Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Understanding mental health, understanding people

A clinical guideline and care pathways for the management of patients with common personality disorders within the Trust

Complex Cases Service

June 2009

In partnership with the University of Cambridge

This booklet is produced by the Complex Cases Service.

The Complex Cases Service is the specialist, tertiary service, within the Cambridgeshire and Peterborough NHS Foundation Trust, providing assessment and treatment services for people with personality disorder who have particularly complex needs and/or high levels of risk. In addition, such specialist services have now been required by NICE to provide consultation and advice to primary and secondary care services, and to oversee the implementation of the guideline[1].

The Complex Cases Service has two bases within Cambridgeshire: one in Peterborough, serving Peterborough and Fenland, and one in Cambridge serving Cambridge, Huntingdon and Ely. The respective contact details are:

Dr Dinesh Sinha
Complex Cases North
The Gables, off Thorpe Road
Peterborough, PE3 6DA
tel. 01733 318162

Dr Chess Denman
Complex Cases South
Springbank, Fulbourn Hospital
Fulbourn, CB21 5EF
tel. 01223 219130

The following booklet is intended for the use of clinicians within the Trust.

This booklet is intended to be helpful; so if it isn't, or you could suggest improvements, do please let us know! If you would like to contact the authors of this leaflet, you can do so by e-mailing us on:

Chess.denman@cpft.nhs.uk or alistair.collen@cpft.nhs.uk

An electronic copy can be downloaded from www.clinicom.cpft.nhs.uk

Dr Chess Denman (Consultant Psychiatrist and Consultant Psychotherapist)
Dr Alistair Collen (Consultant Clinical Psychologist)

[1] "Borderline personality disorder: treatment and management". NICE clinical guideline 78, January 2009. http://www.nice.org.uk/Guidance/CG78

Contents

INTRODUCTION

PART A

1. Identifying personality disorder in clinical practice.
2. Key principles of treatment for all patients
3. Management of risk.
   - 3.1 Patients presenting in any setting who currently pose a risk of suicide or self harm.
   - 3.2 Risk should be classified as acute or chronic.
   - 3.3 Patients who currently present a risk to others.
   - 3.4 Patients who attend repeatedly.
   - 3.5 Personality disordered patients who abuse substances.
   - 3.6 Patients presenting in any setting with acutely disturbed behaviour
   - 3.7 Patients presenting in A&E

PART B

4. Treating patients in the most appropriate location
   - 4.1 By degree of severity
   - 4.2 Case Examples
   - 4.3 Referring and transferring patients
5. Assessment and management of patients with personality disorder within the Care Pathways
   - 5.1 Primary care services
   - 5.2 Intake and Treatment Teams
   - 5.3 Rehabilitation and Recovery Teams
   - 5.4 PD Services Pathway – Tertiary Care / Complex Cases Service
6. Training and ongoing support to teams. Access to services in rural areas

Part C

7. Guidelines for Other Care Pathways
   - Crisis Resolution and Home Treatment Teams.
   - Inpatient Services
   - Child and Adolescent Mental Health Teams
   - Learning Disabilities Teams

Appendix A Brief Psycho-educational intervention for Cluster B personality disorder – Primary Care / IAPT delivery

INTRODUCTION

For too long patients with personality disorder have been viewed as a very troublesome, resource-hungry group (with a dubious diagnosis) who "won't be helped" as much as they "can't be helped".

This document has a different starting point: personality disorder is a legitimate life-long and cruel mental illness, which devastates lives. Mental health services, as yet sadly, have no powerful drugs or talking therapies that will cure this condition. However, we do now understand how we should support patients with personality disorder to minimise the negative effects of their recurrent emotional crises, and to significantly improve the quality of their lives and "recover" – rather than repeatedly alienating them, after making them more unwell.

The following document is in three parts, with a supplementary appendix:

> **PART A** addresses general considerations in working with all patients with PD: recognising PD, and key principles orientating us to how we should engage and conduct this work. The assessment and management of risk are then highlighted as crucial skills both when the patient presents in crisis and in taking the necessary "long view" when supporting patients with a dangerous chronic condition.
>
> **PART B** takes these general themes, and the expectations contained in the NICE Guidance on the treatment and management of Borderline Personality Disorder[2] (Jan. 2009), and recasts them in the context of the Care Pathways within our Trust. The question "where are patients best managed in the new Care Pathways" is discussed and protocols offered for primary, secondary and tertiary adult services.

[2] Our guidelines address the care of Clusters B and C personality disorders, and most specifically Borderline PD. Patients with Borderline PD in various degrees of severity, and in combination with various other personality disorders (and co-morbid Axis I conditions) represent the majority of people with Axis II conditions seeking help from mental health services.

Part C gives guidelines for the assessment and management of patients in other Care Pathways: for CRHT, Inpatient, CAMHS and LD teams

Appendix Finally, a 6-session psycho-educational intervention for use in primary care / IAPT delivery is presented.

This all produces a lengthy document! Nevertheless, the title of the document, "A Clinical Guideline", remains accurate. These are only clinical guidelines, a skeleton telling you *what to do*. The document does not teach clinicians *how* to engage and work effectively with patients with personality disorder. These skills are only acquired thought the experience of actually working, under supervision[3], with this client group.

[3] Throughout the following document, reference is made to "expert/specialist/appropriate" advice and supervision. Who are these experts?

In compliance with NICE guidance (Jan 2009), "the organisation and coordination of services, including training" should be led by a specialist personality disorder service. In the Cambridgeshire and Peterborough NHS Foundation Trust this specialist, tertiary service is called the Complex Cases Service (CCS). The operational details of how CCS will fulfil its responsibilities for oversight, training and supervision are now being developed. For a discussion of these issues, see below: *Section 6.* "Training and ongoing support to teams. Access to services in rural areas".

PART A

1. Identifying common personality disorders in clinical practice.

Personality disorder is a lifelong pattern of disordered personal relationships and life management. Patients are impulsive and act in ways that to others would seem self evidently not in their own best interests. At times the behaviour can seem “manipulative” or deliberately calculated to achieve some effect; at other times it appears chaotic or bewildering.

You should consider the possibility that patients have a personality disorder if they:

- Harm themselves repeatedly, for example by cutting, burning or hitting themselves.
- Take overdoses of medication: sometimes because they want to kill themselves; or they may not care if they live or die; or to get some sleep; or to punish themselves.
- Use street drugs or alcohol to numb or manage their feelings.
- Cause people who support them to have intense feelings of frustration, anger or hopelessness, and even to behave in extreme ways towards them.
- Damage their relationships with friends and carers by:
    - Outbursts of rage
    - Intense involvement and then sudden detachment or rejection
    - Desperately asking for more than the other person is able to give
    - Abruptly withdrawing, or engaging in impulsive or reckless behaviour
    - Isolating themselves
    - Behaving eccentrically or being excessively rigid in their attitudes or behaviour
- Feel profoundly lonely, abandoned or isolated.
- Feel empty, bored or blank most of the time.
- Often feel threatened or criticised even when this is not justified.
- Impulsively make important decisions, which they later bitterly regret; or do things that are seriously irresponsible, or even illegal, even though they know this is a bad idea.
- Find it difficult to make up their minds about what direction to take in life, what job to get, or with whom to have relationships.

If you consider that a patient may be suffering from a personality disorder then a full interview with the patient will be needed. You may also need to talk with a relative or someone who knows the patient from another context. You should look for a pattern of recurrent difficulties that is lifelong, persistent (rather than intermittent) and pervasive (as opposed to only appearing in one aspect of life).

Many patients with personality disorders also have other psychiatric conditions, which can include psychotic illnesses, depression and anxiety, substance abuse, learning disability and organic conditions.

At times it may be appropriate to use more formal methods of diagnosis. There are appropriate screening tools and structured diagnostic interviews available. (Advice on these instruments can be obtained by consulting the Complex Cases Service or local PD Team Links[4].)

[4] The ongoing work to train and support specialist workers on each team is presented in Section 6.

2. Key principles of treatment for all patients.

I. Respect

Patients with personality disorders are often not treated with respect but instead experience contempt and hostility from staff. This is unacceptable. Maintaining respect for patients involves the presumption that however disordered their communication it represents the truth as they see it and needs to be taken seriously.

II. Active and assertive treatment

Patients with personality disorders are often not offered appropriate psychological or pharmacological treatment because they are seen as “not ill” or not treatable. They may drift away from care in a state of disappointment or anger. The advent of better-developed treatment plans for the underlying condition, and the value of treating depression and anxiety, substance dependence or psychotic symptoms (called Axis 1 conditions) even in patients with personality disorder, make a passive approach unacceptable. Patients should be offered active and effective treatment for their condition.

III. Accurate assessment and management of risk

Patients with personality disorders who say they feel at risk of self-harm or suicide are often not treated seriously. It is true that such patients do make many more statements of intention to self-harm seriously than they make actual attempts. However their actual risk of self-harm resulting in serious damage to themselves or death is massively elevated over the general population. Furthermore their level of risk fluctuates over time: the distinction between acute and chronic risk needs to be understood. Risk needs accurate and skilled assessment and management, and regular reassessment and review of management.
Risk management plans should recognise the fluctuating nature of risk in patients.

IV. Consent.

A striking number of patients with personality disorder are never told their diagnosis. Their cooperation is not sought in relation to treatment plans, and accurate information about the risks and benefits of treatment and the availability or restriction of some treatments (rationing) is withheld. Failure to gain adequate informed consent is deception and is unacceptable. Patients should be offered appropriate helpful and truthful information about their condition and about the treatments available for it.

V. Consistency

Many patients with personality disorder experience their treatment as inconsistent and disunited. In a condition characterised by striking emotional and behavioural inconsistency and a fragmented unity of the self, a lack of consistency (and continuity) of care is in itself damaging. A single unified treatment plan on which all are agreed (including the patient), which is carried through concertedly and which, being realistic, is not subject to repeated breakdown is a vital element of treatment.

VI Supervision

Patients with personality disorder will on occasion desperately play out the same patterns of damaging relationships, which characterise their illness, with individual staff and within services. Staff may find themselves uncharacteristically violating professional boundaries and repeating the abuse, neglect, rejection or unfulfilled promises that patients have suffered in the past. Maintaining a compassionate psychological perspective (especially over months and years of support) can be demanding. Regular supervision for individuals and teams is essential to safeguard both patients and staff.

3. Management of risk.

3.1 Patients presenting in any setting who currently pose a risk of suicide or self harm.

Things we know about risk in personality disorder:

- Patients with this diagnosis are at serious risk.
- Patients are more at risk of suicide and deliberate self harm if they have a:
  - history of previous suicide attempts or self harm.
    (The more numerous the past incidents, the more lethal/self-damaging these incidents have been, and the more recent the incidents, then the more elevated becomes the current risk.)
  - history of impulsive behaviour or antisocial behaviour.
  - concurrent drug or alcohol problem.

Key actions in relation to risk:

- An assessment of risk should be done on every occasion that the patient presents.
- Patients should be asked explicitly about risky behaviours and thoughts.
- The patient's own assessment of risk or stated intent should guide but not determine the risk assessment. (There is evidence that many patients underreport the extent of their self-harm, and underestimate the damage they may do to themselves.)

3.2 Risk should be classified as acute or chronic.

Acute risk – recent exacerbations in suicidal risk as a result of psychosocial stress or depressive illness are signalled by acute increases in risky behaviour or thinking.

Acute risk should be managed by:

- Awareness of events/signals that mark the onset of increased risk.
- Active treatment with increased contact, access to support and if necessary admission/home treatment.
- Every effort should be made to avoid detaining patients under the Mental Health Act but if necessary this step should be used.

- Brief admissions can be helpful and should not be regarded as a failure. They should be time-limited and their duration should be agreed in advance. They should have clearly specified aims.
- When contact is ended there should be a robust follow-up plan with an agreed next appointment date.
- Patients who have required admission twice in the past six months should have a full CPA review.

Chronic risk – persistent suicidal ideas or fantasies and persistent risky behaviours.

Chronic risk should be managed by:

- Strategies to reduce the risk of impulsive actions e.g. limiting doses of medication, taking control of all sources of prescribing. Psycho-education about self harm.
- Active treatment of Axis 1 conditions.
- Considering the institution of active treatment for borderline personality disorder.

3.3 Patients who currently present a risk to others.

Patients with personality disorders who present a risk to others can be divided into a number of groups that include:

1) Patients who have plans to physically harm or to materially deprive others.
2) Patients who are impulsively aggressive.
3) Patients who behave in ways that are reckless or selfish and likely to bring harm to others. (e.g. reckless driving)
4) Parents or carers who are neglectful of their specific responsibilities for vulnerable individuals and children.

Patients with personality disorder may seem more able to take responsibility for their actions and therefore may more appropriately be dealt with, if they offend, by the criminal justice system. Nevertheless, a detailed and accurate assessment of risk should be undertaken, repeated regularly and acted upon appropriately.
Staff should be aware of their duty to act in the public interest to prevent harm, but also of their duty of care towards the patient.

Senior or specialist advice should be sought where risk issues are prominent.

3.4 Patients who attend repeatedly.

Patients who present repeatedly in a range of settings or the same setting pose particular problems. Their behaviour represents an indication for referral to and advice from the specialist personality disorder service.

The mainstay of management is a flexible and practically deliverable crisis plan negotiated between all parties.

3.5 Personality disordered patients who abuse substances.

Personality disordered patients who abuse alcohol or drugs are at substantially increased risk of completed suicide. There are differences between this group and either patients with personality disorder alone or substance abuse alone. The pattern of drug and alcohol use is often characteristic. The use of alcohol tends to be in binges with periods of abstinence. The pattern of drug use tends to be one of multiple drug use. This group of patients often have Axis 1 conditions as well: including depression, psychosis and organic brain damage.

This group of patients warrants specialist treatment. The decision between using a drug and alcohol service based approach or specialist treatment for personality disorder should depend on patient preference and pragmatic considerations (e.g. service availability).

3.6 Patients presenting in any setting with acutely disturbed behaviour.

In very great measure personality disordered Patients become acutely disturbed for one of three reasons:

- Perceived rejection
- Rage
- Agitation.

Patients experience refusals to engage in contact as rejecting. They have little capacity to appreciate stresses or other demands on staff. They often have little capacity to tolerate delay. The resulting disturbance is not a manipulative attempt to gain contact but a distressed response to acute anxiety. Rage responses develop in relation to thwarting and also experiences of being really, or apparently, disrespected. In men, rage responses may result in violence; in women, they may result in self harm.

In relation to both rage and rejection the appropriate response is normally:

- Attend to safety issues for the patient and others.
- Use de-escalation techniques (offering a cup of tea, taking the patient outside for a walk).
- Make sustained, tolerant and unhurried enquiry as to the reasons for the behaviour.
- Acknowledge the patient's perspective on disputes and experienced slights.
- Explain the limits of what can be offered as limits to treatment rather than as appropriate treatment.

Agitation with severe suicidal ideation is a common experience. It may be unprovoked or in response to interpersonal blows. Unlike continuous low mood or agitation in depressed patients it may resolve rapidly in minutes only to flare up again unpredictably.

In relation to agitation the appropriate response is normally:

- sympathy.
- offers of distraction or exploration of other coping strategies.
- Consideration of the use of medication.
- Increased vigilance for suicide risk and consideration of a period of more intensive support and treatment (admission, increased vigilance for inpatients).
- Acknowledgement that the mood state may return unpredictably and willingness to offer further contact at that time.

3.7 Patients presenting in Accident and Emergency

Patients with personality disorder who present in A&E should be treated with courtesy and respect.

An appropriately qualified individual[5] should offer them all a psychosocial assessment.

Both past behaviour and stated intents should guide risk assessment but not predetermine it.

Patients who wish to leave casualty before they have been assessed may lack the capacity to appreciate how to act in their best interests as a result of intoxication, agitation or psychotic phenomena.

Patients who lack capacity should be detained and expert advice sought.

[5] As yet, it is uncertain who at A&E this should be.

PART B

4 Treating patients in the most appropriate location

Wherever patients present, and if active treatment is indicated, then it is important to decide where they will best be managed. The task is to match levels of clinical need to types of service provision

4.1 Deciding where to manage patients by degree of severity

1. Diagnostically "personality disorder" encompasses a (debatable) list of 9 or 10 different, discrete types of PD. A little more helpfully (but only just) this long list has been divided into three clusters, labelled: Cluster A – odd, eccentric, Cluster B – emotionally unstable, and Cluster C – anxious, dependent.
2. However, for planning service provision, more important than "type", is the **degree of severity of PD** with which a patient presents. Unfortunately there is no official single measure of severity[6]. In preparing the PD Care Pathways, it can be seen that the following considerations guide "which patients, where and what to do":
    i. Risk to self and others (particularly dependents) including additional risk factors e.g. drug and alcohol abuse and other co-morbid Axis I conditions.
    ii. Psychosocial impairment e.g. social isolation, poor social networks, lack of employment, unstructured chaotic unhealthy lifestyle.
    iii. Burden of service usage: duration, frequency, severity of crisis.
3. From these factors the grid below can be generated to give a rough mapping of **"which patients go where"**. Assuming that Burden correlates positively with Impairment (and to a lesser extent with Risk), the grid has the two dimensions of Risk and Impairment:

[6] There is a consensus among some experts that the number of different PDs with which a patient can be diagnosed represents a rough index of severity.

		IMPAIRMENT		
		High	Medium	Low
RISK	High	Complex Cases Service in partnership with current team.	Rehab. and Recovery with advice and support from CCS	Intake and Treatment or Rehab. and Recovery, with advice and support from CCS
	Medium	Secondary Care	Secondary Care	Primary Care Psychological Health Service (incorporating IAPT)
	Low	Secondary Care	Secondary Care	Primary Care: GPs

4.2 Case Examples

The following illustrative case examples give some idea of the sorts of patients who might be found in some of the categories.

I. Low Risk and Low Impairment presenting in primary care

Jenny began to cut herself in the context of college stresses, and this was a repeat of behaviour she had shown at school. She described feeling low and being confused by the difficulties and stresses of university life. She wasn't sure whether it was brilliant or rotten and found herself having difficulties fitting in. Jenny said she often felt like this in new situations and described herself as a moody person. She admitted reluctantly to binging on food sometimes but never made herself sick. When she attended her GP on a second occasion the self-harm behaviour had largely stopped and she reported being more in control. She had plans for the summer holidays.

II. Moderate Risk and Low Impairment – suitable for a brief intervention

Philip was picked-up by the police for being drunk and disorderly. He picked a fight with the arresting officer and ended up spending a little time in the police cells. But he had no other criminal record. In the cells he became anxious and said he was suicidal and so he was assessed. He admitted to regular drinking binges and also to smoking cannabis to calm himself down. He was discharged, but presented again a week later in casualty having taken a small overdose. He said he just wanted a break from feeling so bad and angry, and that he had been feeling increasingly suicidal of late. Philip said he had always had problems with his temper even at school. He also said he always felt like a misfit. Strikingly he was continuing to work most days helping his Uncle who was a painter and decorator.

III. Medium Risk and High Impairment – treating team with support from CCS

Paula was a longstanding patient of mental health services. She had a traumatic past history with both sexual and physical abuse. She was persistently auditory-hallucinated and frequently had suicidal thoughts and impulses. In the past she had deliberately self-harmed very regularly, but more recently these behaviours had moderated to a considerable extent. Paula's main problem was social isolation and difficulties with motivation. She tended to lead an isolated and restricted life going out as little as possible and spending a lot of time alone in her flat, which was often in a very poor and neglected state.

IV. High Risk and High impairment – CCS in partnership with treating team.

James had learning difficulties and sufficient emotional oddness to have lead to suggestions that he might have Asperger's Syndrome. He repeatedly and impulsively took serious overdoses when stressed. In one recent month he telephoned emergency services 30 times and attended casualty 6 times having taken overdoses of medication. James often had little apparent insight into the cause of his overdosing. Although he tended to panic having taken an overdose and ring for an ambulance, his overdoses were large and had, notwithstanding rapid treatment, been life threatening.

4.3 Referring and transferring patients.

I. The structure of services will inevitably mean that patients will need to move from one caregiver to another as they are routed towards the most appropriate service. Patients with personality disorders lack some of the capacities that we rely upon when we refer patients to other professionals:

- Patients with personality disorders often have poor frustration tolerance.
- They may have executive dysfunctions that impair their capacity to organise themselves to receive and attend appointments.
- And they almost always have problems with trust.
- They are sensitive to rejection even in situations that to others would not seem rejecting.

In order to be successfully referred:

- Patients have to believe that their situation will be dealt with and they will not be dropped, lost or forgotten.
- They need to be able to cope with a delay in getting help.
- They will need to be able to develop sufficient generalised trust in the system to believe that the next person who sees them will be helpful.
- They need to be able to get up in time for appointments and find their way to places in order to attend.
- They need to be able reliably to receive a letter or electronic communication.

It is worth bearing these points in mind when making referrals; and it is because of this range of possible difficulties that **non-attendance cannot be taken as a sign that there is nothing wrong or that the patient no longer wants help**.

II. Depending on the degree of impairment patients may need.

i. reassurance and support

ii. to see their new carer in the company of the old one

iii. assertive help to attend an appointment e.g. a phone call, someone to fetch them.

5. Assessment and management of patients with personality disorder within the Care Pathways

5.1 Primary care services[7]

5.1.1 The importance of recognising personality disorder

Recognising that someone has a personality disorder – either as a primary diagnosis or as co-morbid with an Axis 1 condition – has important implications for the safety of their future management. (Standard approaches for the treatment of individual symptoms of a personality disorder, or brief interventions targeted at co-morbid Axis 1 conditions, may well be ineffective and, indeed, run the risk of making the patient more unwell). Hence, early diagnosis and accurate assessment is essential.

5.1.2 Initial recognition

5.1.2.1 In Primary Care

In primary care, patients will be most often be suspected of, or recognised as, having a personality disorder by the signature of "repeated self-harm, persistent risk-taking behaviour or marked emotional instability" (NICE, June 2008). This signature should alert the primary care physician (or Gateway Worker) to the need for an accurate risk and needs-led assessment (see below, 5.1.3), with the goals of deciding:

I. If a personality disorder is present (as a primary or co-morbid condition)

II. If the degree of risk and level of impairment is such that the patient can appropriately be managed by the GP (i.e. low risk, low impairment) or within the Primary Care Psychological Health Service (incorporating IAPT) (i.e. low risk, low or medium impairment)

III. Or, if the patient should be referred to secondary services (or less frequently the tertiary service) for one or more of the following reasons:

[7] See also the leaflet for GPs: "Managing Borderline Personality Disorder in General Practice: useful rules of thumb"

i. clarification of the diagnosis is required

ii. expert advice/consultation on management in primary care is required

iii. management in secondary care needs consideration

- because levels of distress and/or risk of harm to self or others , although initially low, are clearly increasing
- because further help from specialist services is requested by the person
- because the patient's level of risk is prominent, and/or the personality disorder is co-morbid with an Axis 1 condition, and support from secondary care is clearly required

IV. (If the person is younger that 18 years old they should be referred to CAMHS for assessment and treatment)

5.1.2.2 Discovered at another point in the Care Pathway

On occasion, however, the personality disorder will only be discovered when the patient is already receiving treatment in the Primary Care Psychological Health Service, or another care pathway. Whenever the patient is suspected of, or recognised as, having a personality disorder, the current intervention (or care plan) should be immediately reviewed and an accurate risk and needs-led assessment should be undertaken.

5.1.3 Initial accurate risk and needs-led assessment of personality disorder

Initial assessment should always gather information about the following:

- Duration of psychological difficulty and nature of onset of first difficulty.
- Recurrent pattern of psychological difficulty
- Quality and timing of best level of psychological functioning
- Quality and timing of worst level of psychological functioning
- Current life circumstances and psychosocial adaptation.
- Current level of risk to self and others
- Past levels of risk to self and others.

5.1.4 If the diagnosis of PD has already been established

5.1.4.1 Crisis management of patients appropriately held by the primary care physician

Patients with low or medium risk and low impairment experience some difficulties in self-management and life adaptation but can live stably and without undue recourse to mental health services. They tend to present when in crisis: often as a result of a life crisis such as bereavement or major interpersonal difficulties.

NICE guidance advises the primary care physician to:

- Assess the current level of risk
- Enquire about previous similar episodes and successful management strategies used in the past
- Help to manage the person's anxiety by enhancing coping skills and helping them to focus upon the current problems
- Encourage the person to identify manageable changes that will enable them to deal with the current problems
- Offer a follow-up appointment at a time agreed with the person.
- (To this list we would add that the GP (or Gateway Worker) should be able to advise the patient of their diagnosis and offer relevant literature and direction to service user groups.)

However, the patient should be considered for referral to the Primary Care Psychological Health Service when:

i. Levels of distress and/or risk of harm to self or others are increasing

ii. Levels of distress and/or risk have not subsided despite attempts to reduce anxiety and improve coping

iii. Further help from a specialist worker is requested by the person.

5.1.4.2 Management of patients held by the primary care physician who present with a new episode of a co-morbid Axis 1 condition.

Patients presenting with mild to moderate personality disorder may also present on occasion with episodes of Axis 1 conditions, for example, depression, anxiety, OCD.

Managing these patients in general involves:

i. Diagnosing the Axis 1 condition

ii. Assessing risk to self and others, and where risk is prominent referring for more specialist assessment and treatment.

iii. Assessing the patient's needs and current level of impairment and, where this has increased or when the patient requests specialist referral, consider referral for more specialist assessment and treatment.

5.1.5 Treatment options in primary care (including the IAPT)

Patients with low or medium risk and low impairment, with a new or established diagnosis of personality disorder, whose condition is deteriorating or who are presenting with a new episode of an Axis 1 condition may be considered for treatment options, still within primary care.

5.1.5.1 General considerations

I. Patients who present with personality issues in primary care may *not* respond well to *brief* interventions targeted at their Axis 1 condition.

II. All patients with evidence of a Cluster B or Cluster C personality disorder should be discussed with a senior supervisor before initiating treatment.

III. Patients with Cluster C personality disorder should be considered for treatment at a higher level of intensity earlier in the stepped care process.

5.1.5.2 Cluster B personality disorder

Patients with cluster B personality disorder should be considered for one of the following interventions.

i. **Expert review of management plan.**

   This should be sought whenever serious issues of current risk present and if the patient's level of adaptation has markedly declined. Expert review should explicitly consider the best location for future management of the patient.

ii. **Psycho-educational and crisis planning package in Primary Care Psychological Health Service (incorporating IAPT)**[8]

   This should be offered to patients with few problems of risk whose chief complaint is mood variability, personal and interpersonal instability and chronic anhedonia. (Appendix 1 contains a structured package to guide this intervention)

iii. **CBT for presenting condition.**

   In some cases it may be possible to offer a specific program of treatment for a specific symptom, particularly if this symptom is not centrally related to issues of identity and the current level of the patient's functioning is good. Examples of such conditions include specific phobias and some cases of agoraphobia. But, such treatment should only be undertaken in the context of a full risk management and care plan and with appropriate supervision. If self-harm or risky behaviour re-emerges in the course of the therapy then advice should be sought and the termination of therapy should be considered.

iv. **No active treatment.**

   Patients who are currently functioning substantially better than their worst ever level of functioning but who are currently presenting with a new mental health problem and who also satisfy criteria for a Cluster B personality disorder may be seriously destabilised by individual psychotherapy. In such a case patients need to make informed decisions about the potential risks as well as the benefits of further treatment. Explaining to the patient that they might damage their current level of adaptation by undertaking active treatment may be an important intervention.

[8] Currently (June '09) this option is about to be piloted.

5.2 Intake and Treatment Teams

5.2.1 Criteria

Intake and Treatment Teams should be responsible for the routine assessment, treatment and management of people with personality disorder who present for the first time, and for many patients with enduring personality difficulties who re-present when their condition relapses into a more severe state.

Patients with personality disorders who are likely to be suitable for this pathway will be those whose personality difficulties, while recurrent and troubling, do not pose repeated anxieties about life-threatening risk or who have significant psychosocial impairment such that would benefit from long-term involvement. Patients in this group may have chronic problems deriving from their personality difficulties, but ones that are normally relatively well controlled in primary care. Their referral will normally be in response to an acute exacerbation of their condition.

5.2.2 Assessment

The first steps in managing the patient will involve.

I. Diagnosis of the personality disorder and any Axis 1 condition

II. Assessment of risk to self and others (including dependent children), and identifying which elements of risk are acute and which are more chronic risks. Teams should take particular care to identify events which may have caused exacerbations of chronic risk into a more acute state.

    Most particularly in patients who are known to services, risk should not be assumed to have remained static even in a very brief interval between presentations.

    Where risk is prominent, specialist advice should be sought.

III. Assessment of the patient's needs and current level of impairment.

Comprehensive assessment should draw information from a range of sources including the patient, their medical record, carers and relatives and other agencies involved with the patient.

IV. Assessment should then inform a comprehensive care plan (within the context of CPA), which should:

i. Clearly identify roles and responsibilities of all health and social care professionals.

ii. Identify short-term treatment aims and specify steps that the person and others may take in order to achieve them.

iii. Identify long-term treatment goals that are realistic and linked to short term treatment strategies.

iv. Include a crisis plan, which refers both to self-management strategies and support in and out of hours when self-management is insufficient.

5.2.3 Management

I. Key NICE Guidance

i. Treatment of Axis 1 conditions should not be carried out in isolation but in the setting of a management plan which addresses personality issues.

ii. Drug treatment directly aimed at the personality disorder itself is not indicated.

iii. Sleeping tablets should be avoided in this group of patients as they tend to become drugs of dependence.

II. Appropriate treatment plans within the Intake and Treatment pathway could include.

i. Psycho-educational and crisis planning package.

This should be offered to patients with few problems of risk and whose chief complaint is mood variability, personal and interpersonal instability and chronic anhedonia. (The Appendix contains a structured package to guide this intervention. This could be undertaken by the Care Coordinator.)

ii. Supportive input and problem solving in relation to life crises/novel symptoms.

This should be offered to patients with personality disorder who have become unwell in the context of new adversity or who, having been well, have now relapsed into a symptomatic pattern, e.g. of social isolation, alcohol or drug use

or recurrent self harm. Input should involve as many members of the multidisciplinary team as needed.

iii. Structured program of treatment

This should be aimed at helping to resolve some aspects of the underlying personality difficulties and should be conducted using an evidence based therapy such as CAT, MBT or DBT. But such treatment should only be undertaken in the context of a full risk management and care plan and with appropriate supervision. If self-harm or risky behaviour re-emerges in the course of the therapy then advice should be sought and the termination of therapy should be considered.

iv. Management in collaboration with Complex Cases Service.

This should be offered to patients where risk is high or where service usage is fragmented, chaotic or unduly burdensome. Patients in this group will be causing their health workers and carers substantial levels of emotional stress and anxiety. The management of these patients is discussed below (see 5.4).

5.2.4 Discharge

From the outset, ensure that patients are informed of the approximate length of their time in Intake and Treatment, then:

I. Discharge from secondary care to primary care, should be discussed several months in advance with the person, and wherever possible, with their carers.

II. Discharge should not coincide with other losses.

III. Preparation for discharge would include development of an agreed care plan. It should specify:

   i. the steps the patient can take to try to manage their distress

   ii. how the patient can cope with future crises

   iii. how the patient can re-engage with community mental health services if needed.

IV. This care plan should be communicated to the primary care clinician

5.3 Rehabilitation and Recovery Teams

5.3.1 Criteria

Teams in this pathway will be responsible for managing many of the more chronically unwell patients with personality disorder. Many will have co-morbid conditions which further impair their functioning and which make continuing psychiatric input and support in the longer term an important part of maintaining and developing functioning. However, patients in this group will not present a current acute, severe management problem.

5.3.2 Assessment.

I. Comprehensive needs lead assessment of patients

II. Accurate and regularly updated assessment of risk.

5.3.3 Management

Management should involve a complete psychosocial package and its aims should be:

I. Collaborative construction and regular review of a comprehensive care program which embodies the principles of recovery and of matching response to fluctuating need and capacity.

II. Stabilisation of crises and accurate management of risk, set within a comprehensive management plan that addresses the underlying personality disorder.

III. Long-term involvement of the patient with a committed, empowered mental health professional (backed up by a team), with the aims of minimising harm and psychosocial damage from crisis events, and of promoting recovery.

5.3.4 Referral/resolution

I. Decisions about ending involvement with the team should embody a commitment to the patient that endures, yet also promotes self reliance and minimises harmful dependency.

II. In some cases, referral back to primary care with appropriate information to the patient and primary care physician: to include information about the diagnosis and sources of support.

III. Referral to, or shared care with, the Complex Cases Service where patients meet the criteria for this service. (See below: **5.4.1**)

5.4 Personality Disorder Services Pathway – Tertiary Care / Complex Cases Service

5.4.1 Criteria

This Trust-wide team – CCS(North) in Peterborough and CCS(South) in Cambridge - will be responsible for managing the most risky and severely unwell patients with personality disorder. Its priority will be to manage patients who would formerly have required out-of-area placement or who have complex, multifaceted difficulties such that secondary mental health care teams would have difficulties managing them. Patients who present a current acute severe management problem should also be under the care of this team. Patients may come from a wide range of sources.

5.4.2 Assessment

I. Diagnostic assessment and formulation of complex cases.

II. Comprehensive needs lead assessment of patients.

III. Accurate and regularly updated assessment of risk.

The assessment will then be reviewed at an initial Case Conference where a treatment plan will be set out for the patient.

5.4.3 Management

5.4.3.1 Principles

Patients are offered a range of interventions depending on their specific needs. The key principles of management are:

i. Rapid acute support at times of life crisis to prevent more serious disasters unfolding.

ii. Collaborative construction and regular review of a comprehensive care program which embodies the principles of recovery and matches response to fluctuating need and capacity.

iii. Stabilisation of symptomatic behaviour and accurate management of risk set within a comprehensive management plan that addresses the underlying personality disorder where possible.

iv. Long term involvement of the patient with a team of committed, empowered mental health professionals with the aims of minimising harm and psychosocial damage from crisis events, and promoting recovery.

5.4.3.2 Treatment options.

All patients regardless of status are offered.

i. A daily "Open Clinic" where they can attend or telephone or email without appointment and be offered brief crisis support and advice.

ii. "Lifeworks" – a comprehensive, structured program of 'ordinary' activities focused on rehabilitation and recovery: user lead but supported by professionals with particular understanding of personality disorder.

Patients are entitled to use these two aspects of the service at any time after acceptance, and this right is only lost when they choose to give it up.

A subgroup of patients are offered further input which will include:

iii. Case Management

Patients have a team member within Complex Cases who meets with them regularly, with a focus on problem solving and symptom control. The style of approach is assertive, with active engagement to promote attachment. The case manager retains an overview of the case from a specialist perspective. In some cases the case manager will also be the care coordinator.

And, some case-managed patients may also be offered

iv. Specific psychotherapy - one or more of a range of specific therapeutic elements:

Group(s) focussed on:

- stopping self harming
- promoting compassionate self regard
- improving current life circumstances and planning for the future
- art therapy

- music therapy

Individual psychotherapy: brief or longer term.

v. Care Coordination.

Normally care coordination will remain with the secondary care mental health services when they are providing aspects of the patient's care that cannot be resourced from within Complex Cases Service (e.g. CPN support, social work input).

5.4.4 Referral/resolution

I. Decisions about ending involvement with the team should embody a commitment to the patient that endures, yet also promotes self reliance and minimises harmful dependency.

II. In some cases, referral back to primary care with appropriate information to patient and primary care physician: to include information about the diagnosis and sources of support.

III. In other cases, referral back to secondary mental health services once involvement has achieved the maximum in terms of risk management presently possible

IV. In all cases an open-ended option for involvement in a supported user movement and psychosocial group setting and crisis support, i.e. "Lifeworks" and "Open Clinic"

5.4.5 Relationship with inpatient wards

Currently personality disorder patients who may require admission are managed initially by the Crisis Resolution and Home Treatment Teams and then by the inpatient ward if admission is deemed necessary.

6. Training and ongoing support to teams. Access to services in rural areas.

6.1 Introduction

The preceding clinical guidelines clearly have implications for the provision of specialist PD training and supervision within the Trust:

- Given that a diagnosis of personality disorder cannot be an exclusion criterion in any Care Pathway, *all* teams need to enhance their existing skills – or gain new skills – in the recognition and management of patients with personality disorder. (The assessment and management of chronic and acute risk is a particular priority.)
- Regular supervision of individual clinicians and of teams is of equal importance to ensure the safety of both patients and staff.

NICE guidance suggests that the specialist services carry the responsibility of ensuring the provision of training and of supervision.

Additionally, specialist services should have responsibility for the oversight of the delivery of services to all patients with personality disorder. The specialist team should:

- "Develop systems of communication and protocols for information sharing among different parts of mental health services for people with borderline personality disorder, including forensic services."
- "Ensure that clear lines of communication between primary and secondary care are established and maintained."
- "Oversee the implementation of NICE guidance."

These expectations will be met be met by the Complex Cases Service, not only in and around the urban centres of Peterborough and Cambridge, but also across the rural areas of Fenland and Huntingdon.

6.2 Models of Training and work allocation for non-specialist teams.

Training is a key function of the specialist service. Training can be provided to whole teams or to specialist "PD Team Links" within the team. The PD Link model is the preferred model of training as it provides opportunities to cascade training to more staff and to provide continuing supervision and support to trained staff. This model also provides a solution to the problems of widening access to rural areas.

The PD Team Links develop expertise in assessment and management of personality-disordered patients within teams, and take specialist responsibility for promoting good practice in the team.

A significant advantage of employing a model of PD Team Links is that a more thorough and intensive training can be delivered to a smaller staff group – rather than whole-team training. A group of staff covering the different Care Pathways, who were trained and supported as a group, are well placed to begin addressing the practical issues and of problems of communication and information sharing between teams.

6.3 Providing access to rural areas.

Specialist services have to tackle the geographical difficulties of a large trust with big rural areas as well as two large towns. Patients cannot all travel to the two town based centres. To deal with this we suggest a model that combines the concept of link-working, PD champions and electronic access.

In areas where patients could not realistically travel to a town based centre we suggest that the specialist service have a Link Worker whose task is to:

I. Develop skills within secondary care by training up PD champions.

II. Treat specific patients and provide them with access to aspects of the service provided by the town-based centres based on a mix of some travel and some electronic access.

III. Develop local user groups and socio-therapy initiatives, perhaps in partnership with Third Sector agencies.

PART C

7. Guidelines for Other Care Pathways

7.1 Crisis Resolution and Home Treatment Teams.

7.1.1 Understanding Crises in Borderline patients.

Crises that erupt in the lives of personality-disordered patients often have interpersonal precipitants; and in some patients are associated with substance or alcohol abuse. Patients in crisis are frequently aroused and can be demanding; some may even appear manipulative in seeking certain outcomes. However, **it is crucial to appreciate that their behaviour is then being driven by an internal experience of desperation** in the context of extreme beliefs about their few (if any) options.

Overt angry counter-responses are of course inappropriate; but staff must also be self-aware as patients are extremely able in detecting concealed anger. Likewise, it is important to appreciate the extent to which the response of the system may (inadvertently) involve counter-manipulation, driven by constraints or considerations that are external to the patient (for example lack of resources).

7.1.2 The key principles of managing a crisis are:

I. Calm concern and repeated attempts to get close to the patient's mind and to hear about their inner experience and worries.

II. Where at all possible, assessment and initial contact from someone known to the patient and in whom they trust.

III. Careful and situation-specific assessment of risk: both short-term and long-term risks.

IV. Maintaining an emphasis on self-help, home treatment and low intervention strategies while conveying that, if these fail, help is available and will be offered, up to and including admission to hospital.

V. Consulting and using agreed crisis plans, but applying these flexibly

VI. Take time over the whole business. Often allowing time to pass will help the patient change from an agitated and worked-up state into a calmer and more reflective one. This puts a major premium on an unhurried approach.

VII. If further treatment is not immediately needed, then it is crucial to ensure, then and there, that clear and definite plans are made for a follow-up appointment.

7.1.3 Subsequent management

Patients in crisis may appropriately be subsequently managed in a number of ways.

I. Crisis support followed by referral into an appropriate mental health pathway or return to treating team if they are already in treatment.

In general new patients presenting in crisis should be offered more than a one-off assessment; and it will be appropriate for there to be some form of later follow up. Known patients should be returned to their treating team where a review of the crisis plans should be undertaken with the patient and any appropriate alterations made.

II. A brief period of intensive support from a crisis intervention service.

Some patients will benefit from a brief focused intervention in times of severe stress. This can include taking control briefly of the patient's medication if they are at risk or a piece of work with their carer(s).

III. Admission to hospital (see below: **7.2**)

Patients in crisis do end their lives. Often there are many more cries of "wolf" than there are severe suicide attempts. Notwithstanding, patients with personality disorder are at serious risk of suicide, and hospital admission can be an intervention which reduces the risk. Treating chronic risk with admission to hospital is rarely beneficial and may result in unhelpful dependency. However when there are severe acute exacerbations of risk, well-managed hospital admission can be beneficial and keep the patient safe.

7.2 Inpatient Services

7.2.1 General principles for managing inpatients with personality disorder

I. Appropriate inpatient admissions.

Patients with personality disorders do not need routine admission to hospital and, in general, the benefits of inpatient treatment need to be set against some serious drawbacks. Patients who display prominent suicidal agitation with unpredictable behaviour may need to be admitted to hospital until the crisis passes.

II. A core function of admission is safety and support. A second function can be offering patients help in learning how to manage states of acute agitation.

III. Managing dependency and the risks of admission.

Admissions should be as brief as is consistent with the functions of the admission.

IV. Admissions should be informal: detaining patients using a section of the mental health act should be considered only as a last resort.

V. Admissions should be local.

VI. During the admission patients should be encouraged to take as much responsibility for their own safety as possible. But great care should be taken to ensure that this encouragement is not read as dismissal and abandonment by the patient.

7.2.2 Special topics in relation to inpatient care

I. Intensive nursing observations ("specialing")

This is appropriate for the management of some cases of agitation and suicidal ideation. Although for some patients it can be experienced as profoundly reassuring, others find it intrusive and distressing.

i. its use should be explicitly discussed with the patient

ii. increases and decreases in the level of observation should be assessed very regularly (two or three times a day). In contrast with psychotic or depressed patients where the pattern of observations is, in general, a steady progress from intensive to minimal, in patients with personality disorder who require "specialing", the level of observation should be expected to fluctuate.

iii. Observations should be as “natural” and as integrated into the life of the ward as possible.

iv. With selected patients consideration should be given to allowing them to set their own level of nursing observation.

II. Disturbed behaviour and contracts.

Patients with serious borderline personality disorder do not have the capacity to make and keep promises or, when aroused, to envisage the future consequences of their actions. They do not, when aroused, respond well to offers of delayed gratification because these are not real to them. These features limit the value of contracts.

III. The patient who wants to leave or to discharge themselves from the ward or unit.

i. Leaving after a short admission may be appropriate.

ii. If the patient is well enough to go home and not a risk to themselves or others it is appropriate to:

- Explore the reason for wanting to leave particularly considering issues of perceived rejection during the time on the ward.
- Support the patient in feeling better enough to go home if this is genuinely the case and enquire about future plans/immediate support.
- For a new patient with a personality disorder, take time to offer psycho-education about the condition with access to literature and user groups.
- Offer follow-up and support.

iii. Some patients wish to leave because they have suicidal plans or rarely because they have plans to harm others:

- All patients should be asked directly about suicide and self harm plans as well as plans to harm others.
- Risk should be carefully and repeatedly assessed.
- If the patient is not detainable, risks should be explicitly discussed with the patient and their carer(s), and the patient encouraged to remain on the ward.
- High acute risk patients who are adamant they wish to leave should be detained.

7.3 Child and Adolescent Mental Health Teams

The NICE guidance recognises the existence of personality disorders in young people and recommends that these are managed within CAMH teams.

The principles of management should be the same as for adult patients with personality disorders but particular care should be taken in relation to

- Considering the appropriate way to involve carers
- Being mindful of the provisions of the Children's Act

A critical moment in the treatment of these conditions comes at the point when transfer to adult services is needed.

- Transfer should be to the most appropriate adult service based on assessment of risk and severity.
- Adult and CAMHS should work closely together to achieve a smooth transfer.
- The needs of the patient should be paramount in the timing of the transfer rather than applying an arbitrary cut off related to chronological age.

7.4 Learning Disabilities Teams

People with borderline personality disorder and learning disabilities

- Adults with mild or moderate learning disability should be treated within the mainstream service that matches their level of risk and the severity of their condition considered as a whole.
- They should usually be managed using the CPA and consideration should be given to involving a specialist in learning disabilities when developing care plans.
- People with a severe learning disability should not normally be diagnosed with borderline personality disorder, but where they have behaviour and symptoms suggestive of borderline personality disorder they should be referred to a specialist in learning disabilities for assessment and treatment.

APPENDIX

A Brief Psycho-educational intervention for Cluster B personality disorder.

Introduction

The object of the intervention is to increase the patient's knowledge about personality difficulties and to help them take simple steps that may improve their level of functioning. Each session is prescribed in some detail. The therapist should attempt as best as possible to adhere to the agenda for each session while also allowing the patient to air their own issues to a certain extent.

Principles of management

In all the sessions four principles of management apply:

I. In advance, having a plan for a crisis.

Make sure that you and the patient both know what to do in the event of a crisis or sudden disaster. Likewise, ensure that the person responsible for taking action and 'picking up the bits' also knows that that is their role.

II. Active management of strong feeling

Actively manage strong feeling in sessions. Express sympathy and support and allow a certain amount of ventilation, but also use gentle methods of moving the patient back to a calmer frame of mind. During expressions of very strong feeling (affect storms) stay calm yourself and wait, doing very little other than reflecting and sympathising with the difficulties. Note if the patient is becoming more or less vehement. If the patient is calming down slowly then wait until this has happened before starting any new part of the session. If the patient is becoming more distressed then suggest various things e.g. time out from the session (for example for a cigarette) or offer a token of support such as a glass of water or a cup of tea. If the patient still becomes more distressed, end the session gently and if necessary call for help.

III. Flexible but persistent pursuit of objectives.

Patients with Cluster B personality disorders have very variable moods and attitudes. They find task persistence difficult and may present very differently from session to session. In this brief intervention the therapist needs to be responsive to the different states that the patient presents from session to session or within sessions. Nevertheless, the therapist needs to keep the session's objectives in mind and deliver them as best as possible.

IV. Boundaries and Supervision

Patients with personality disorder have a tendency over time to enact unhelpful patterns of behaviour with others with whom they are in close contact. Even in this brief psycho-educational intervention this may begin to happen. Note particularly any strong positive or negative feelings that the patient evokes or violations (sometimes quite subtle) of therapeutic boundaries, and take these to you supervision for discussion. Keep notes of each session, recording the content of the session and behaviour of the patient.

Session Timetable

Session 1: Hearing the story.

Objectives

1) Induct patient into the treatment plan.
2) To gain a narrative understanding of the patient's story and difficulties, getting as good as possible a sense of the way the patient sees them.
3) To give the patient feedback on their story showing them how aspects of the story are consistent with their personality difficulties, and floating the diagnosis of personality disorder.
4) To begin to detoxify the diagnostic label by showing acceptance that the patient's difficulties are real and troubling. Expect and acknowledge that such acceptance may not always have been the patient's past experience of interactions with staff.

Strategies.

- Tell patient the treatment plan and give leaflet.
- Ask open-ended questions.
- Non-judgemental curiosity.
- Following affective threads.
- Pacing feedback to the patient's reaction.
- Giving direct information/explanation about Cluster B personality disorders.
- Acknowledging and accepting previous experiences of poor care.

Session 2: Explaining the condition.

Objectives

1) To give the patient basic information about the condition and to explore the ways in which the condition manifests in the patient's life and story.
2) To help the patient understand repetitive patterns in their life and their current difficulties as related to the diagnosis of personality disorder.
3) To give the patient access to appropriate sources of further information about the condition. The choice of such information will depend upon the patient's level of educational attainment, their access to information sources, and their wish for information.

Strategies.

- Providing verbal and written information about personality disorder.
- Fitting or 'personalising' this information to the patient's particular experience.

- Pointing out repeating patterns in the patient's life and asking the patient if they can give examples of other patterns.
- Linking repeated difficulty to the features of personality disorder.

Session 3: Awareness of risk and self-harm

Objectives

1) To explore with the patient any and all risky or self-harming/self-destructive behaviours they may use to help them cope.
2) To help the patient see that these activities might be helpful in the short term but may also have long-term ill effects.
3) Selecting only one or two behaviours and using a 'minimax' strategy (minimum effort to change for maximum gain if change is achieved) to explore possible ways of changing behaviour.

Strategies

- Persistent systematic (but gentle) enquiry into all areas of risk, self-neglect and self-harm.
- Exploration of the reason for these behaviours, including acknowledgement of their utility in managing mood states.
- Exploration with the patient of the consequences of these behaviours on themselves, their relationships and other people.
- Identification of the most harmful and worrying behaviours, and of previous effective efforts the patient has made to change behaviour.
- Identify things that worked and things that didn't work to change the behaviours.
- Exploration of one or two strategies for behaviour change in areas where the patient would get a lot out of achieving the change.

Session 4: Leading an ordered life.

Objectives

1) To give the patient an awareness of basic mental health promoting activities which may benefit them in coping with the condition.
2) Helping the patient to appreciate that their condition makes certain kinds of lifestyle particularly likely to be both tempting and risky.
3) Selecting only one or two new activities, and using a minimax strategy (minimum effort to change for maximum gain if change is achieved) to explore possible ways of changing behaviour.

Strategies

- Giving information about the way in which borderline personality disorder imposes a need to lead a consciously well-ordered life.
- Careful delineation of current lifestyle: sleep, eating, exercise, leisure, work.
- Exploration of how lifestyle choices interact with illness to improve or worsen it.
- Selection of one or two changes in lifestyle that might be particularly beneficial and reasonably easy to make.

Session 5: When it all goes pear-shaped

Objectives

1) Helping the patient take a compassionate (but accurate) view of major illness driven disasters in life, and helping the patient acknowledge that these may occur again.
2) Identifying risk factors for major disaster, and warning signs of impending catastrophe
3) Exploring a range of strategies for dealing with catastrophic situations, and creating a personal crisis plan.

Strategies.

- Review of bad times and sudden crises.
- Search for early warning signs and moments when alternative strategies could be used.
- Exploration of the aftermath of crises: helpful and unhelpful things the patient did then or others did to the patient
- Realistic exploration of barriers to implementing strategies for self help and getting help from others.
- Explanation of the “Odysseus strategy” (Odysseus tied himself to the mast so he could hear the song of the sirens. The idea, therefore, of identifying situations where retreat from life and self imposed brief withdrawal might be the only option)
- Joint construction of a tentative personal crisis plan

After Session 5, in preparation for Session 6, write a “Goodbye” letter that summarises what has been achieved - brief formulation, coping strategies, crisis management plan – and what the patient might profitably do in the future.

Session 6: Saying goodbye

Objectives.

1) Acknowledging that the intervention has been minimal and that the patient will need to do much more work on his or her own. Allowing and accepting the strong feelings that this solitary task may evoke.
2) Reviewing significant strengths that the therapy has revealed in the patient which may be helpful in the future
3) Reviewing the crisis plan and exploring how it might be used in the future.
4) Delivery of a caring but clear-sighted “Goodbye” letter.

Strategies.

- Exploration of feelings about this being the last session.
- Acknowledging the lifelong nature of the difficulties.
- Discussion of any new learning, ideas, behaviours that the therapy has provoked
- Exploration of ways to continue these when encouragement from the therapist is not present
- Linking with User groups encouraged.
- Review of crisis plan and anticipation of how it might be used.
- A “goodbye” letter addressed to the patient that is also copied to the GP.