinicalPsychology,* **42** (3) 243–256.

Marks-Maran, D. & Rose, P. Reconstructing Nursing: beyond Art and Science. London: Bailliere Tindall, 2002.

Moore E. (2012). Personality Disorder: Its impact on staff and the role of supervision. *Advances in Psychiatric Treatment*, **18** (1) 44-55

Nehls, N. 1998. Borderline personality disorder: gender stereotypes, stigma, and limited system of care. Issues in Mental Health Nursing, 19, 97-112.

NHS England (2014) *Commissioning for Effective Service Transformation: What we have learnt*. http://www.england.nhs.uk/wp-content/uploads/2014/03/serv-trans-guide.pdf Accessed 11/05/2015.

National Institute for Mental Health in England (2003a). *Personality disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder.* London: Department of Health.

National Institute for Mental Health in England (2003b). *Breaking the Cycle of Rejection. The Personality Disorder Capabilities Framework*. London: Department of Health.

National Institute for Health and Clinical Excellence (2009). *Borderline personality disorder: The NICE Guideline on treatment and management*. Leicester/ London: The British Psychological Society & The Royal College of Psychiatrists

Newton-Howes, G., Weaver, T., and Tyrer, P. (2008). Attitudes of staff towards patients with personality disorder in community mental health teams. *Australian and New Zealand Journal of Psychiatry*, **42** (7) 572-577.

Perry, L. (1997). Critical incidents, crucial issues. *Journal of Clinical Nursing*, **6** (2) 131-137.

Roth, A. D and Pilling, S. (2013) *A competence framework for psychological interventions with people with personality disorder*. UCL www.ucl.ac/CORE/

Weight, E. J. & Kendal, S. 2013. Staff attitudes towards inpatients with borderline personality disorder. Mental Health Practice, 17, 34-38.

Westwood, L and Baker, J (2010). Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, **17** (7) 657 - 662

Willis, L (2015) *Raising the Bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants*. Health Education England / NMC.

Woollaston and Hixenbaugh (2008). 'Destructive Whirlwind': nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, **15** (9) 703–709. doi: 10.1111/j.1365-2850.2008.01275.x

Wright, K. & Jones, F. 2012. Therapeutic alliances in people with borderline personality disorder. Mental Health Practice, 16, 31-35.