



Treatment and Recovery from Borderline  
Personality Disorder  
*Care Pathway, Narrative and Procedures*



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### Foreword and Introduction

Transform is a care pathway for people with Borderline Personality Disorder (BPD) that aims to promote good clinical practice. The pathway details how mental health services will aim to work with people experiencing BPD in order to provide high quality treatment. The pathway is informed by the NICE guidelines for BPD and other protocols including the Durham protocol for positive risk taking.

The pathway is not prescriptive but is underpinned by 11 principles of care which define the overall approach, treatments and standards. Keys to the delivery of this pathway is based on individual need, timely delivery of evidence based interventions by appropriately trained and supervised staff and that interventions are assessed for effectiveness through the use of outcome measures.

This pathway document covers the entire care pathway, from transition from CAMHS through assessment, treatment and to discharge. The pathway should operate for all people with a suspected diagnosis of Borderline Personality Disorder (BPD) referred for care with Southern Health NHS Foundation Trust (SHFT).

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## Principles of Care

The Borderline Personality Disorder (BPD) pathway is supported by eleven principles of care. These principles underpin the approach that all people experiencing difficulties as a result of a BPD can expect to receive from the care provided by SHFT.

### **Principle 1**

People with borderline personality disorder should not be excluded from any health or social care setting because of their diagnosis or because of their self-harming or self-defeating behaviours

### **Principle 2**

People with BPD can expect care which is underpinned by up to date bio-psycho-social understandings of the development and maintenance of psychological distress and recovery.

### **Principle 3**

People using SHFT services for the treatment of BPD, can expect care to be directed toward recovery within an atmosphere of respect, trust, hope and optimism at all points in the care pathway.

### **Principle 4**

People using SHFT services for the treatment of BPD can expect to be supported to maximise the amount of control they have over their lives, care and treatment at every point along the care pathway. Active and collaborative involvement in treatment options will be supported at every point along the care pathway.

### **Principle 5**

Care will be delivered by a team of multidisciplinary staff that are adequately trained, clinically supervised and supported to deliver evidence based treatments that are aligned to guidelines such as the NICE Guideline for Borderline Personality Disorder (2009) and that psychosocial outcomes from any treatment will be appropriately measured to ensure recovery and progress is transparent to both service user and staff.

### **Principle 6**

People should not be excluded from care because of their cognitive ability or language.

### **Principle 7**

Care packages offered will be “holistic”; taking into account all domains of the person’s life which are impacted on by the experience of the symptoms of BPD and provided advice about appropriate support, involving families &/or carers whenever possible.

### **Principle 8**

Risk of harm to self and others will be discussed openly in a transparent manner with the person experiencing BPD and the multidisciplinary staff team involved in their care in order to manage the risk to achieve the most positive outcome possible at that point in time.

### **Principle 9**

Dialectical assumptions and strategies will be used to navigate the balance of acceptance and therapeutic change.

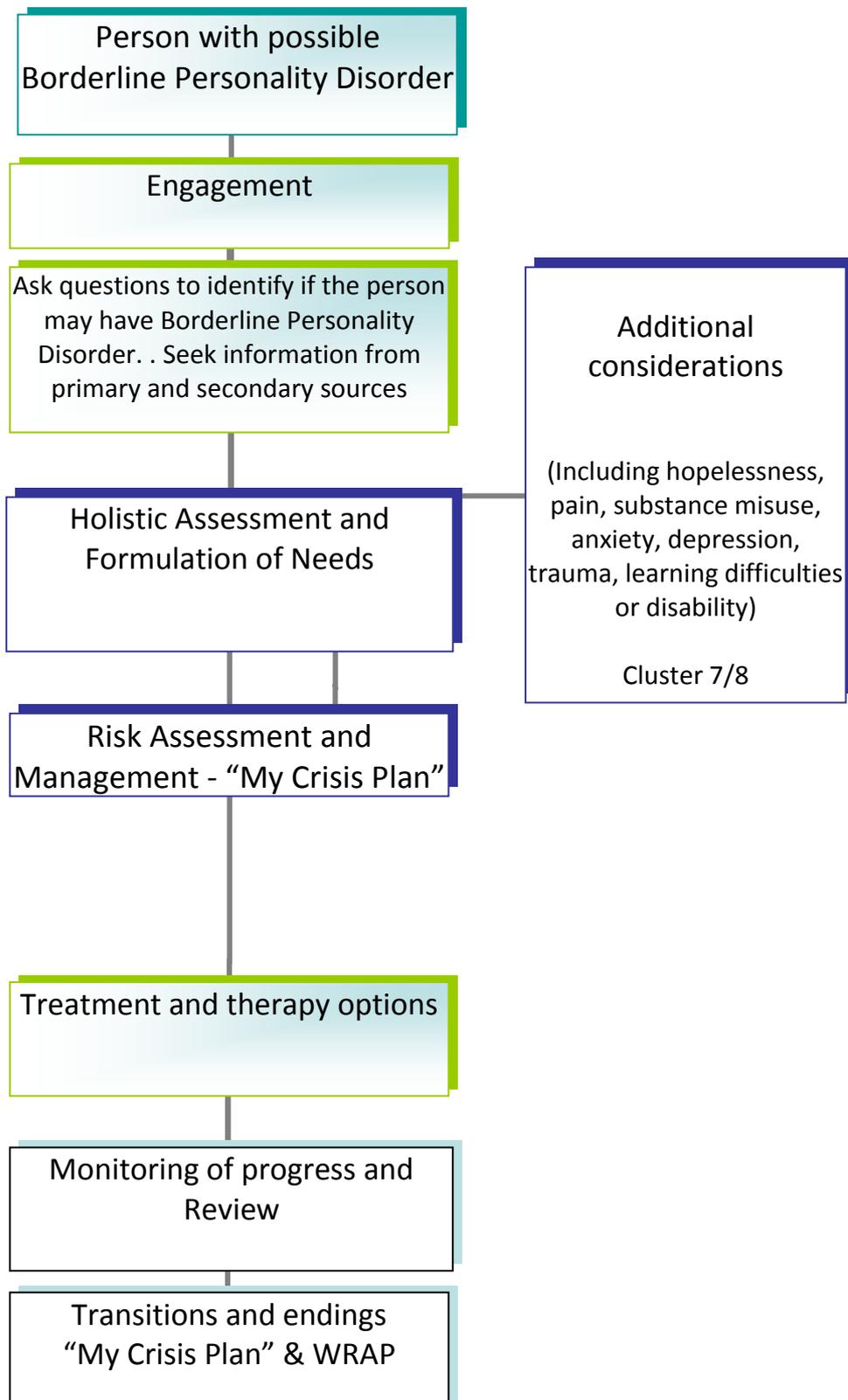
### **Principle 10**

Care packages will anticipate that withdrawal and ending of treatments or services, and transition from one service to another may evoke strong emotions and reactions in people with borderline personality disorder therefore all such transition points will be discussed beforehand and planned in a structured and phased manner.

### **Principle 11**

Stigma can have a significant impact on recovery. People can expect to be treated in a compassionate and de-stigmatising environment which will be evidenced by the behaviour of staff, expressions of understanding by staff and the adherence to these principles.

## Care of the Individual



## Engagement

Engagement is the process of getting to know the person, their strengths, weakness and aspirations. It is something that begins at the first contact of the practitioners with clients and is ongoing throughout the service user's contact with services. Due to the development of BPD, people with this disorder often feel misunderstood, unheard, stressed and isolated. Empathy, validation and compassion are crucial skills to be employed by practitioners at every stage of their interaction with the service user.

## Identification of Borderline Personality Disorder

### **Ask questions to identify if the person may have Borderline Personality disorder**

Borderline Personality Disorder is a severe mental disorder resulting from serious dysregulation of the affective system. Individuals with this disorder show a characteristic pattern of instability in emotional regulation, impulse control, interpersonal relationship and self-image.

Identification of BPD can include the use of diagnostic criteria and validated measures to conceptualise the information the service user receives. For example ICD-10 and/or DSM IV–TR.

## ICD-10

According to ICD 10: Symptoms of emotional instability in addition to the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

## Diagnostic Guidelines

Conditions not directly attributable to gross brain damage or disease, or to another psychiatric disorder, meeting the following criteria:

1. Markedly disharmonious attitudes and behaviour, involving usually several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others.
2. The abnormal behaviour pattern is enduring, of long standing, and not limited to episodes of mental illness.

3. The abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations.
4. The above manifestations always appear during childhood or adolescence and continue into adulthood.
5. The disorder leads to considerable personal distress but this may only become apparent late in its course.
6. The disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

### DSM-IV-TR

In the DSM-IV-TR, Borderline Personality Disorder is defined as a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

## Holistic Assessment

### Rationale for assessment

If a service user is thought to be presenting with probable Personality Disorder issues (i.e. they are presenting with long term recurrent, persistent inter and intra personal issues that are resistant to change despite treatment as usual) they should be considered for further assessment.

The following circumstances might indicate the need for assessment:

- ❖ High risk/para-suicidal behaviours or potential harm to others
- ❖ Service user is not responding to standard treatment for Axis I disorder
- ❖ There are significantly differing professional opinions regarding the presentation
- ❖ There is no clear formulation of the service user's difficulties

The assessment aims to:

- ❖ Aid the formulation and/or understanding of the service user's difficulties
- ❖ Inform the treatment plan, e.g. suggest a specific treatment is indicated, or highlight treatments that are contraindicated or not likely to be helpful
- ❖ Consider whether a diagnosis of BPD would be helpful and/or alter the treatment currently being offered
- ❖ Help the service user's own understanding of their difficulties

A multidisciplinary team approach is required, which may consist of a psychiatrist, clinical psychologist or psychological therapist, nurse, social worker, occupational therapist, support time and recovery worker. Consent for the assessment should always be obtained from the service user and an explanation given as to its purpose and possible outcomes.

Further assessment for personality disorder should not take place if:

- ❖ It is thought not to be in the service user's best interest
- ❖ It would be counterproductive to their care or welfare

The assessment may consist of:

- ❖ A face to face clinical interview undertaken jointly by two professionals
- ❖ Full history, to include risk history, and HCR 20 (Checklist of Risk) if appropriate, should be taken both face to face and from the notes allowing sufficient time for this process.
- ❖ Information from family, carers and other relevant organisations (e.g. Police, A&E, primary care, social services and the voluntary sector) should also be included where possible.
- ❖ Indirect observation and review of case notes.
- ❖ Formal assessment of personality such as the Millon Clinical Multi-axial Inventory and the Structured Clinical Interview for DSM-III-R personality disorders (The SCID) may complement the face to face assessment.
- ❖ Psychometric assessment can be considered – e.g. WAIS III, WMS III, BADS, if memory, executive functioning or cognitive impairment is thought to be present.
- ❖ Advice, information and support from other relevant organisations (e.g. specialist teams, forensic team etc.) should be sought when required.
- ❖ Approaches to take when or if the Service User is not willing or able to engage in treatment.
- ❖ Every effort should be made to engage the person in an assessment at this stage including being flexible about time, place and format of the assessment, remembering that people who highly emotionally dys-regulated may be feeling hopeless, frightened and vulnerable, not knowing who to trust

## Formulation

Following completion of the assessment, an individual personalised formulation should be developed, taking into account the service user's readiness to change and motivation. This may include:

- ❖ Describing the development of the service user's difficulties
- ❖ Identifying potential triggers and vulnerability factors that could lead to crises
- ❖ Psychological and behavioural factors that are maintaining the service user's difficulties
- ❖ Potential unhelpful dynamics that may develop between the service user and others (including the service)

The formulation should lead to the development of an individualised action plan, outlining the focus and goals of intervention, or the rationale for no treatment if that is recommended.

The Emotion Focused Formulation is an accessible formulation that all staff could make use of with adequate ongoing supervision. More detailed formulation approaches based on specific therapeutic models (e.g. DBT, CBT, CAT) are available but should be used by appropriately trained psychological therapists.

### Emotion Focused Formulation.

- ❖ Starts by validating the emotion(s) driving the behaviour
- ❖ Tracks collaboratively the different unhelpful behaviour patterns that follow from the emotion and validates that these coping strategies are understandable as well as acknowledges the immediate pay off they provide
- ❖ By mapping these patterns with the client it illustrates how each coping strategy serves to exacerbate the emotion the person seeks to escape – and in this way how they are kept stuck by these patterns
- ❖ It acknowledges and validates the past events, both distant and more immediate, that set up the emotional vulnerability in the first place, and re-triggered it more recently (if applicable)

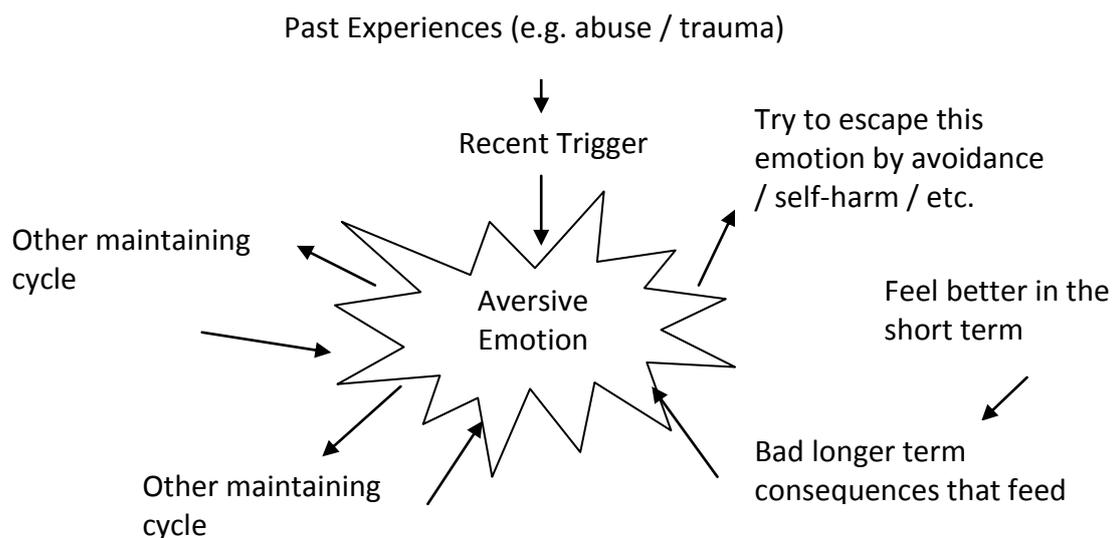
- ❖ While distinguishing clearly between these past events that need to be accepted and current maintaining cycles that is the focus of therapy.
- ❖ In this way it both demonstrates a rationale for the individual's situation, and works on motivation to engage them in the task of breaking free.

Referenced in a number of places, including:

Durrant, C., Clarke, I., Tolland, A. & Wilson, H. (2007) Designing a CBT Service for an Acute In-patient Setting: A pilot evaluation study. *Clinical Psychology and Psychotherapy*. 14, 117-125.

and Chapter 6 of: Clarke, I. & Wilson, H. Eds. (2008) *Cognitive Behaviour Therapy for Acute Inpatient Mental Health Units; working with clients, staff and the milieu*.

London: Routledge.



After the assessment and formulation are complete

- ❖ The outcome should be fed back to the service user in a respectful and acceptable manner. Sufficient time for questions should be allowed and written information given whenever possible.
- ❖ With permission from the service user, the outcome of the assessment should be shared with all relevant parties (i.e., those organisations who have regular contact with the service user).

## Multi-disciplinary team (MDT) Discussion

MDT should involve at a minimum psychological therapist, medical, nursing and social care views and aim to agree a working formulation and or provisional diagnosis and risk assessment. To do this, the assessing clinician should have available:-

- Service user's readiness to change
- A problem list with associated goals identified by the service user
- A list of strengths, skills and coping assets
- A description of the development of the service user's difficulties
- Factors that maintain the current difficulties
- Identifying potential triggers for crises
- Potential unhelpful dynamics that may develop between the service user and others (including the service)

The outcome should be fed back to the service user in a respectful and acceptable manner. Sufficient time for questions should be allowed and written information given whenever possible. With permission from the service user, the outcome of the assessment should be shared with all relevant parties (i.e., those organisations who have regular contact with the service user).

## Documentation

The following documentation should be completed for all patients with a diagnosis of Borderline Personality Disorder.

1. My Crisis Plan documented on RIO and updated as required.
2. Care plan (with specific focus on management of their disorder) documented on RIO
3. HONOS completed on RIO
4. Risk Assessment updated on RIO
5. Hope Agency Opportunity (Enter 'PROM HAO offered' in progress notes)

## Collaborative Care Planning

- ❖ All steps should be taken to draw up a care plan in collaboration with the service user, although it is acknowledged that there may be times when it is difficult to reach agreement about this.
- ❖ It is essential that MDT working is in place where good working relationships and close collaboration within the team are fostered, treatment is more likely to be consistent and implemented according to agreed plan.
- ❖ Where it becomes evident that professionals have differing opinions it is essential that a professionals meeting is held and agreement made as to a consistent approach to care delivery.
- ❖ It is important to involve and communicate with the service user's General Practitioner as part of the care planning process.
- ❖ For a minority of service users there may be exceptional circumstances in which it may be appropriate to involve and liaise with other agencies, such as the Police, Accident and Emergency Departments (As per Trust Policy Guidance for staff practice guidelines for confidentiality and information sharing).
- ❖ Wherever possible, with the agreement of the service user, involvement of carers should be sought.
- ❖ Short/long term goals/crisis plan

A core care plan template is on RIO and can be used as a guide. (See Appendix B)

## Risk assessment and management

Risk assessment in people with Borderline Personality disorder should:

- Form part of a full assessment of the person's needs and not be completed in isolation.
- Identify and set out long-term and more immediate risks.
- Clearly state what the risks are, and if they relate to self or others.
- Should be agreed by the MDT where appropriate.
- Agree explicitly the risks being assessed with the person and develop where possible a collaborative risk management plan that:
  - Address both immediate and longer term risks, Relate to the overall long-term treatment strategy,
  - Takes account of changes in personal relationships, including the therapeutic relationship,
  - Factors that would indicate the benefits of taking a positive risk approach.

### Therapeutic (positive) risk taking

- The necessity for therapeutic risk taking is evidenced in the treatment of people with BPD. This may involve holding back from short term risk reduction strategies (e.g. hospitalisation, increased observations, increased visits from community) for the longer term gain of reducing long term unhelpful coping strategies.
- This should be well documented and take account of the other principles described above. The risks being taken need to be clearly justified in terms of the therapeutic gains expected and in line with supporting people the opportunity for personal growth and change.

The following provides guidance in how to assess and manage risk from a positive stance. (Refer to appendix C)

All staff providing clinical intervention to people with BPD should attend regular team-based risk reflective practice groups. These groups are facilitated by staff who have received training from Steve Morgan, a respected expert in the field of positive risk-taking. The content of team-based risk reflective practice groups is guided by Steve Morgan's document, "Practical ways of working with risk: whose risk is it anyway?"

## Management of Suicidality

### Linehan's Suicide Crisis Protocol (Linehan, 1993)

1. Assess long-term and imminent risk of suicide or parasuicide
2. Focus on the present
3. Problem solve the current problem
4. Reduce high risk environmental factors
5. Reduce high risk behavioural factors
6. Commit to a plan of action
7. Troubleshoot the plan
8. Anticipate a recurrence of the crisis response
9. Re-assess suicide potential

### Risk Panel Meetings

Refer to appendix D for Risk Panel meetings

## Transitions and Endings

Endings and transitions can often be difficult and may be experienced by the service user as rejecting or abandoning. Therefore a plan for ending and transitions should be clearly agreed. This should allow sufficient time to allow a gradual reduction of the frequency and intensity of support and treatment, and opportunity and time to discuss the service user's feelings about ending.

For those with a diagnosis of BPD, involvement with CAST – the Trust's service user consultation and advice service team may be appropriate, as well as attendance at the DBT graduate skills group.

## Transition protocols from CAMHS to AMH

Recommendations:

- There is already a protocol for admission and transfer between CAMHS and AMH inside the trust. Recommendation:  
Joint policies between organisations running CAMHS (e.g. Soton City) and SHFT would very useful.
- According to the protocol, the transition process includes the agreement between the consultants from the two services and the CPA involving the young patient and the family.

Recommendations:

1. A more explicit involvement of the carers in the process of transition can be requested.
  2. A full handover between all the professionals involved in the care, eventually in the frame of a professionals meeting followed by the CPA
- The transition process could be planned over 6 months according to the current CAMHS policy. Following a routine referral to CMHT an assessment is undertaken within 7 weeks of the receipt of the original referral, according to the CMHT policy.

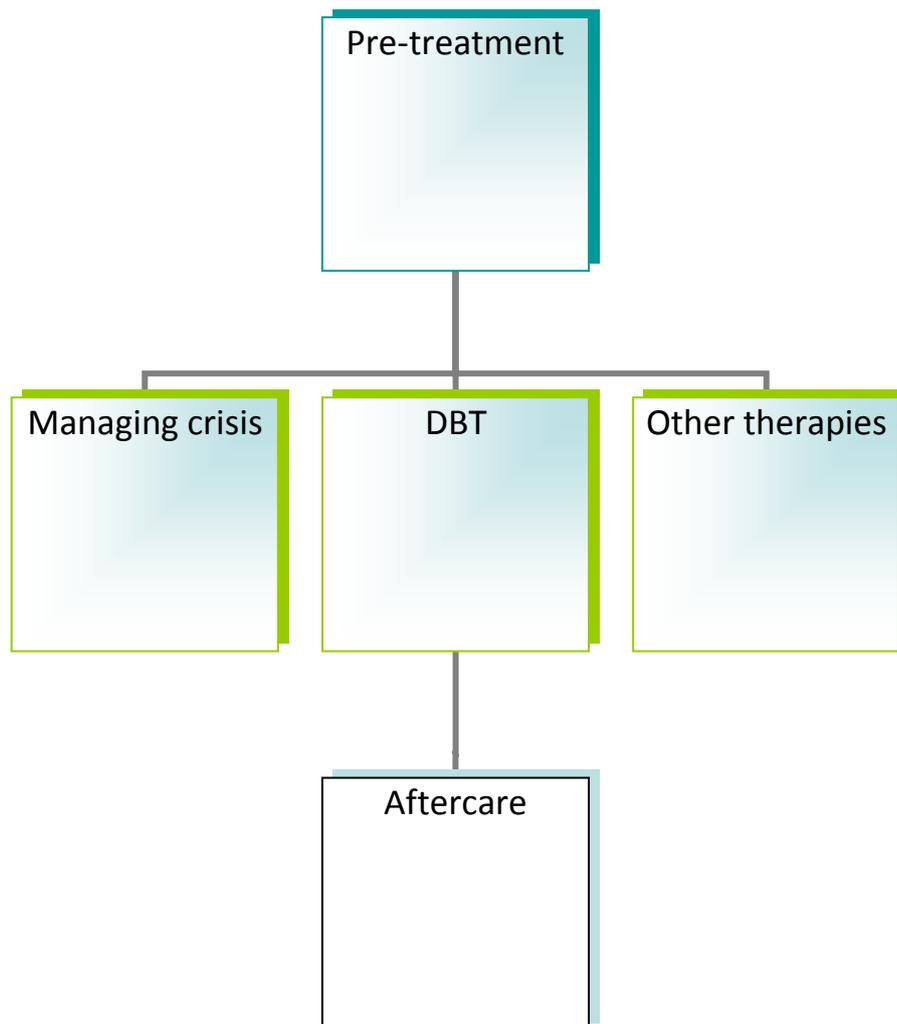
Recommendation:

1. A more explicit early identification of care coordinator in order to allow the development of a therapeutic relationship before the actual transfer happens.

2. Reconsidering the 7 weeks' time frame in case of transferring complex cases in order to allow a smoother transition and use of resource.

### Treatment and Therapy Options

Based on a biosocial theory of understanding, BPD is recognised as a pervasive emotion dysregulation system which has arisen from a combination of emotional vulnerability and invalidating social environments. The National Institute of Clinical Excellence (NICE, 2009) recommends that psychological interventions are the most effective method of treatment for this population.



People with BPD are not a homogenous group of people; individuals will be at different stages of being able to engage in treatment. There are number service users who are unable or unwilling to engage in psychological treatments and it is proposed that we adopt a stepped care approach. The national IAPT programme (2014) highlights the need for more accessible, efficient care for people with BPD. Stepped care approaches aim to improve access to psychological therapies by offering the least restrictive treatment option, yielding the greatest health gain. This approach has proved successful in increasing access to therapies in primary care, and is likely to prove beneficial in secondary and tertiary care settings.

### Step 1 – Pre-Treatment

Low Intensity Programmes can be accessed through the Intensive Support Programme (ISP) which is a psychologically led initiative, delivered in Acute Mental Health Services. Staff at all levels are involved in teaching, coaching and supporting people to help them learn and apply new skills and ways of coping, with training and supervision from psychology.

These programmes consist of the following psycho-educational interventions delivered by appropriately trained practitioners under the governance of the Psychology Services. ISP gives the following messages to the service user:

- Your distress is understandable and taken seriously
- The ways in which you are currently coping are understandable. Introducing different coping strategies and looking at things in a new way may though help reduce your distress
- You will need to take the central role in making this change
- The service will help you to see how to do this and provide every support

Interventions are informed by Dialectical Behaviour Therapy, Cognitive Behaviour Therapy & Acceptance & Commitment Therapy. For example,

- Dealing with crisis
- Emotional coping skills
- Values
- Introduction to mindfulness,
- Understanding your diagnosis
- What is trauma?
- Family and friends programme

This list is not exhaustive and interventions can be delivered individually or in groups.

## Step 2

Southern Health NHS Foundation Trust has invested in Dialectical Behaviour Therapy as the first stage treatment for this disorder due to its efficacious evidence base and recommendations by NICE, (2009).

### Dialectical Behaviour Therapy (DBT)

DBT is a principle-driven, flexible and comprehensive cognitive behaviour treatment devised by Linehan (1993) and is recognised as the gold standard psychological treatment for people with chronically suicidal individuals diagnosed with borderline personality disorder.

For any psychological treatment to be effective, both the service user and therapist must have the choice of committing to DBT and therefore all DBT service users begin in pre-treatment.

- ❖ Discrete phase in its own right. Arguably the most important phase of therapy
- ❖ Usually last 4-6 weeks. Time spent here will save you time and effort in the long run
- ❖ Client and therapist need to come to a mutual, informed decision to work together on helping the client make changes

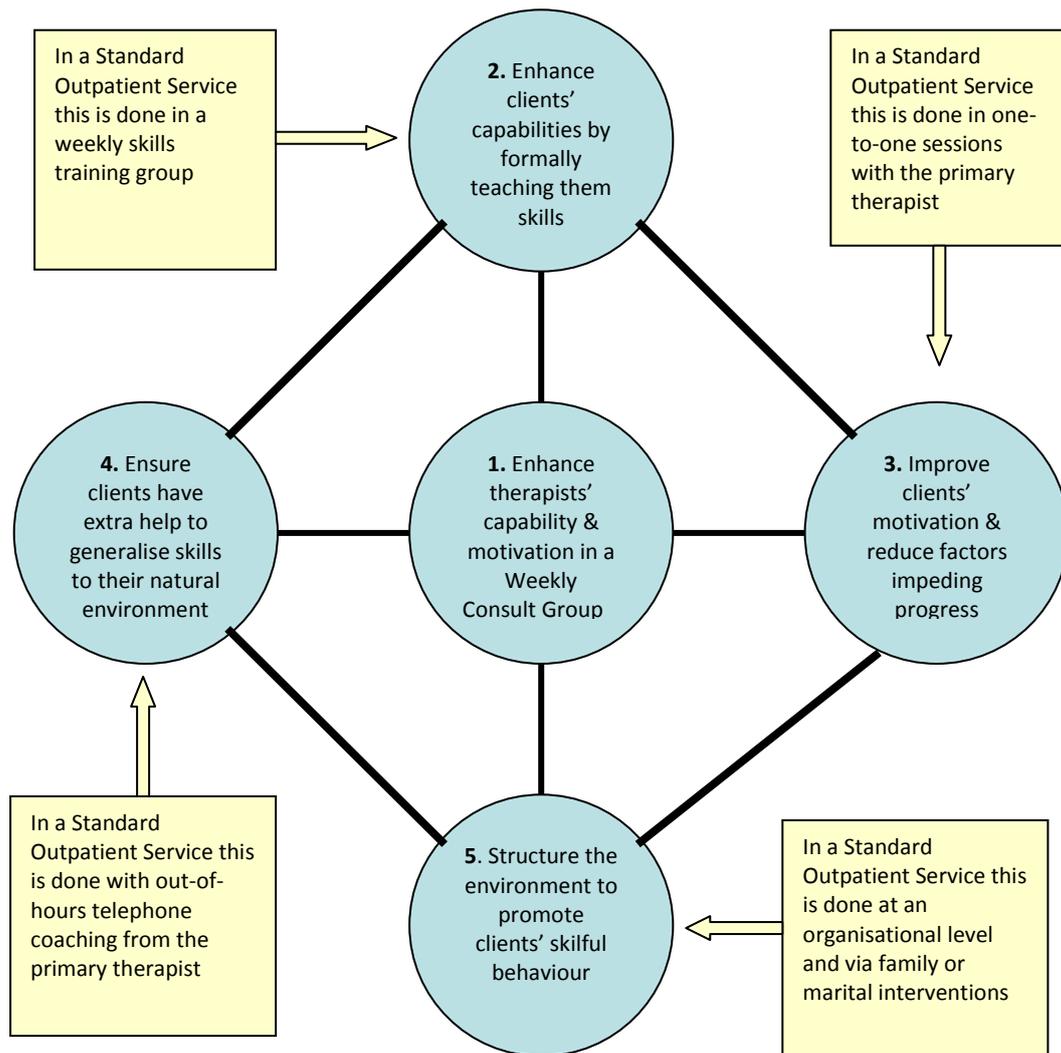
### Pre-treatment goals

- ❖ Agreement on Goals. Working out what the client wants to gain from therapy so there can be a real agreement from the client on:
  - Commitment to Change
  - Initial Targets of Treatment
- ❖ Agreement to Recommended Treatment. The treatment is explained in detail so the client has a chance to make an informed choice. Also the therapist and DBT team get to know the client better so they can be sure this is going to be the most effective treatment for them.
  - Patient agreements
  - Therapists agreements
- ❖ Agreement to Therapist-Client Relationship. The treatment goes on for a year or more so the client and therapist need to get to know each other and agree they can work together for this time.

## DBT Treatment

The primary focus of stage 1 treatment is to help the service user attain the basic capacities to stay alive to engage in treatment, followed by those needed to improve the service user's quality of life.

There are five components in the delivery of DBT treatment  
Treatment must meet all five of these functions



DBT is a team treatment where a community of therapists treat a community of clients. All DBT therapists must attend a weekly consultation meeting. Therapists' consultation meeting is the minimum requirement of any DBT intervention.

If only some of the 5 functions are met then the therapy is 'DBT informed' rather than full DBT. It is important to be clear with clients about what therapy they have received. In some cases clients report that they have 'had DBT' when they have only attended a skills training group. The standard out-patient DBT treatment takes one year to complete.

Some adaptations reduce the treatment duration by increasing the number of Skills training sessions per week or cutting down some of the skills group content. These adaptations do not have the same evidence base as the standard program.

### **DBT Graduate Groups**

Please refer to appendix F for further details

DBT is the first treatment in a possibly long Recovery journey. Other treatments addressing the effects of trauma and other disorders should also be considered.

### **Step 3**

## **Other Treatments/Therapies**

### **Cognitive Analytic Therapy**

Cognitive Analytic Therapy (CAT) is an integrated, time-limited therapy that can be helpful for those with Borderline Personality Disorder (BPD). It combines CBT methods aspects of psychoanalytic therapy, with a focus on using the therapeutic relationship to facilitate change. It has been widely used to help people who have experienced childhood abuse, neglect and trauma, including people who self-harm, and is recommended as an appropriate treatment for BPD in the NICE guidelines.

Within individual CAT recurrent patterns of relating to self and others are identified and understood as strategies that helped the person to survive difficult early life experiences. The aim of therapy is to help the person to develop greater recognition of these recurrent patterns, using both a written and diagrammatic formulation, and use this understanding to develop new ways of relating to self and others. People with BPD are typically seen for 24 sessions, with an extended follow-up.

CAT is also a useful consultancy model, and can help teams make sense of and avoid re-enacting unhelpful patterns of relating that may occur between teams and service users.

### **Acceptance and Commitment Therapy (ACT)**

Acceptance and Commitment Therapy is a third wave cognitive behavioural treatment that gets its name from one of its core messages: to accept what is out of the person's control, while committing to action to improve the quality of the individual's life.

The aim of ACT is to help people create a rich full and meaningful life, while effectively handling the pain and stress that life inevitably brings. ACT (which is pronounced as the word 'act', not as the initials) does this by:

- a) teaching psychological skills to deal with painful thoughts and feelings effectively – in such a way that they have much less impact and influence. (These are known as mindfulness skills.)
- b) helping to clarify what is truly important meaningful to the person – i.e. values - then use that knowledge to guide, inspire and motivate the individual to change their life for the better.

### **Cognitive Behaviour Therapy for Personality Disorders (CBTpd)**

CBTpd is developed for the treatment of BPD and antisocial personality disorders. It is an effective short therapy for self-harming and suicidal people with BPD and for men with antisocial personality disorder who are violent and living in the community. CBTpd is delivered individually in 30 sessions over one year. Therapy is based on a written formulation, agreed between therapist and service user, focussing on core beliefs and self, others and problematic behavioural patterns. After the initial five or so sessions to develop the formulation, the service user and therapist work collaboratively to develop new more adaptive ways of thinking about self and other and more effective ways of coping.

### **Schema-Focused Cognitive Therapy**

Schema-Focused Cognitive Therapy (or Schema Therapy) is an integrative approach to treatment that combines elements of cognitive therapy, behavioral therapy and psychoanalytic therapies into one unified model.

The Schema-Focused model was developed by Dr. Jeff Young for people with personality disorder and other complex problems. He found these people typically had long-standing patterns in thinking, feeling and behaving/coping. His therapy is aimed at helping people to change these patterns or "schemas".

Schema-Focused Therapy consists of three stages. First is the assessment phase, in which schemas are identified. Questionnaires may be used as well to get a clear picture of the various patterns involved. In the next phase the client is encouraged to increase their emotional awareness and get in touch with these schemas and learn how to spot them when they are operating in their day-to-day life. Thirdly, the behavioral change stage becomes the focus, during which the client is actively involved in replacing negative, habitual thoughts and behaviors with new, healthy cognitive and behavioral options.

## Social / Occupational Initiatives

Occupational needs have an impact upon the health, well-being, personal development, life satisfaction and/or risk of harm to self and others. Identifying the nature and extent of occupational needs presents a challenge as people with BPD either present with an illusion of competence or incompetence. They may either be more capable than they appear or have deficits in areas that result in the individual struggling to maintain a balanced routine of work, leisure, self-care and social occupations.

## Assessment

A thorough occupational assessment and formulation taking into account the individual's perceptions, thoughts and beliefs about vocation is required. As the individual's functioning may fluctuate greatly over time and particular in times of crisis, initial assessments of competence will require updating.

## Vocation

Record in care plans current daily activities and occupational goals. Sometimes when people are emotionally dysregulated or experiencing crises, or not keen to start on vocational work, the care coordinator or team member has to improve engagement and do preparatory work.

- Joint care planning is a good strategy and includes occupational long/short term goals and assessment of skill level (NICE guidelines), motivational interviewing, information gathering (including past education/past employment/work experience). The team should start partnership working with Job centres, employment advisors, non - statutory advisors to provide Independent Placement and Support (IPS, NICE, 2015). Work environment should also be considered including a graded return to work.
- Consider if a need for psychology and neuropsychological testing for skill level and suggestions for support or aids to create successful vocational experiences

- Collaborative review of perceptions, current emotional difficulties and the impact on work to create an action plan that supports and links with employers for adaptations/support
- Skills based work either Group or Individual based. More effective outcomes have been found with group work.

### Pre Vocational Work

- Pre-work skills questionnaire
- Creating C.V
- Social skills
- Interview skills
- Form filling/applications
- Writing personal statements
- Career choices
- IT skills
- Exhibition of projects - team working
- Problem solving
- Coping strategies

### 'Work Hardening'

- Adhere to structured day
- Attendance at groups
- Self-care and personal presentation
- Life skills (e.g. DIY, first aid, staying safe/drugs awareness, budgeting)
- Pre-work habit training adding to current routine

### Social contact

Social contact is hugely important. Services can offer befriending schemes along with social groups, some of which may include physical activity, e.g. music, football and walking groups.

- Service users should be directly to locally available social schemes.

## WRAP

As a component of standard treatment, all service users should be given the opportunity and support to complete a Wellness and Recovery Action Plan (WRAP).

WRAP is promoted in SHFT as an essential element of service users' care, and is based on five key best practice principles:

- **Hope:** people who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.
- **Personal responsibility:** it's up to you, with the assistance of others, to take action and do what needs to be done to keep yourself well.
- **Education:** learning all you can about what you are experiencing so you can make good decisions about all aspects of your life.
- **Self-advocacy:** effectively reaching out to others so that you can get what it is that you need, want and deserve to support your wellness and recovery.
- **Support:** while working toward your wellness is up to you, receiving support from others, and giving support to others, will help you feel better and enhance the quality of your life.

WRAP plans will be utilised by mental health care teams to inform treatment plans and support across all stages of the individual's experience of psychosis. WRAP plans will be revisited following any crisis or major change in the person's life. They are an important part of a post-crisis collaborative debrief informing the next phase of care.

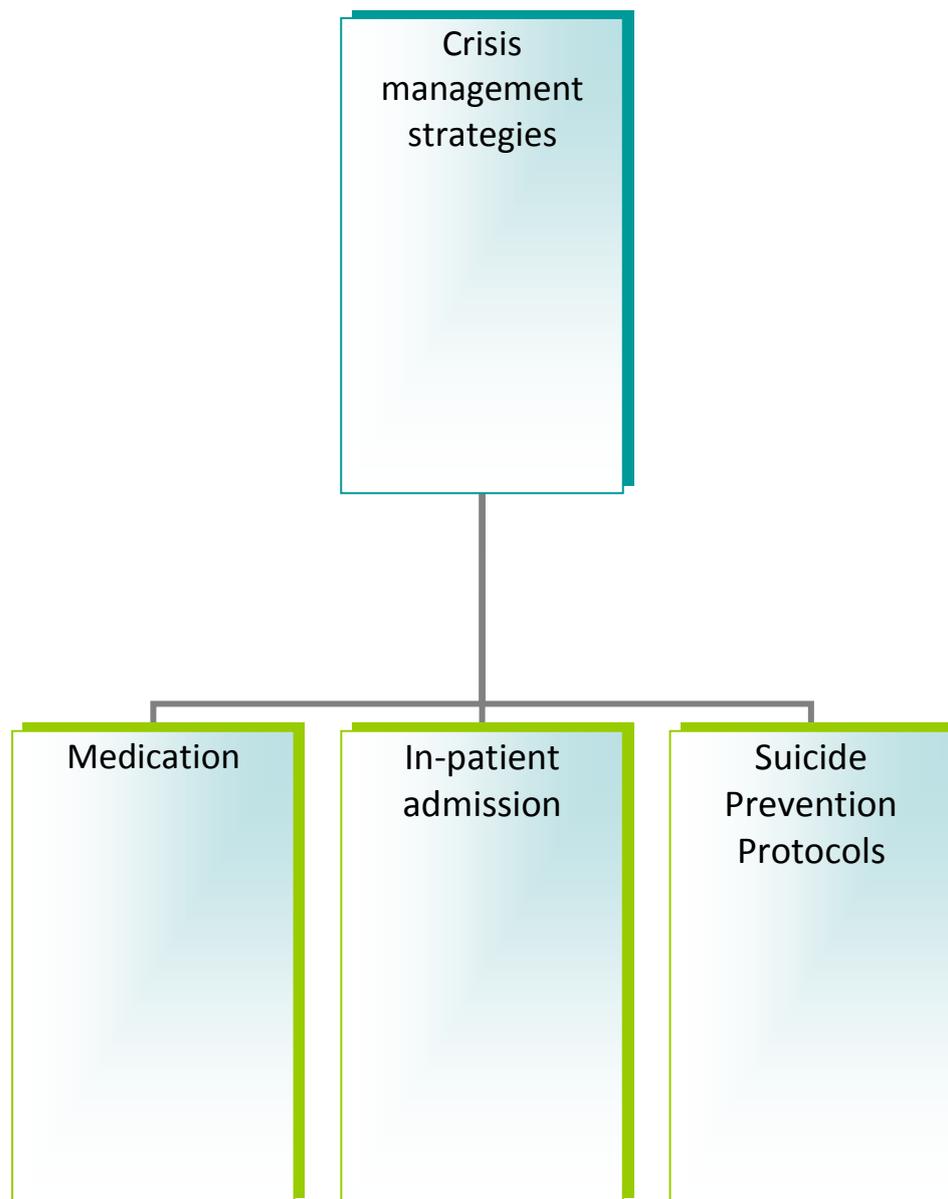
## Crisis Management

### Crisis Planning – “My Crisis Plan”

The national definition (cross speciality) of urgent and acute is:

**Definition of Urgent Care:** A condition that requires an assessment and planned intervention within seven days, or which is likely to lead to an emergency within four weeks

**Definition of Emergency Care:** Not always life threatening, but needs prompt assessment and a planned intervention within 24 hours



## Managing Crises

All service users should have a crisis management plan. This should include:

- ❖ A joint assessment of the crisis is required by the RC and or lead clinician, care co-coordinator and the AMHT with clear discussion and communication with all those involved in the service users care.
- ❖ A chronological history of risk including contextual details associated with episodes of crisis and high risk.
- ❖ A risk assessment including factors that are likely to increase and decrease risk as well as the factors that would indicate the benefits of taking a positive risk approach.
- ❖ A detailed plan which specifies as much as possible the strategies and course of action that would be beneficial at a time of crisis. This plan should be developed in collaboration with the service user, and if appropriate, their carer. It should be shared as widely as possible and include agreements on how the various professionals and team will conduct themselves at times of high risk (As per Trust Policy Guidance CP92 – Risk Assessment and Management of Patients/Service Users)
- ❖ This risk plan should be available RIO.
- ❖ After each episode of risk, the plan is to be reviewed and up dated accordingly so a clear Advanced Directive is available for the next crisis.

### All service users should have a “My Crisis Plan”

- ❖ The crisis plan should be started as soon as the service user enters the service.
- ❖ It should document what the service user is like when they are well, factors that are likely to increase and decrease risk as well as the a detailed plan which specifies as much as possible the strategies and course of action that would be beneficial at a time of crisis.
- ❖ This plan should be developed in collaboration with the patient/service user, and if appropriate, identified family/friends.
- ❖ It should be shared as widely as possible and include agreements on how the various professionals and team will conduct themselves at times of high risk (as per Trust policy guidance).
- ❖ The trust has adopted the ‘my crisis plan’ to document this on the RIO system.

- ❖ After each episode of risk / crisis, the plan is to be reviewed and updated accordingly so a clear Advanced Directive is available for the next crisis.
- ❖ It is just as important when managing a crisis to support patients/service users to apply newly acquired coping skills, or if necessary to teach such skills. The whole care team will support the use of new/alternative coping
- ❖ This crisis plan needs to be located in the “My crisis” plan section of RIO

When a person with borderline personality disorder presents during a crisis, consult “My Crisis Plan” and:

- ❖ maintain a calm and non-threatening attitude
- ❖ try to understand the crisis from the person’s point of view
- ❖ explore the person’s reasons underlying the distress
- ❖ focus on the emotions and not the content
- ❖ use empathetic open questioning, including validating statements, to identify the onset and course of the current problems
- ❖ seek to stimulate solutions
- ❖ Do not use questions such as “How can I help?” as it may overwhelm the individual but rather use statements such as
- ❖ “I can hear you’re upset, how long have you been feeling like this?”
- ❖ avoid minimising the person’s stated reasons for crisis
- ❖ refrain from offering solutions before receiving full clarification of the problems
- ❖ Explore other options before considering inpatient admission or crisis unit
- ❖ Offer appropriate follow-up within a time frame agreed with the person.

## Inpatient/Residential Admission

Residential/in-patient admission should only be considered when there are no safe alternatives and it should be brief, time limited and goal determined.

- ❖ The decision to admit a service user must be made within the context of a joint assessment between CRHT, Care Coordinator and RC and or lead clinician.
- ❖ Admission should be undertaken with care and dignity with the best interests of the service user as paramount.
- ❖ A professionals meeting known as the Risk Panel Meeting should be convened as soon as practically possible to ensure a full review of care and treatment occurs and clear admission objectives are agreed. As there could be differences in professional opinions the team should consider inviting an objectives observer to contribute to the meeting. This person (usually a clinical psychologist or psychological therapist) should be someone in a position to view the clinical case objectively and assist the team in future care and treatment planning. Due to the nature of the service user's presentation and its impact on practitioners, it is expected that all team members will attend reflective practice sessions.
- ❖ A clear goal and plan for the admission should be developed with the service user and the limitations/boundaries of the admission made explicit
- ❖ Where possible admission should be informal, admission and discharge should be negotiated with the service user.
- ❖ An estimated discharge date should be agreed and communicated to the service user.
- ❖ Once the service user arrives in hospital a plan of care must be formulated in collaboration with the service user. This plan must include the goals identified at the point of assessment by the CCO, RC, AMHT and service user. This plan should also include when hospital admission may end earlier than planned as the goals of admission are not met.

- ❖ Where a service user is already engaged in a community psychological therapy a review of this will occur to determine if this should continue while an inpatient.
- ❖ Where appropriate referral and following an emotion-focused formulation attendance at the Emotional Skills Group (based on DBT principles) should form part of the purpose of admission.
- ❖ During admission a CPA should be convened where the risk and “my crisis” plan can be updated. It is essential that all key professionals are in attendance at this meeting and also actively involve the service user and family/carers when appropriate.
- ❖ Where a crisis and/or WRAP plan does not exist it is essential that “My Crisis” plan is developed in collaboration with the service user prior to discharge and placed on RIO.

### **Prescribing and the use of medication for patients with BPD**

#### **When a decision has been made to use medication in crisis situation or otherwise prescribers should:**

- ❖ Ensure there is a consensus among treating professionals about the drug used, who prescribes it and an agreed date of review.
- ❖ Take account of the psychological role of prescribing and the impact that prescribing decisions may have on the therapeutic relationships and overall treatment plan
- ❖ Ensure a drug is not used in place of other more appropriate interventions
- ❖ Prescribing should be appropriate to the patient’s clinical presentation, including treatment of co-morbid psychiatric disorder
- ❖ Prescribing should be based on evidence based clinical guidelines (NICE, Maudsley,BAP) and in accordance with Trust prescribing guidelines for BPD

#### **When choosing a drug for BPD, it should have:**

- ❖ A low side effect profile.
- ❖ Low addictive potential.
- ❖ Minimal potential for abuse.

- ❖ Relative safety in overdose.

**Once the decision is made to use drug treatment, the prescribers should:**

- ❖ Discuss with the service user, the target symptoms, monitoring, and anticipated duration of treatment
- ❖ Prescribe the minimum effective dose
- ❖ Prescribe fewer tablets more frequently
- ❖ Consider the risk/benefit and discontinuation of the drug after a trial period if there is no improvement in target symptoms.
- ❖ Consider alternative treatment strategies, including psychological if target symptoms do not improve.
- ❖ Arrange a review of the overall care plan once the crisis has passed

**Trust Prescribing Guidelines**

Please refer to appendix F for information

## Appendix A Acute & Community Pathway Summary Flowcharts

### **Acute & Crisis Pathway**

Can we identify the goals of admission?

What behaviours brought the patient into hospital; what are the psychological factors and behaviours keeping the patient in hospital and what the behaviours are that need to be identified to enable discharge?

What are our aims for working with X and what is getting in the way?

What is (if anything) getting in the way of adhering to the overarching principles?

What is the current crisis plan? Does this need to be updated?

What risks are present (short-term and long-term), how can these be managed / minimised what positive risk taking options are there?

What treatments are available?

Are significant others involved in the patient's care?

## Appendix B Standardised Borderline Personality Disorder Care-Plan Guide for Clinicians

Box 1

Problem.....emotionally unstable personality issues

### Summary

Need.....interventions to minimise harm and improve well being

\*Potted history

\*Areas of difficulties.....

\*Strengths and resources.....

\*Risk behaviours

### Care plan interventions

#### **Engagement**

Early stages of engagement maintaining a consistent contact **that is not** contingent on risk behaviours.

Developing a collaborative alliance that has clear expectations and responsibilities on both sides.

Demonstrate a respectful, non-judgemental and validating approach.

Consistent service response in line with collaborative agreement.

### Assessment and formulation

Develop a collaborative formulation of difficulties and share with service user and those involved in their care.

Consider further assessment of specific problem area i.e. drug / alcohol, eating disorder.

### Strengths and resources

Identify individual's current strengths and resources

What helps the person to stay well?

How can these be maintained and enhanced?

### Interpersonal difficulties

Identify potential barriers on both sides to therapeutic alliance and interventions.

Identify barriers to appropriate communication of need

Interventions aimed at developing skilful and appropriate communication of need (consider, for example, managing emotional arousal, encouraging respectful and assertive communication, etc.)

### Managing emotions

Awareness and identification of potential triggers

Awareness and identification of graded early warning signs/signs of distress (consider thoughts, emotions, physical responses and urges/behaviours) (consider intensity and likely associated level of risk)

Develop a range of coping strategies to match need and level of distress (consider for example; self-soothing, activity scheduling, pleasurable activities, mindfulness and distraction)

### Problem Solving

This is an important skill for improving emotion regulation or solving emotional problems. Identify the problem that is creating the emotional distress Consider problem solving strategies after the level of emotional arousal has been reduced.

## High risk/Life-threatening behaviours

Document specific risk behaviours.

Consider triggers and factors which increase these risks. Remember that risks are fluid and presentations can change rapidly. Just because the person is not suicidal at the time of assessment does not mean that they will not be in the future.

Note vulnerability factors that were present during each crisis.

Assess role / pattern of alcohol / drug misuse if relevant. Assess and encourage motivation to change and consider specific harm minimisation strategies.

Specific crisis interventions

(service user actions, service response, clear plan for identified risk behaviours)

Use and update "My Crisis Plan"

## Transitions and endings

How each session ends with borderline service users is very important. Many people report that they experience intense negative emotions and have great difficulty in regulating their emotions without resorting to maladaptive behaviours. The following points should be considered:-

Sufficient time should be given for ending so that the service user does not feel rushed

Service user should be given notice that the session is coming to an end.

The practitioner should help the service user cope with the session's ending

The practitioner should help the service user close up emotionally.

Wherever possible service user to be given notice of significant changes to key professionals involved in their care.

To be offered appropriate support during any such transition.

## Carers and families

Share formulation and care plan with significant others as identified and agreed by service user.

Consider offer psycho-education and support to carers and families.

## Appendix C

**Positive risk-taking is:** weighing up the potential benefits and harms of exercising one's choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. good risk management) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It involves using 'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes.

It is characterised by:

- *Real* empowering of people through *collaborative* working from the outset of discussions about risk and risk-taking
- A clear understanding of *responsibilities*, that service users and services can reasonably hold in *specific situations*; and understanding the consequences of different courses of action
- Making *decisions* based on a range of choices available, and supported by adequate and accurate information
- Supporting people to *access opportunities* for personal change and growth
- Establishing *trusting* working relationships, whereby service users can *learn* from their experiences, based on taking chances just like anyone else
- Working positively and constructively with risk depends on a full appreciation of the service user's *strengths* in order to identify the positive resources that underpin the confidence to take the risk
- Focusing on the '*here and now*', but with clear knowledge of what has worked or not worked in the past, and why. The influence of *historical* information lies in the deeper *context* of what happened rather than the simple *stigma* of the events themselves
- It is an *on-going* risk decision-making process, not a one-off decision
- A clear focus on the specific *outcome* to be achieved, so it involves a process of attempting to script what the future could look like

Practitioners should adopt a person centred approach. Identifying and working with strengths should be the ethos of working from outset with everyone, including working through crises and difficulties. It is part of teasing out the appropriate therapeutic interventions; helping the person to tell their story... it is a skilled intervention not to be done in a patronizing way (i.e. not for practitioners to just run through a checklist quickly as if strengths is then done!)... it is an intervention in itself. Consider the timing for asking of subtle delicate questions related to individual personal circumstances. As a process it can be a subtle communication of optimism, hope and validation, and is closely aligned to the ethos underpinning Wellness Recovery Action Plans (WRAP).

Further comments relating to the concept of positive risk-taking:

- Being very clear what the risks are and why we want or need to take the risk
- Taking calculated risks through careful consideration of the specific risk, the specific individual and the environment

- “Feel the fear but do it anyway.”
- Acknowledging the anxiety that comes with taking reasoned risks; we cannot make everything right and risk-free
- ‘Risk to others’ raises caution much more than ‘risk to self’
- Giving responsibility and independence back to the individual as quickly as is reasonable... people have rights, but with these come responsibility for their actions
- Suggestions for implementing the definition in routine practice include:
  - Expecting all practitioners to understand the need for clarity of describing and understanding the specific concept, so we are all working towards the same vision
  - Highlighted in supervision, and in case discussion forums (including Multi Disciplinary Team reviews)
  - Use as a means of reasoning some decisions made, particularly when explaining them to other staff
  - As a focus for discussion in reflective practice groups/forums or discussion groups as an educational tool
  - Used to influence the way we think about writing care plans
  - Informing Trust Policy & Guidance so processes are understood

Some examples:

- Borderline Personality Disorder requiring creative working, including services taking the lead with positive risk-taking decisions to establish clear boundaries or restrictions, but always on the basis of a clear identification of the positive outcome to be achieved, and how the person may be persuaded of the course of action/outcome.
- Person with history of multiple overdoses requiring a consistency of approach from all service providers that is focused on leading to promoting the person’s ownership of their own behaviours, actions and consequences for own recovery... consistency is often about service providers not buying into the stereotype of maladaptive and manipulative behaviour, etc.
- A person who has a history of admissions and increasing self harm behaviours... a team split on what to do and all therapies seem to have been exhausted... plan to review her needs afresh and focus on reducing the team’s aspirations of what we are responsible for, and shift to appropriate personal responsibility... discharge into independent living.

### A Structured Approach to Risk Decision Making

[From: Morgan, S. (2010) Making good risk decisions in mental health and social care. *Health Care Risk Report*, 16(5), 16-17.]

- Is the required decision *reactive* (to what the person is doing or plans to do) or *proactive* (to be initiated more by the service providers)?
- Is the service user’s understanding and experiences of risk clearly understood (it may be very different from the professional’s assessment of the risks)?

- Is the carer's (as appropriate) understanding and experiences of risk clearly understood (it may at times contradict that of the service user)?
- What behaviours are identified as being risky in relation to the specific circumstances of the decision (i.e. what is your risk assessment)?
- What is the clear definition of the risk that is being taken (the emphasis is on the detail)? Have you considered the other options that are available?
- What are the positive desired *outcomes* to be achieved through taking the specific risk (short &/or long-term)?
- What *strengths* can be identified and used in pursuit of a positive risk-taking plan (including personal qualities, abilities, achievements, resources, motivations and wishes)?
- Are there any clearly defined stages to be accounted for in a risk-taking plan?
- What are the potential pitfalls, and estimated likelihood of them occurring? Have you thought of these in relation to the other appropriate options? [Important for demonstrating that alternatives have been evaluated in the risk decision-making process]
- What are the potential safety nets (including early warning signs, crisis and contingency plans)?
- Has this course of action been tried before, and if so what were the outcomes?
- If tried before, how was the plan managed and what can now be done differently (what needs to, and can change)?
- What is your *formulation* from all the above information (clearly weighing up the different alternatives considered and presenting the reasoned decision that has been taken)?
- Who agrees (and importantly disagrees) with the plan?
- How will progress of the plan be monitored?
- When will the plan be reviewed?

From: Positive Risk taking document by Steve Morgan

## Appendix D

### Risk Panel Meeting

### Borderline Personality Disorder Or Emotionally Unstable Personality Disorder

### Terms of Reference

## Based on the principles of Dialectical Behaviour Therapy and the concept of Recovery

### Aim

To offer a space to reflect on the care being provided to a patient with a diagnosis of BPD/EUPD where there may be perceived difficulty (high emotion in team / sense of stuckness, admission longer than 72 hours etc).

- To clarify what behaviours brought the patient into hospital; what behaviours are keeping the patient in hospital and to identify behaviours that are necessary to enable discharge
- With particular emphasis on adherence to principles/values to increase the understanding of the patients self-harming & self-defeating behaviours
- To identify and name risks and provide a forum to consider options for positive risk taking
- To identify the triggers for dysfunctional behaviours including the potential unhelpful dynamics that may develop between the patient and others ( the service)
- To identify and name outcomes we are working towards and problem solve barriers
- To initiate (or develop further) the Wellness Recovery Action Plans
- To be educative for staff by being transparent, accepting that we are all fallible, openly discussing the DBT principles, demonstrating a dialectical stance and drawing on the biosocial model.
- To provide support for individual workers so that the panel members share the responsibility for decision making.

### Panel Membership

Consultant clinical psychologist or a representative (Lead facilitator)

Consultant psychiatrist,

Hospital at Home Team Leader or representative

Ward manager

Occupational Therapist

Named nurse or equivalent for the patient

Care coordinator/ discharge liaison practitioner

Other professionals to be invited as required

Students/trainees on placement

### Pro forma

To occur every Tuesday from 11:00 till 12:00

Each panel meeting will be one hour

What is the perceived need or the question being brought to the panel?

### Sharing of Information

Crisis contingency plans and in progress notes on Rio

Handover Sheets – to record outcome of panel meeting

Outcome of panel meeting to be shared at BUG meeting

Feedback to community team via care-coordinator or representative

### Outcomes

Staff feedback – do staff perceive support from Panel,

Adherence to principles,

Impact on length of stay.  
No of times patient presents in crisis

## Appendix E

### DBT Graduate Groups

The evidence based treatment of dialectical behaviour therapy (DBT) did not include any post treatment wind down sessions. Many service users/clients find the end of DBT difficult. It can be hard to go from an intensive treatment which involves both individual and group weekly contact to purely individual therapy follow-up sessions. Thus across the Trust some DBT programmes have developed Graduate or Advanced groups to help with this transition.

The principle in DBT is that, if you do well you get more and these groups are based on this principle. They also follow the ethos that DBT is a skills based treatment aimed at helping people to build a 'life worth living'. As the randomised controlled trials that DBT is based on did not include this after care element the format by which it is delivered, and even if it is delivered at all, will vary.

In general terms graduate groups include a component of going over skills taught in the DBT programme and helping clients to embed these into their lives. Advanced Groups are for clients who have a good grasp of the skills so discussions are often around concepts from DBT rather than the standard skills e.g. dialectics and how we can use this in our lives and relationships.

Groups will run at least monthly and may be time limited. The purpose is to help clients move on with their lives applying DBT as 'life skills' rather than separate skills that are part of a treatment programme.

## Appendix F

### Pharmacological Treatment of Anti-Social & Borderline Personality Disorder