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Treatment guidelines for personality disorders

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Abstract

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PROJECT AIR
A PERSONALITY DISORDERS STRATEGY

Treatment Guidelines for Personality Disorders

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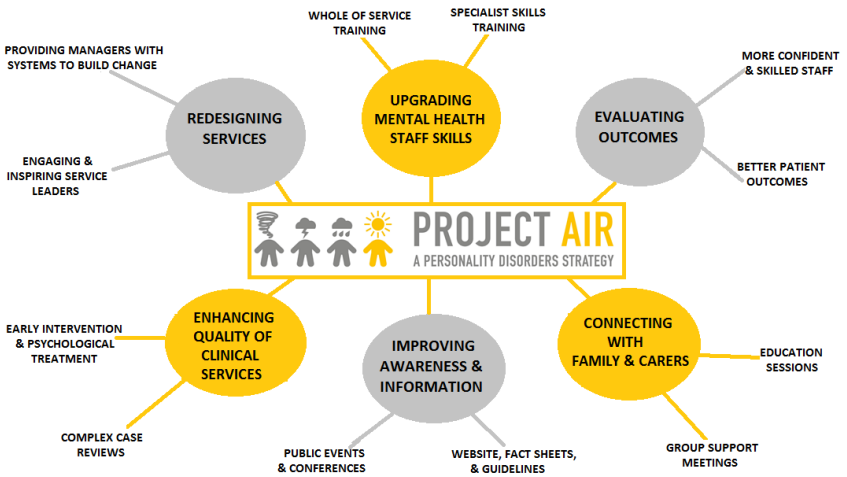
Introduction to the Guidelines

These treatment guidelines are organised according to a typical sequence of a whole of service experience: from a presentation in crisis to a hospital emergency department, through to long-term treatments. Along the way, it presents guidelines for good practice in assessment, brief interventions, care planning, involving family members and carers[1], and ongoing community treatment.

These Australian treatment guidelines have been developed by the Project Air Strategy for Personality Disorders.

The Project Air Strategy seeks to improve the capacity of mainstream mental health services to manage and treat personality disorder and to expand specialist treatment options, including improved referral pathways between generic and specialist treatment. The project delivers education and supervision programs in addition to the provision of expert interventions. It also evaluates specialist intervention models to provide guidance for future service development.

The Project Air Strategy for Personality Disorders developed an innovative model based on 6 key strategies. This is the first project in the world to have developed a whole of service approach to the treatment of personality disorder. The 6 key components of the model developed by the Project Air Strategy team are: Strategy A. Redesigning services; Strategy B. Upgrading mental health staff skills; Strategy C. Evaluating outcomes; Strategy D. Connecting with families, carers and consumers; Strategy E. Improving awareness and information; Strategy F. Enhancing quality of clinical services. The 6 strategies and the 12 specific components are shown in the following figure.



[1] The term carer will be used throughout the remainder of this document to broadly refer to the client's legal guardians, parents, family members, cultural elders, mentors, partners, spouses, friends or their main support person.

The Relational Model of Treatment

This set of treatment guidelines has been developed to assist health services provide improved strategies for people with personality disorders. These guidelines apply to all age and specific groups. The full range of treatment options are recommended to be made available to all people with personality disorders within their appropriate treatment facilities where possible. These guidelines are based upon a systematic review and analysis of existing guidelines, latest research findings, and the views of expert consultants and an advisory group. They have been further developed and tested through implementation in the actual day to day practice of a large health service.

The following guidelines are based on a relational treatment model proposed by the project. This model advocates an integrative collaborative approach to the treatment of personality disorders. It focuses not only the person with personality disorder but also supports carers, health services and clinicians. The integrative and collaborative model is developed and implemented on these principles:

- Treatment of people with personality disorders works when it is collaborative, based in multi-disciplinary teams, and is well integrated between individual clinicians and services (such as public services, private, non-government, general medical practitioners and physician services, mental health, drug and alcohol, human and community services, justice, housing, and police)
- It is essential that a common shared treatment model is understood by the person with personality disorder, clinicians, carers and all others involved in the person's treatment
- Policies around admission to hospital and referral pathways need to be clear and consistent, with assertive follow-up and defined treatment teams trained in managing complex high risk people
- Support and clinical supervision of clinicians is an essential and integral part of evidence-based treatment for personality disorders
- Treatment works best when people with personality disorders are actively involved in the development of their Care Plan, based on their identified needs and goals
- A personality disorders-friendly health service gives hope to people with personality disorders, their carers and clinicians about the efficacy of treatment
- Clinicians who have the interest and skill should be provided with evidence-based therapy training (e.g. individual, group and family) and have the support of a team so they are not isolated.

In the relational treatment model, the person's problems are seen as stemming from problematic and dysfunctional relationship patterns that have developed over time. These relationship patterns are considered both intrapersonal (how the person relates to themself, including their feelings and thoughts) and interpersonal (how they relate to others). The treatment aims to help the person understand and modify any unhelpful relationship patterns in order to more effectively get their needs met. The analysis of unhelpful relationship patterns proceeds on a number of levels:

a) The analysis of individual relationship narratives told in treatment (e.g. a narrative about a relationship breakup)
b) The aggregation of relationship narratives told to formulate core relationship themes (e.g. multiple narratives about relationship breakups, abandonment and separation experiences)
c) The relationship between the clinician and the person reflects the person's habitual relationship themes and is used to recognise them and then to disconfirm and repair them (e.g. concerns about trusting the health service and the clinician to provide help). This addresses previous client experiences of rejection, abuse, neglect and trauma, and the stigma associated with obtaining help.

This relational model assists clinicians to understand their clients' feelings of unfulfilled relationship needs, and the anger and self-destructiveness resulting from the continued failure to find someone to meet these needs.

A combination of genetic inheritance and life experience is expressed as a more pronounced interpersonal hypersensitivity. As such, people with personality disorders may be quicker to be critical of either themselves or others or both. In response, carers and health services need to develop an active, engaged and tolerant approach. The clinician should always strive to maintain empathy and compassion. The clinician therefore needs to possess a level of comfort with the spectrum of interpersonal challenges that can be presented in the context of the helping relationship. These can include neediness, aggression, hypersensitivity, ambivalence and acts of self-destructiveness. Within this treatment model, clinicians are less reactive to crises, avoid being over-sympathetic, and can handle and defuse aggression appropriately.

The model advocates that services and clinicians develop confidence around tolerating and working positively with chronic risk taking or parasuicidal behaviours. Self-harm and chronic suicidal thinking must be understood and tolerated to facilitate improvements. Multiple safe options that promote growth and development should be explored. These issues need careful thought, consultation with suitably experienced staff, and clear documentation.

The model advocates flexibility in the kinds of services offered. Because it is normal for people with personality disorders to have interruptions in treatment, both short and longer courses of treatment can be offered.

People with personality disorder are particularly sensitive to how others respond to them and have frequently reported prior negative experiences in relationships with health professionals. For this reason, the provision of treatment and care requires a high level of communication, education and support. The following key principles may assist:

Key Principles for Working with People with Personality Disorders

- Be **compassionate**
- Demonstrate **empathy**
- **Listen** to the person's current experience
- **Validate** the person's current emotional state
- **Take the person's experience seriously,** noting verbal and non-verbal communications
- Maintain a **non-judgemental** approach
- Stay **calm**
- Remain **respectful**
- Remain **caring**
- Engage in **open communication**
- **Be human** and be prepared to acknowledge both the serious and funny side of life where appropriate
- Foster **trust** to allow strong emotions to be freely expressed
- Be **clear, consistent,** and **reliable**
- Remember aspects of challenging behaviours have **survival value** given past experiences
- Convey **encouragement** and **hope** about their capacity for change while validating their current emotional experience

Adopting and maintaining these key principles throughout involvement with the person helps to engage them in treatment and fosters a belief that a valuable and beneficial service is on offer. Maintaining such an approach can be challenging and requires considerable skill. Therefore, reflective practice, self-awareness (e.g. knowledge of strong or negative feelings the person may evoke), and clinical supervision and consultation are recommended.

Guidelines for Working with People in Crisis and Conducting a Risk Assessment

Working with people with personality disorders can be challenging, particularly during a crisis. When a person presents in crisis they are generally at their worst - symptoms are at their most extreme and risk-taking and suicidal behaviours are evident. If self-harm and suicidal behaviours are not appropriately responded to, these behaviours can become more dangerous. However, paying too much attention to these behaviours may inadvertently reinforce self-destructive behaviours. Focus on finding a balance between attending to the self-harming behaviour and its ramifications and understanding the nature of the person's self-harming behaviours. For example, if you only attend to the person's physical injuries or aggressive behaviours, you may miss what led to the crisis and how best to support the person in the future.

The following steps are recommended when responding to a person who presents in crisis:

Key Principles of Responding to a Crisis

1. Remain calm, supportive and non-judgemental
2. Avoid expressing shock or anger
3. Stay focused on what is happening in the here and now. Avoid discussions about the person's childhood history or relationship problems as these can 'unravel' the person and are better addressed in ongoing treatment
4. Express empathy and concern
5. Explain clearly the role of all staff involved including how, when and what each will be doing to support the person
6. Conduct a risk assessment. Remember, the level of risk changes over time, so it is important to conduct a risk assessment **every time** the person presents in crisis
7. Make a follow-up appointment and/or refer the person to an appropriate service
8. After the crisis, ensure that the follow-up appointment and referral was successful

Conducting a Risk Assessment

A risk assessment is conducted to:

1. Identify risk and protective factors
2. Elicit suicide thoughts, plan, and intent
3. Guide decision-making.

A thorough risk assessment decreases the risk of suicide and repetition of self-harm. See the *NSW Health Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour*. When conducting a risk assessment, give attention to each of the following:

Risk Assessment Checklist

- ✓ Distinguish chronic from acute risk - does the current episode follow a chronic pattern or does it represent an escalation in acute risk and lethality? This will help determine how serious the risk is NOW. Be aware that if chronic risk is treated in the same way as acute risk (e.g. use of hospitalisation) suicidal behaviours may escalate. Include the basics of a risk assessment: Is the person *thinking about* self-harm/suicide? Does the person have a *plan* to self-harm/suicide? Does the person have *intent* to self-harm/suicide? Does the person have *access to the means* to self-harm/suicide?
- ✓ Identify static and dynamic risk factors. Static risk factors include things like young chronological age, male gender, recent self-harm or previous history of self-harm or suicide attempts, family-history of self-harm or suicide attempts or suicide in the person's peer group. Dynamic risk factors include things like current relationship problems or financial difficulties. This will help to determine HOW the risk has changed over time and what factor/s precipitated the person's escalation in risk. It is also important to identify what supports the person has in place.
- ✓ Perform a mental status examination and

identify the existence of any key psychological factors. Some key factors include depression, hopelessness, thoughts about suicidal intent, whether a suicide plan exists and if the person has access to the means to carry it out. People who present in an uncommunicative or dissociative state are at higher risk and require prompt intervention.

- ✓ Perform a psychosocial risk assessment
- ✓ Identify if there is risk of harm to others, **including the welfare of any dependent children**
- ✓ Clearly document your risk assessment, including the how and why of your reasoning and not just the level of risk. Consult with colleagues and have decisions regarding risk supported by senior staff.

Tolerating Risk

Given many people with personality disorders have a history of self-harm or failed suicide attempts, and many continue to engage in risk-taking behaviours, the evaluation of risk is not always easy or straightforward. It is not unusual for clinicians to also feel anxious about the person's level of risk. Points to consider:

1. Understand the reasons for self-harming behaviours including its function. For example, people frequently report self-harm as a means to feel physical pain, control feelings or overcome emotional pain, punish oneself for being 'bad', express anger, feel numb or overcome numbness, cope or self-soothe, or to prevent suicide. It can also be useful to decipher what the person is communicating by self-harming. For example, is the person attempting to evoke a response from another person rather than attempting to die (attempts to evoke a response generally involve less risk)
2. After the person's distress has been validated, develop risk management strategies in collaboration with them
3. Acknowledge that part of the therapeutic engagement (whether short or longer-term) is about finding reasons for living. There may also be times when the person's desire to die needs to be acknowledged
4. Be aware of high risk times or situations, for example, people with borderline personality disorder are known to be at risk of suicide around times of discharge from hospital
5. Collaboratively construct a case formulation letter differentiating acute from chronic risk and collaboratively agree upon a written safety contract.

It is not uncommon for clinicians to experience strong reactions or responses to issues of risk. Some clinicians may feel angry or annoyed with the person for threatening to self-harm or suicide, whereas others may feel anxious or guilty and believe they should be doing more. However, if a person is determined to die they will do so irrespective of any attempts to keep them safe.

People presenting with challenging and risk-taking behaviours can evoke particularly strong reactions in clinicians. This can manifest as either strong identification with a desire to help or as frustration and a tendency to dismiss their concerns. In such situations, it is easy for clinicians to treat particular clients differently from usual. This can result in clinicians enforcing rules and limits more strictly or harshly. It is highly recommended that clinicians seek supervision and peer consultation to manage these challenges.

Tolerating Risk in Young People

Because of their age, clinicians can find themselves doing more to help the young person than they usually would, perhaps disclosing more personal information or giving out private mobile numbers for support and so on. Similarly, young people can present as more helpless or extreme in their emotional responses, which can make it difficult for clinicians to provide a consistent response. It is crucial for clinicians to recognise these reactions and seek support through supervision and peer consultation.

Chronic Risk

Typically, chronic risk behaviour tends to be less harmful and risky and the person does not wish to die. These behaviours are usually

recurring responses to interpersonal stress, particularly to a sense of rejection and abandonment, and act as a means of communicating emotional distress. However, accidental death remains a risk. Ambivalence about dying may also form part of the pattern, for example, the person may have a suicide plan which they do not intend to immediately act upon but serves to mentally give them a way out and thereby allow them to continue to live.

Responding to Chronic Risk

If the risk is assessed as chronic, the following steps are recommended:

1. The person should be offered an appointment with a mental health service provider in the community. Some people will prefer brief treatment episodes where they can get some help with a clinician to deal only with their current problems. Engagement in long-term treatment can help to work on personality and relationship issues. It is important to note that people with personality disorders do not usually complete suicide whilst engaged in treatment
2. Where possible, ensure continuity of care - it is preferable for the person to consult with the same clinician each time they present to mental health services
3. Establish a risk profile over time. All information regarding the person's risk should be forwarded to the primary treating clinician or team
4. The person should not be admitted to hospital unless the risk is considered to be acute or potentially lethal, that is, a high level of risk. Avoid overprotective responses that are related to staff anxiety as opposed to the person's risk
5. The person should be encouraged to clearly communicate their needs verbally. This requirement should be included in their Care Plan as a strategy for reducing their level of distress or crisis.

Acute Risk

Acute risk refers to the very real risk of a person completing suicide. Characteristics of acute risk may include:

- The person has a clear plan for suicide
- The means by which the person intends to die is potentially lethal
- The person has access to the means, or can readily gain access to the means, to enact the plan
- There is nothing to suggest hope of rescue
- The person expresses feelings of hopelessness regarding the future
- Delusions may be present, causing the person to believe they must die
- Comorbid depression and/or substance abuse is present.

Responding to Acute Risk

If the person is deemed to be at acute risk, the following steps are recommended:

- Identify the person's psychosocial support system and contact their support people, including their primary clinician and carer, and discuss the treatment plan and crisis intervention
- Avoid overprotective responses that are related to staff anxiety, as opposed to the person's risk
- Consider a brief hospital admission to contain the crisis. Prior to the person's admission, specify the duration of hospitalisation considered appropriate or negotiate the length of hospital admission with the person.

Immediate Interventions for a Suicidal Person

1. Do not leave the person alone. If they leave, call the police
2. Reduce access to the means of suicide
3. Consult with senior staff
4. Inform others and gain support (may be from medical practitioner, crisis team, mental health service, hospital, family members, carers or others)
5. Provide a clear explanation to the person of the steps you are taking
6. Never agree to keep a plan for suicide secret
7. Do not use guilt or threats
8. Find out what and who has helped in the past

9. Establish a Care Plan.

Managing Risk

If the person is unknown (or not well known) to the clinician or service, it is recommended that a conservative risk assessment be undertaken. Some people also have unusual or unrealistic ideas and beliefs about what would follow their suicide (e.g. “I would be able to see everyone crying at my funeral”, “I thought I’d finally feel calm or peaceful”, “everyone will be better off without me”). Where appropriate, it may be useful to challenge these beliefs.

Managing Risk in Young People

The assessment of risk in young people who engage in suicidal and non-suicidal self-harming behaviour can be complex. Assessment of intent to die is often complicated in young people as they sometimes report their intent changes (e.g. “I start off wanting to die, but realised I didn’t half way through”), or is less clear than expected (e.g. “I don’t really know if I wanted to die or not”). In addition, young people sometimes have a poor understanding of the lethality of the means they are using to self-harm and consequently might be at high risk of a serious accidental outcome.

Guidelines for Developing a Care Plan

Background Information

The purpose of the Care Plan is to provide an individualised plan to assist the person to reduce their level of risk and frequency of crisis. The Care Plan is devised in collaboration with the client. It formally identifies short and long-term treatment goals, triggering situations, helpful strategies and skills to use in times of crisis, strategies and skills that have not been helpful, places to call in the event of an emergency and the people involved in their care. The Care Plan can be folded up into a wallet size slip and carried by the person so it can be easily accessed.

A Collaborative Care Plan helps to:

- Manage and reduce the person's level of risk
- Increase the person's level of safety
- Provide a structured goal-oriented safety plan that helps to contain anxiety of the person and those involved in their care
- Seek agreement on how to most effectively reduce distress for this particular person
- Clarify what has been done in the past that has not helped to reduce the person's level of distress or has made it worse
- Engage the person in their own treatment process and encourage self-responsibility
- Support the person and the clinician to navigate their way through a crisis
- Support quality treatment and support decision making.

A collaborative approach is essential to developing the Care Plan and extends beyond the involvement of the clinician and the person with personality disorder to include other health professionals and families and carers. See *Guidelines for Involving Family Members and Carers*.

A collaborative approach helps the person to:

- Be empowered and motivated to work toward specific goals
- Foster a sense of hope for the future
- Become actively involved in, and take greater responsibility for, their treatment
- Create greater understanding and awareness of the diagnosis, triggers and how to recognise and manage potential crisis situations
- Use the strategies in the Care Plan in a number of situations and across a number of treatment settings with different providers
- Improve decision making in crisis and distressing situations
- Reduce hospitalisations and trips to emergency departments
- Maintain an awareness of progress made over time.

A collaborative approach helps the clinician to:

- Share responsibility for treatment across a number of service providers and/or health professionals
- Build a relationship with the person with personality disorder based upon mutuality, trust and respect. This has been shown to increase adherence to treatment, continuity of care and the person's satisfaction with the services offered
- Enhance the quality of material in the Care Plan
- Minimise the effects of negative relations within the team that may have resulted from the person's interactions with them. A tendency toward idealising and devaluing health workers is a characteristic of personality disorder.

A collaborative approach helps the carer to:

- Feel included in the treatment process and, thereby, motivate, encourage, and support the person with personality disorder
- Reduce any sense of helplessness and hopelessness
- Strengthen their relationship with the person with personality disorder and provide a framework for them to come together as a team to manage the condition (rather than having the condition manage them).

Guidelines

This guideline outlines the steps to follow when developing a Care Plan. The aim of the Care Plan is to identify and gain agreement between the person with personality disorder and the clinician on:

a) the person's goals
b) crisis survival strategies
c) others involved in the person's care, including health professionals and carers.

The Care Plan is considered a working document that evolves over time and should always be developed and reviewed using a collaborative approach. See below for an example Care Plan that can be used with both adults and young people.

The following steps are recommended when developing the Care Plan:

1. WHEN: The Care Plan should be developed early in the assessment process or when the person presents to hospital or crisis intervention setting. It should be reviewed and updated on a regular basis including at the entry to a treatment program
2. WHO: The primary treating clinician should take key responsibility for initiating the development and review of the Care Plan, and this should be done in collaboration with the person with personality disorder. The person should be encouraged to take responsibility for physically writing the Care Plan whilst collaborating with the clinician. This helps to increase the person's involvement, engagement and commitment to their Care Plan, and later utilisation of it.

Carers may also be involved in this process - adopting a collaborative approach also extends to the consultation of colleagues (e.g. reviewing the Care Plan at case conference, individual and group clinical supervision, and team review meetings). This ensures a multidisciplinary approach to treatment and allows for independent input into the Care Plan. Specialist services can also be consulted for input where appropriate; either services already involved in the person's care or those that could offer new assistance

3. WHAT: The Care Plan should do the following:

Identify both short and long-term goals

Goals should largely be determined by the person to provide a general guide and direction for treatment. They should be relevant and meaningful to the person and able to be reasonably achieved.

Sometimes it can be beneficial for the goals to remain vague so the person's sense of hope or self-esteem is not further diminished if they do not meet a more specific goal. It is important that the attainment of goals, including partial attainment, is recognised and reinforced.

Identify situations that trigger distress or risk

Identify the potential situations or events that trigger a level of heightened risk or distress in the person. The Care Plan should address both long-term and acute risks and be explicitly related to the overall plan for treatment to ensure continuity of care and

coherence.

The seriousness of the risk should not be underestimated, particularly in people who make frequent suicide attempts or self-harm. See *Guidelines for Working with People in Crisis and Conducting a Risk Assessment.*

Identify self-management strategies that reduce distress and risk

Identify non-harmful behaviours that are likely to reduce the person's level of distress and risk. Avoid persuading or coercing the person to behave in a certain way - this tends to be counterproductive and rarely leads to change.

The following examples have been reported by people with personality disorders as useful ways to reduce their risk:

- holding ice
- phoning a friend
- taking a cold shower
- listening to music
- sucking on a strong peppermint
- stroking a pet
- cuddling a teddy bear
- going for a walk or run
- doing an art or craft activity like drawing, colouring or painting.

In some cases, planned short admissions to hospital of a pre-determined duration (e.g. 24-48 hrs) and frequency can be effective but must be discussed early in relation to the benefits and potential disadvantages of such arrangements. If the clinician believes this may be helpful to the person, it should always be discussed with the nurse unit manager or clinical director of the local mental health unit before it is mentioned and negotiated with the person to ensure feasibility.

Identify strategies used in the past that have not been helpful, or have made things worse

Identify behaviours or strategies the person or others (e.g. carers, police or health professionals) have engaged in the past that have **not** been helpful in reducing their level of distress or risk. For example, some people may find questions about what led to the crisis helpful, whereas others may need time to calm down before engaging in a thoughtful conversation.

Identify who to contact in an emergency

Identify a list of services to contact in an emergency including 24-hour service providers. This includes contact details (phone numbers and addresses) of the Emergency Department, Mental Health Crisis Team and Lifeline Telephone Counselling Service (or Kids Helpline as appropriate) together with advice about when the person may want to contact each one.

Identify others helping with treatment

Identify the health professionals and carers, including family members and friends, who are involved in the person's care; include their contact details and the role they play in supporting the person with personality disorder.

Consent

Determine whether the person with personality disorder gives consent for the clinician to contact these support people and what can be discussed with each of them. Consent can be provided by writing 'yes' or 'no' in the section of the Care Plan marked 'OK to contact?', however other forms of written consent are also acceptable.

Identify who the person wants involved in discussions about their treatment and the degree of involvement they would like for each support person. Document these discussions in the person's Health Care Record and review on a regular basis.

It is not unusual for people with personality disorder to refuse to identify or involve their carer's in their treatment. They may change their mind about their carer's level of involvement. These fluctuations may or may not be attributed to their mental health condition. However, revisit the issue of consent with the person during treatment.

Set a review date

The Care Plan should be reviewed on a regular basis including at least once every three months. In the early stages of treatment, to assist the clinician and person develop a

greater awareness and understanding of the issues, more frequent reviews are recommended. It is not unusual for a Care Plan to be relatively brief in the early stages of treatment. Ongoing reviews will ensure that changes in personal relationships, goals, potential triggers and strategies that have proven beneficial in reducing distress and risk are well documented.

Be accessible across services

The original Care Plan should be given to the person and copies kept in their Health Care Record and distributed to the Emergency Department, other health professionals involved in their care and carers.

There may be lack of agreement among health professionals regarding the Care Plan. These disagreements are not uncommon and typically reflect the treatment challenges and complexities, and various responses and reactions to the client by health professionals. A case conference should be held to clarify the issues and seek a resolution.

Care Plans for different situations

It may be useful to have several Care Plans that are applicable to different settings (inpatient or outpatient) or people (person with personality disorder or their carers). For example, some crisis survival strategies used in an outpatient setting may not be workable or appropriate for an inpatient stay. In this instance, it may be useful to have a separate Care Plan for hospital setting. Similarly, carers may benefit from having a Care Plan specifically aimed at helping them navigate a crisis with the person with personality disorder who they care for. See below for an example Care Plan for carers ('Carer Plan'). This can be completed in carer sessions (see Project Air Strategy *Brief Intervention Manual for Personality Disorders* and the chapter in this guideline on *Involving Family Members and Carers*).

NSW GOVERNMENT Health

Care Plan

Name: **Clinician Name:**

My main therapeutic goals and problems I am working on

(1) In the short term

(2) In the long term

My crisis survival strategies

Warning signs that trigger me to feel unsafe, distressed or in crisis

Things I can do when I feel unsafe, distressed or in crisis that won't harm me

Things I have tried before that did not work or made the situation worse

Places and people I can contact in a crisis:

Lifeline 13 11 14 **Emergency 000** **NSW Mental Health Line 1800 011 511** **Kids Helpline 1800 551 800**

My support people (e.g. *partner, family members, friends, psychologist, psychiatrist, teacher, school counsellor, social worker, case worker, GP*)

Name	Contact Details	Role in My Care	OK to Contact?

Signature: **Clinician's Signature:**

Date: **Date of next review:**

Copy for the: Client / Clinician / Emergency / GP / School / Case Worker / Other (please specify)

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NSW GOVERNMENT Health

Carer Plan

Name: **Clinician Name:**

My main goals and problems I am working on in relation to my carer role

(1) In the short term

(2) In the long term

My carer crisis survival strategies

Warning signs that the person I support is unsafe, in distress or crisis

Things I can do when the person I support is unsafe, distressed or in crisis that won't harm them or me

Things I have tried before that did not work or made the situation worse

What I can do to take care of myself in stressful times

Places and people I can contact in a crisis:

Lifeline 13 11 14 **Emergency 000** **NSW Mental Health Line 1800 011 511**

My support people (e.g. *friends, family members, partner, psychologist, psychiatrist, social worker, GP*)

Name	Contact Details	Role for me	OK to Contact?

Signature: **Clinician's Signature:**

Date: **Date of next review:**

Copy for the: Carer / Clinician / Other (please specify)

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Guidelines for the Assessment of Personality Disorders

Background Information

The diagnostic assessment will assist in making an accurate diagnosis, engaging the person in treatment, reducing their level of risk, creating a sense of hope for the future, and providing effective treatment. It is a necessary process that is both extensive and time consuming. Failure to complete a diagnostic assessment may result in misdiagnosis, which may lead to an increased risk of suicide and repetition of problematic behaviours.

The principal aim of the assessment is to gather information to make a diagnosis. However, establishing rapport is essential to engage the person in the assessment process and subsequent treatment. Early engagement also helps to promote the identification of other psychosocial problems and prevents the person from dropping out of treatment, which is common for people with personality disorders.

It is not uncommon for people with personality disorder to evoke strong and negative reactions in the clinician and these reactions may be inadvertently reflected in their responses to the person with personality disorder. Supervision can assist with working through these strong reactions to maintain a consistent and calm response.

Informing the person of their diagnosis is an important first step in treatment. It can help the person feel validated, relieved and understood. It also encourages the person to play a more active role in their recovery and identify and recognise their symptoms as they occur. Although there is stigma surrounding a diagnosis of personality disorder, it is often made worse by the health systems response to the diagnosis (e.g. responding with fear, anxiety or punishment). Clinicians may feel anxious and uncomfortable about giving a diagnosis of personality disorder, fearing the client's reaction, but this reaction can further stigmatise the person. Find a way to talk about the diagnosis whilst focusing on the person as a whole – their history, current situation, problems and strengths.

Once the diagnosis has been communicated to the person, consider sharing the formulation with the person, including how their past experiences are linked to their present day symptoms and functioning. This may help to strengthen the person's awareness of their situation. End the diagnostic assessment process by restating the client's strengths.

Guidelines

Psychological and behavioural disturbance can be associated with immediate clinical syndromes or longer-term traits. The main challenge in assessment of personality disorder traits is to determine whether certain presenting problems are state-related (limited to the duration of a clinical disorder) or trait-related (features of a personality disorder).

This means it is essential to accurately assess clinical conditions first and then examine how the person usually behaves and interacts with others when not experiencing episodic or state related conditions.

The aim of the diagnostic assessment is to:

- identify all clinical conditions
- establish if there is a diagnosis of personality disorder
- identify the primary personality disorder or if several personality disorder traits are present
- estimate the severity of the person's functional impairment
- identify the person's strengths
- inform the person of their diagnosis and treatment options
- introduce the person to treatment
- consult with specialist services based on needs (e.g. learning disability services, drug and alcohol services, multi-cultural

services)

- assess the needs of any dependent children currently in the person's care.

HOW to conduct the diagnostic assessment

It is important for the clinician to remain:

- empathic
- respectful
- non-judgemental
- encouraging, and
- hopeful about the person's capacity for change, whilst validating their situation and current state.

This approach helps engage the person in treatment, fosters a belief that a valuable and beneficial service is on offer, and improves treatment retention. It is recommended, where possible, that the clinician conducting the diagnostic assessment will also provide the treatment, as evidence shows this enhances treatment retention.

Throughout the diagnostic assessment the clinician should use non-technical language that is easily understood. Where possible, it is helpful to check diagnostic assessments with another clinician. The clinician who will be providing ongoing treatment should take the lead role.

WHAT to do in the diagnostic assessment

1. *Clearly explain the assessment process to the client*

The assessment process may be anxiety provoking or upsetting for the person with personality disorder, particularly if the focus is on past traumas or painful experiences. To assist the person to feel safer:

- talk through the aims of the assessment/s
- be transparent about the content of the questions and offer opportunities for the client to ask questions
- explain that the length of the assessment may vary - it can take a few hours, a few weeks or a few months.

Remember that the assessment is an integral part of the overall treatment. It acts to support the therapeutic process and shape the treatment plan.

2. *Conduct a semi-structured interview*

A semi-structured interview utilises well-validated psychometric tests to gain a specific understanding of the person across a broad range of domains. It aims to ascertain the:

- person's treatment goals
- person's treatment history and service utilisation
- presence of clinical disorders
- presence of personality disorders
- level of global, relational, social and occupational functioning
- person's strengths (including what works for the person at times when things are going well in their life)
- level of chronic risk.

Consider the use of these instruments:

- Structured Clinical Interview based on diagnostic criteria (SCID)
- Global Assessment of Functioning (GAF)
- Global Assessment of Relational Functioning (GARF)
- Social and Occupational Functioning Assessment Scale (SOFAS)
- International Personality Disorder Examination (IPDE; be aware that this instrument is not sensitive to the detection of antisocial personality disorder)
- Lifetime Suicide Attempt Self-Injury Interview (LSAS-I formerly the Lifetime Parasuicide Count (LPC))
- Psychopathy Check List: Screening Version (PCL:SV)
- Historical, Clinical and Risk Management (HCR-20) violence risk assessment.

- Note that there are also screening questionnaires which have reasonable sensitivity and specificity to assist diagnosis, including the DSM SCID Personality Disorder Questionnaire, the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD), Borderline Personality Questionaire (BPQ), and the International Personality Disorder Examination Screener (IPDE-S).

3. *Score the semi-structured interview and make formal diagnoses*
   Following administration of an assessment:

- offer the person a break in the interview
- discuss any points of uncertainty with a colleague
- score the measures
- make formal diagnoses
- begin a case formulation that incorporates the person's strengths.

NOTE: people with moderate to severe learning disabilities should not be diagnosed with personality disorder without consultation with appropriate specialist services.

In order to diagnose observed phenomena as personality disorder traits, the DSM-V recommends looking for a one-year history in people under 18 years and a five-year history in people over 18 years. Note however that antisocial personality disorder cannot be diagnosed in a person under 18 years. In order to make a realistic but conservative diagnosis, a two-year history can be used for people aged between 18 and 25 years.

4. *Provide feedback to the person*
   At this stage of the diagnostic assessment it is appropriate to:

- inform the person of their diagnosis (See the *Diagnostic Feedback Script* below)
- share your formulation with the person, if appropriate
- acknowledge the person's resilience and strengths and discuss how these have helped them navigate through difficulties in their life
- provide the person with Fact Sheets (see Project Air Strategy Fact Sheets available at www.projectairstrategy.org)
- explore the next steps in treatment with the person
- convey optimism about the person's recovery
- provide opportunities for the person to make their own choices about their treatment
- provide appropriate support, particularly when sensitive issues have been discussed such a history of abuse or neglect.

Diagnostic feedback script (Holm-Denoma et al., 2008)
Basic steps:

- Set the agenda (e.g. "*today we're going to talk about the assessments you completed and your diagnosis*")
- Review the main symptoms the person has reported
- Talk through the name of the personality disorder and provide the person with information (e.g. use Project Air Strategy Fact Sheets available at www.projectairstrategy.org)
- Review what is known about treatment for the disorder (e.g. "*we know a lot about personality disorder and the different treatments. We can talk together about what might be helpful for you*")
- Advise the person to be aware of misinformation regarding the diagnosis, including information that may be sourced from the internet
- Answer any questions.

Script:

"Now that I have a sense of what has brought you here, I'd like to discuss the symptoms you've described to me today. You told me that recently you've been experiencing these symptoms ____ and that you've been feeling ____. These symptoms and feelings cluster together into a syndrome. There's a name for what you've described, and it's called ____. This typically consists of symptoms like _____. People with this typically feel like ____. We know a lot about it including how to treat _____ effectively.

There is a lot of information available about personality disorders. However, some information you find on the internet or on blogs may be incorrect. I'll be happy to help you to find good sources of information. Do you have any questions or is there anything you'd like to know at this point?"

Discuss the involvement of carers

Discuss whether the person would like to inform their carers of their diagnosis. If so,

discuss how you can best support the person in this process. For example, would it be beneficial to set up a meeting between you, the person, and their carer/s, or would the person prefer to inform them on their own?

It may be useful to provide the carer with Fact Sheets about diagnosis, treatment, and how the family can best support the person (e.g. use Project Air Strategy Fact Sheets for families and carers available at www.projectairstrategy.org). For additional information, refer to the chapter in this guideline on *Involving Family Members and Carers*.

Offer post-assessment support

Post-assessment support is particularly important when sensitive or traumatic material has been discussed. This can include out-of-hours phone support with the Mental Health Crisis Team and Lifeline Telephone Counselling Service (or Kids Helpline as appropriate).

Guidelines for Hospital Settings

Background Information

When a person presents to an emergency department (or hospital) in crisis, the role of hospital staff is to assist the person to stabilise. Crisis response is different from long-term treatment as it centres on helping the person regain a sense of control over their life. In a crisis, it is common for the client to feel out of control.

The challenge for hospital settings, and emergency departments in particular, is to manage the crisis and assess risk while validating the person's experience and enabling them to make active choices about their care. See *Guidelines for Working with People in Crisis and Conducting a Risk Assessment* and *The Relational Model of Treatment, Key Principles for Working with People with Personality Disorders*. Also see the *NSW Health Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour,* Flow Chart for Emergency Departments and Flow Chart for Mental Health In-Patient Facilities.

Self-Harming Behaviours

People with personality disorders may engage in high risk behaviours, resulting in repeated presentations to hospital. Dealing with multiple self-harm and repeated suicide attempts can be extremely challenging for staff. It is also easy to become complacent when a person presents often with the same symptoms or behaviours.

Self-harm and suicidal behaviours can be the only way that some people know to communicate their distress.

Self-harm includes, but is not limited to, overdosing, cutting, scratching, bruising, burning, head banging and biting. More unusual self-harm behaviours include attempts to break bones, drip acid on the skin or reopen wounds.

Self-harm is often:

- used to help manage overwhelming and intense emotions or to provide relief from negative or painful emotions
- used to provide immediate relief from emotional distress
- associated with high levels of impulsivity
- performed in secret and presented in crisis
- performed after a triggering event such as separation, an experience of rejection, loss or failure, or when the person feels alone
- accompanied by endorphins which means some people don't feel any associated pain
- followed by shame and remorse.

Guidelines

Hospital Admissions and Issues

In many cases, it is preferable not to admit a person to hospital, but to engage the person in community based care, particularly if it is provided quickly (e.g. within 1-3 days of crisis presentation). The Project Air Strategy has developed a Brief Intervention Manual based on brief sessions of psychological therapy to support a person through a crisis and as an alternative to hospitalisation. Hospital admissions for people with personality disorders, particularly involuntary admissions, present numerous challenges to the development of rapport and the therapeutic alliance. Involuntary admissions undermine the crucial goal of treatment in personality disorder: to help the person become a partner in taking responsibility for their progress.

People who are psychotic or depressed may be considered 'sick' and treated accordingly. However, people with

personality disorders may be viewed by some members of staff as difficult, self-destructive, non-compliant, aggressive, manipulative or even bad. In response, staff may attempt to restrain or 'stop' the person from behaving badly instead of treating their condition. Personality disorders are a recognised mental illness.

Hospital admission is influenced by the ability of all treating clinicians to develop positive relationships with the person. Understanding that the person may experience difficulties in relating to others and that these difficulties are based on a fragile sense of self, problems with early attachments and basic mistrust. It also helps to recognise the survival value the person's behaviour has that led to the crisis. Lack of awareness of the aetiology of personality disorders can influence treatment in negative ways. Education and clinical supervision are recommended to encourage compassion and facilitate thoughtful treatment planning.

Admission and Planning

Further considerations for mental health inpatient unit clinicians include:

1. *Preventing involuntary admissions*

- Involuntary admissions can cause an exacerbation of symptoms
- An alternative to an involuntary hospital admission is a planned brief hospital stay – this may assist the person manage increased self-harm or suicidality
- The Care Plan should include an agreement stipulating that the person can, at their discretion, use the hospital for a specific period of time
- Often there can be difficulty establishing a predetermined planned hospital admission with hospital staff, however, once it has been established it does tend to decrease the number of bed days and free up beds in the longer-term.

NOTE: Research shows that when admissions are predetermined, brief and initiated by the person with personality disorder they can prevent death and break the cycle of hospitalisation.

2. *Setting limits*

- Firm limits for challenging behaviours are crucial. These include expectations regarding daily routine and clear consequences when rules are broken
- Limits and consequences should be clear to all staff and be supported by all staff involved in the person's care
- Firm limits must not be used as a licence for health professionals to engage in punitive behaviours such as punishment
- Physical restraint and/or seclusion should only be used for the most extreme behaviours that threaten life or property.

3. *Clarifying roles*

- Clarifying each staff member's role within the hospital unit - this provides structure for the person with personality disorder and the treating team
- Remember that is it is beneficial for the person to have therapy with just one clinician. Because therapy generally lasts longer than the length of admission, this clinician should be community based. Hospital clinicians can support therapy by using consistent language and displaying a consistent attitude.

4. *Managing difficulties within the treating team* (see *Guidelines for Clinical Supervision and Consultation*)

- Conflict within the treating team can arise which can affect intra-ward dynamics
- Staff from different and similar disciplines may hold strong opinions about the management of people with personality disorders. Recognise these differences and to allow time for discussion to reach a consensus
- **All staff should conceptualise themselves as part of the treating**

team and work together to avoid relationship problems within the team

- See *Guidelines for Clinical Supervision and Consultation*.

5. *Preventing revolving door admissions*

- Well thought out discharge plans are the most effective way of reducing readmission
- Comprehensive discharge plans that include a clear structure for follow-up, strategies for dealing with a crisis, names and phone numbers of people to contact and psychosocial plans to support the person's re-connection with their community are crucial (See *Guidelines for Developing a Care Plan*).

When a person presents to hospital, including an Emergency Department, the following steps are recommended:

1. Respond to the medical and physical needs of the person first. Provide clear explanations about medical treatment
2. When attending to physical injuries or wounds, refrain from reinforcing self-harming behaviours by paying too much attention to it (e.g. beyond the minimum amount required to stabilise the person). It is more fruitful to focus on the triggers that led to the crisis and the course of events from that led to the deliberate self-harm
3. Conduct a thorough risk assessment (See *Guidelines for Working with People in Crisis and Conducting a Risk Assessment*)
4. Determine whether the person requires a hospital admission
5. Once the person's level of risk has stabilised, determine if the person is:
   a) currently engaged in longer-term treatment with a health practitioner - refer them back to their primary treating clinician (see *Referral for Follow-up Services* section below)
   b) NOT currently engaged in longer-term treatment - provide them with a brief intervention appointment (see *Referral for Follow-up Services* section below)
6. After the person's level of risk has stabilised AND they have been referred for a follow-up appointment with a brief intervention clinic or primary treating clinician, they may be discharged.

Attempt to AVOID:

- discussing issues related to childhood, relationships or other life situations
- paying a lot of attention to the injury itself, as this will only serve to reinforce self-harming behaviours – find a balance
- involuntary admissions, as it is best to have the person's consent including agreement on the goals of the admission which should be outlined in a Care Plan (see *Guidelines for Developing a Care Plan*).

Working With Young People in the Hospital Setting

Young people engaging in self-harm and suicidal behaviours have rarely established a recurrent pattern of harming themselves in order to be admitted to inpatient wards.

Even when this pattern appears to be emerging, there is an important opportunity to intervene and help the young person establish more appropriate ways of accessing care and support; developing a Care Plan is useful to assist with this (see *Guidelines for Developing a Care Plan*). It is important to remember, many unhelpful and frustrating patterns of behaviour are reinforced by the behaviour of clinicians. For example, telling a person their behaviour is not severe enough to be admitted to the inpatient unit may actually increase self-harming behaviours to gain hospital admission.

Hospital Admissions

People in crisis may require an admission to a Psychiatric Emergency Care Clinic or Mental Health Inpatient Unit as part of a comprehensive treatment approach. Any hospital admission should be brief and goal-directed, for example, focusing on stabilising the patient or engaging the patient with

outpatient treatment. Goals could include stabilising the person's mental state, helping the person regain a sense of control over their life, or making preparations for future treatment. There is evidence that brief planned hospital admissions with specific goals improve outcomes for people with personality disorders, particularly for people with borderline personality disorder. Conversely, prolonged hospital admissions tend to exacerbate symptoms.

A hospital admission needs to be viewed as a resource to be utilised for specific purposes. It should aim to:

- Prevent the exacerbation of symptoms and risk
- Help the person become a partner in taking responsibility for their own progress and stabilisation while working toward discharge
- Be short-term and have well clarified goals
- Have a predetermined duration and frequency (number of stays permitted over the course of a calendar year) that is stated in the person's Care Plan
- Link the person into an appropriate therapy.

At the time of admission:

- IDENTIFY: the admission goals
- CLARIFY: what led to the crisis and subsequent admission
- CONSIDER: other mental health conditions such as substance abuse, major depression and psychosis. This will influence the treatment and discharge planning
- RECORD: mental state and behaviour
- REVIEW: the Care Plan or develop a Care Plan (if the person does not have one). It may also be useful to develop a Care Plan specifically for use in an inpatient setting. This can be kept on file in the person's medical record in the inpatient unit for future reference
- CONSULT: with the primary treating clinician, where one exists, to ascertain recent functioning and stressors
- INVOLVE: any support workers including key workers, residential workers or family workers
- PLAN: discharge planning needs to start as soon as the person is admitted to hospital
- COMMUNICATE: mental state status and discharge plans with other clinicians and carers. Don't send the person home without telling someone first. See the *NSW Health Discharge Planning Policy for Adult Mental Health Inpatient Services.*

Referral for Follow-Up Services

The following steps are recommended when referring patients for follow-up services (e.g. the Brief Intervention Team, Community Mental Health Team, or private therapist):

- The person should be referred to a follow-up service prior to discharge
- Provide the person with details of the new service they are being referred to. Ideally this should include a map and a telephone number to contact in a crisis
- Provide the person's carer with the same information about the new service (see *Guidelines for Involving Family Members and Carers*). Send the new service a copy of the risk assessment and a discharge summary within 24 hours of discharge. Include current contact details for the person and their carer/s
- Encourage the new service to make contact with the person within 72 hours of discharge
- Encourage the person with personality disorder to make contact with the new service if they haven't heard from them within 72 hours
- Send a copy of the discharge plan and referral to the person's GP and any other relevant service providers.

Collaboration with Carers in the Hospital Setting

Collaboration with carers is enhanced when they are:

- Contacted within 48 hours of admission

to share information

- Given information about the person's diagnosis, strengths and management strategies
- Involved in discharge planning
- Offered a feedback and review session if the admission is longer than 7 days.

Guidelines for Medical Practitioners

The following guidelines aim to support medical staff (e.g. GPs, psychiatrists, Emergency Department doctors, mental health nurses, and other medical officers) provide optimal health care within the pressures and constraints of health settings.

The most effective treatment of people with personality disorder requires collaboration. An integrated health care approach involving all health care professionals in partnership with the person with personality disorder is recommended.

For new people entering treatment, the following guide may be useful:

- REVIEW: the person's Care Plan
- ASK: for details relevant to assessing and treating the immediate medical issues only
- AVOID: discussing issues related to childhood, relationships or other life situations - direct these issues to their primary treating clinician / psychologist
- PROVIDE: the person with clear statement about medical treatment and what they can expect
- CONTACT: mental health services or other workers involved in the person's care.

Considerations for Optimal Care

APPROACH: People with personality disorder may have experienced rejection, abuse, trauma and stigma related to their disorder. When working with people with personality disorder:

- maintain a non-judgmental approach
- be clear, consistent and reliable
- be aware of your own views about people with personality disorder including how these views can affect your interactions with people with personality disorder or their carers (see *The Relational Model of Treatment, Key Principles for Working with People with Personality Disorders*).

RESPOND TO CRISES: See *Guidelines for Working with People in Crisis and Conducting a Risk Assessment*.

REFER: People with personality disorders may need specialist longer-term treatment. However, treatment is best conducted when all health care providers work in collaboration and share a common treatment plan (e.g. GP, practice nurse, physician or other medical staff).

DIAGNOSIS: It can take time to accurately diagnose a personality disorder. It may be mimicked by other problems such as substance abuse or hypomania. A second opinion regarding diagnosis may also be useful. See *Guidelines for the Assessment of Personality Disorders*.

MEDICAL HISTORY: It may be useful to discuss any recurrent or ongoing medical issues with the primary treating clinician or local community mental health service, with the person's written consent.

MEDICAL AND DENTAL CARE: People with personality disorders may neglect their medical and dental needs. This may be associated with fear of intimate contact. In some circumstances, it may be best to have a same-sexed or nominated person present during examination or to refer to a same-sexed medical practitioner.

BOUNDARIES AND STRUCTURE: People with personality disorder may be erratic, miss appointments, demand appointments at inconvenient times, or attend the clinic without an appointment.

Consistent, clear and predictable interactions with all staff are crucial. In general practice, the function and role of the GP should be made clear. A shared care strategy developed with the person, practice manager, reception staff, nurses and the GP that outlines when and how the person can access care is highly recommended. These strategies can also be employed in community mental health centres and other settings.

Plans for when and how to access emergency or crisis care are critical. For example, if the person's self-harm is life threatening, the plan should recommend treatment in the Emergency Department and not with the GP clinic. These plans should be made when the person is functioning well and should be reviewed periodically.

Health care professionals are encouraged to review the person's Care Plan when necessary. See *Guidelines for Developing a Care Plan*. If there is no Care Plan in place, develop an interim plan and refer the person for a full psychiatric assessment.

CONSIDERATIONS FOR USING MEDICATION AS A PRIMARY TREATMENT FOR PERSONALITY DISORDERS: The literature is in its infancy in relation to the use of pharmacotherapy for personality disorders, with some exceptions. Pharmacotherapy has been shown as largely ineffective in the treatment of borderline personality disorder. There is also some evidence that low dose antipsychotic medication might be helpful for schizotypal personality disorder (Herpertz et al., 2007).

Pharmacotherapy is not generally recommended as a primary treatment for personality disorders, especially borderline personality disorder. Medication can be used to target specific symptoms but it is important to avoid polypharmacy. Ensure medications are trialled sequentially in a systematic way that includes regular review. This review should also examine whether the benefits of using the medication outweigh the risks.

MEDICATIONS FOR CO-OCCURRING CONDITIONS: Medications may be appropriate for the treatment of comorbid problems when there is evidence for pharmacotherapy.

Clinical conditions (e.g. major depression) are legitimate foci for pharmacotherapeutic intervention and require appropriate treatment. However, it is important to consider that some symptoms may be better accounted for by the personality disorder instead of a co-occurring mental illness.

RELATIONAL APPROACH TO PRESCRIBING: Therapeutic principles apply to prescription practices. For example, the person should be encouraged to work in partnership with the doctor to make an informed choice about medications. Coercive practices are usually counterproductive except when the situation might be life-threatening.

Both medical practitioners and people with personality disorders may hold strong views about the likely efficacy of pharmacotherapy and these can have both positive and negative effects. Some examples include:

- high expectations about the likely efficacy of medication at the commencement of treatment can cause problems when the expected improvements are not forthcoming
- it can be difficult for the medical practitioner to resist the person's requests and demands for medication
- some people with personality disorder are unwilling to explore pharmacotherapy when other treatment methods have proven ineffective.

Remind the person about the limited evidence base for the use of pharmacotherapy for personality disorders and the corresponding stronger evidence base suggesting psychotherapy is more effective.

The medical practitioner can be at risk of prescribing, or failing to prescribe, pharmacological agents based upon their own biases and interactions with the person. For example, the medical practitioner who is idealised by the person may prescribe pharmacological agents when asked to do so, while one who is devalued may withhold medication. To prevent this pattern, it is important to consider the evidence-base for prescription based upon the person's presentation.

When considering pharmacotherapy, it is important to be clear about both the specific goals of prescribing and the therapeutic

targets. Every effort should be made to help the person make an informed decision (e.g. education about side-effects, scientific support for the pharmacological agent prescribed).

Encourage the person with a personality disorder to report any side effects of medication. This will assist in a realistic review of its efficacy and benefits, and support a collaborative decision to end an unsuccessful medication trial.

While they are frequently prescribed, it should be noted that there is little support in the literature for the use of atypical antipsychotic agents or for mood stabilisers in borderline personality disorder.

When considering a particular medication, plan for its decrease and cessation. Remember that psychological treatment and psychotherapy is the primary treatment for personality disorder.

Resources for general practitioners: GP's can use the GP Psych Support Service to discuss diagnosis and treatment options (www.psychsupport.com.au).

Guidelines for Working with Young People

People under the age of 18 years may also have a diagnosed personality disorder, emerging personality disorder or personality disorder traits and should be provided all appropriate services to meet their needs. Young people should receive help in youth-oriented services where possible.

For young people, the following considerations are important:

- balancing the autonomy of the young person with the responsibility of their legal guardians
- the legal framework underlying work with children and adolescents
- a young person should be retained in youth-oriented services for as long as possible (up to 25 years if services are available)
- transfer to an adult service needs to be handled carefully to ensure effective transition and support
- it is preferable to offer both brief and longer-term treatment because young people tend to move in and out of treatment
- the prevalence of personality disorders is highest in the late adolescent and young adult age group and gradually declines into middle and older age
- the age of onset of personality disorders is typically late adolescence to early adulthood, although the development of traits can be traced back into childhood.

Diagnosing the Young Person

There can be a reluctance to make a diagnosis of personality disorder in young people. This reluctance is generally counterproductive, and may stem from health professionals own views about personality disorders. Young people often experience relief when they are given a diagnosis that explains the difficulties they have been experiencing.

Points to consider include:

- young people with personality disorder can present differently to adults
- the diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* apply more clearly to adults
- the young person may tend to present with extreme distress or impairment. To avoid misattributing this to '*normal adolescent difficulties'*, as can often be the case, note whether the person is suffering more impairment than their same-aged peers.

Early Intervention

Retrospective studies of adults with personality disorders have shown that they first present to psychiatric services in the teenage or early adult years, even if the diagnosis of personality disorder is not made at that time. Arguably, the best time to intervene is in this late adolescent to early adult age range. This helps to mitigate the heightened risk of diverse functional and psychopathological impairments experienced by people when they are not diagnosed and treated early. The evidence for early intervention is strongest for antisocial and borderline personality disorders.

Some of the most difficult aspects of working with personality disorders arise from iatrogenic problems. Intervening early provides an opportunity to limit or prevent these sorts of difficulties. For example, young people have rarely developed the toxic relationships with health services that are evident in some adults with personality disorder, which often results from repeated rejection after presentations to emergency departments requesting admission.

When working with young people, it is also useful to speak openly and empathically about the trajectory that they are on with their current behaviours. This fully informs the young person and helps to shape treatment to ensure that they refrain from following this path.

It is useful to help the young person work out what they need, focus on assertiveness and provide them with skills to negotiate with people and services.

Guidelines for Involving Family Members and Carers

This guideline uses the term carer and/or family to apply to all people who have regular close contact with a person with a personality disorder, including parents, partners, siblings, children, friends and other significant others identified by the client.

Carers of people with personality disorder often experience high levels of burden, grief, vicarious trauma and distress including poor physical health, marital problems, poor emotional health, financial strain, lower standards of living, limited social networks and variable career trajectory. The burden may also be increased if the carer experiences difficulties navigating the mental health system including problems gaining access to information regarding the person's diagnosis, treatment strategies and plans for discharge.

Families may feel blamed for the person's personality disorder. This can be heightened when family members learn about the aetiological factors associated with personality disorder (e.g. problems with attachment, history of abuse and neglect). It may also be useful to remind carers about the significant genetic and biological component of personality disorders - abuse or neglect is not always present. In some studies, the genetic component of borderline personality disorder has been estimated as strong as 40%.

Involving Carers and Families

Working with carers not only helps the person with personality disorder - as carers are often the main source of support - but also helps improve family relationships. Working with carers includes providing education about the person's diagnosis and building upon the family's strengths and resilience.

Increasing the level of emotional involvement, validation and expressiveness of carers has been shown to improve outcomes for people with personality disorders. However, this needs to be balanced with encouraging self-care to prevent burnout. Carer outcomes also improve by increasing their sense of support and their capacity to communicate with the person with personality disorder. Overall, it is widely accepted that mental health services are enhanced when carers are engaged with services providers.

General service provision carers can expect:

- Recognition of their caring role
- Sharing of information regarding diagnosis, treatment and plans for discharge (following consent – see below)
- Opportunities to ask questions, provide feedback, and discuss concerns
- Support in their caring role and in negotiating the mental health service system
- Consideration and responsiveness of culturally and linguistically diverse communities.

Clinicians must have sound knowledge of what information may be given to carers by referring to the relevant sections of the *Australian National Standards for Mental Health Services (Commonwealth of Australia, 1996).*

Working with Families and Carers:

- Gain written consent from the person with personality disorder to involve their family or carer/s. If the person is resistant or refuses to involve their carer explore these issues (see below)
- Meet with the family
- Engage the family (e.g. demonstrate interest in who they are - ask how the family is coping, remember that when the person is in crisis, the family are likely also in crisis)
- Identify immediate needs or problems
- Provide information about the person's diagnosis (jargon free), prognosis, strengths, treatment plan and any plans

for discharge

- Provide information about the mental health system and other relevant resources
- Consider developing a Care Plan for the family (see the Carer Plan in *Guidelines for Developing a Care Plan*)
- Once family needs are established, identify pathways for treatment and support. This may include regular family meetings, a support group, structured skills group or family therapy
- Following a crisis, provide information about the person's treatment within 7 days of the person's intake to the service
- Offer feedback and review sessions every 3 months, particularly in the early stages of treatment.

See the Project Air Strategy website (www.projectairstrategy.com) for Fact Sheets for family members and carers.

Reluctance to involve carers and family members:

Research has shown improved outcomes for people with personality disorders and their families when families and carers are involved in treatment. However, sometimes people with personality disorder may be reluctant to involve others in their care. This may be due to a number of factors including problems in relationships, feeling alienated from family members, feeling guilty about involving carers, fearing the clinician will judge their family or carer relationships, and/or issues related to abuse or neglect.

Working with resistance includes:

- Acknowledging that the person with personality disorder has a right to decide the level of involvement of their carer and family
- Exploring the reasons for the person's reluctance or resistance. This will assist in developing a Care Plan, case formulation and treatment plan.

Although it is generally beneficial to involve families, it may be detrimental at times. If there are concerns about involving family members in treatment, it is highly recommended these issues be explored within the team and in supervision. It may sometimes be more useful to involve families or carers later in treatment.

General anxieties and fears about involving families can usually be overcome by explaining the benefits of inclusion. Discussions about involving carers should be revisited during treatment.

Other Supports

Families and carers of people with personality disorders may benefit from an individual support session with a clinician. This may involve a brief service contact including assessment of need, care planning, psychoeducation, additional appropriate referrals and general support. This will help families better understand the disorder, identify pathways for further support and navigate the mental health system. This session may also help the family develop an action plan for future crises (e.g. Carer Plan; see example in *Guidelines for Developing a Care Plan* chapter). Brief intervention for families is considered one to three sessions, and may provide referral for more intensive family treatment as appropriate. See the Project Air Strategy *Brief Intervention Manual for Personality Disorders* for an example carer session.

Families and carers may also benefit from a family support group. Groups help families develop connections with others, problem solve difficult situations, reduce stigma, burden and isolation.

Considerations for Parents

- Parents of a person with a personality disorder may be heavily burdened and experience emotional, physical, financial and marital strain
- Parents may feel guilty or blamed for their child's disorder. They may feel wary of mental health professionals and be sensitive to perceived criticism or accusations
- Parents often find themselves taking a polarised position; one parent may jump in when the child is in crisis, whereas the other may respond by imposing rules or boundaries. This sends confusing signals

and adds to family and marital strain.

When working with parents:

- Acknowledge the significant burden of caregiving and recognise that they are doing the best that they can
- Remind the parent about the significant genetic and biological component of personality disorders (abuse or neglect is not always present)
- Assist the couple to collaboratively agree on a unified approach to crisis management, boundary setting, and consequences of behaviours, ensuring that they are both able and willing to be consistent with this plan
- Encourage the couple to prioritise maintaining their own relationship through effective communication and self-care.

Considerations for Spouses and Partners

- A spousal or partner relationship is typically reciprocal, therefore partners may experience anger and resentment in supporting the person with personality disorder
- Initially, partners may go to extreme lengths to work on their relationship and try to 'fix' the personality disorder. In time, the partner may come to a cross roads - accept the personality disorder or leave
- Separations from people with a personality disorder can be particularly lengthy and painful.

When working with spouses and partners:

- Encourage the partner to spend time taking care of themselves and establishing appropriate boundaries
- Encourage communication between the couple, and explore crises and anger as expressions of a need rather than manipulations.

Considerations for Siblings

- Siblings are generally less tolerant of the behaviours of the person with personality disorder and may resent the impact that personality disorder has on their parents and family environment
- Siblings often find themselves pulled into a caregiving role, or pressured to be the 'perfect' child to compensate for the behaviours displayed by the sibling with personality disorder
- Siblings may feel that their own accomplishments and problems fail to be recognised, as parents are often preoccupied with the child with personality disorder
- Siblings may express their frustrations with passive-aggression or acting out behaviours
- Siblings may be drawn into a caretaker role, which might compromise their own healthy development
- Siblings may feel that their parents are too lenient towards behaviours of the child with personality disorder. This may create further conflict within the family, and strain family relationships.

When working with siblings:

- Ascertain if the sibling is at risk of harm
- Acknowledge that the sibling may feel neglected by their parent's caregiving and may experience potentially complex emotions (such as resentment) towards the person with personality disorder
- Engage the sibling in collaborative family decisions around crisis management, boundary setting and the consequences of behaviour, and ensure that they are able and willing to be consistent with these plans.

Considerations When the Parent has a Personality Disorder

- Personality disorders involve diagnostic features that can provide particular challenges when parenting. This includes problems with interpersonal relationships and an impaired sense of self that can significantly impact on the capacity to relate to others in a consistent way
- Early intervention with parents and their family is essential to ease the burden on children, to enhance psychological

health, ensure safety and to build strong and positive relationships.

When working with parents with a personality disorder:

- Ascertain if the child is at risk of harm
- Develop a Care Plan to assist in crisis management and self-care, including how child protection will be assured if the parent becomes very unwell
- Develop the parent's capacity to communicate their mental health difficulties with their children in an age appropriate way
- Provide skills so that the parent may protect the child from being witness to the extremes of the disorder (e.g. self-harm)
- Assist parents to reinforce boundaries, including roles within the family, and reduce 'parentification' of the child
- Engage the parent in treatment to encourage them to hold the child's needs in mind
- Develop the parents ability to recognise and meet the children's needs
- Reduce self-blame and criticism by reinforcing attempts at 'good enough' parenting rather than perfection.

Considerations for Children

- Children with a parent with personality disorder may blame themselves for their parents' moods and behaviours
- Children may believe that they are 'bad' as their parent may be reactive or upset with them
- Children may learn how to keep their parent calm to avoid conflict
- Children require guidance and support from the other parent or other adults to balance the difficult situation
- It is likely that an open and honest conversation, when appropriate, about the parent's difficulties, disorder and treatment may be helpful
- Children of parents with personality disorders may experience greater depression, medical problems, behavioural difficulties, suicidality, functional impairment, substance abuse or other mental health issues compared to their peers.

When working with children:

- Ascertain if the child is at risk of harm
- Depending on the child's age, encourage the child or an appropriate adult to develop a Care Plan for crisis management and self-care
- In the event of a crisis, it may be helpful to explore the potential triggers with the child to reduce self-blame and increase recognition of future impending crises
- Children should be supported to engage in activities and opportunities that are developmentally appropriate (for instance, schooling, sport, music or other interests) similar to their peers. This may involve referring to appropriate services for additional support such as group or community programs to reduce feelings of isolation and burden
- Set-up a support system for the child - involve extended family, other adults, school teachers and counsellors.

What if a family member is a perpetrator or the family is considered too problematic?

People with personality disorder may have experienced early trauma including childhood neglect or abuse. The perpetrator of the abuse may reside in the family or have a significant relationship with the person with personality disorder. A thorough assessment of the family relationships will assist in developing a treatment and support plan. If the person continues to be at risk, refer to your health service safety and risk policies and procedures. You may need to take action to support safety and promote justice.

There may be times when a family member is considered problematic by the service (e.g. a partner or parent has severe alcohol or substance dependence) and services may consider excluding the family member's involvement in the person's care. However, if the family is excluded from the service, it may jeopardise the person's engagement in treatment, especially if the

person is dependent on the family (e.g. reliant on the family for housing or financial support or transport). These situations are extremely complex and sensitive, and often require supervision and consultation to establish clear treatment goals and boundaries.

Guidelines for Brief Intervention

Background Information

Treatment compliance is greater for people with personality disorders when:

1. A referral for a follow-up assessment and treatment has been made
2. An accessible and brief intervention has been offered.

Aims and Principles of Treatment

Brief intervention is a short time-limited intervention for people with personality disorders who are not currently engaged in longer-term community treatment. A brief intervention typically follows a presentation to an emergency department or a hospital admission and helps to improve psychiatric follow-up. It is anticipated that referral to a brief intervention team will promote a shift away from reactive crisis-based behaviour and support further engagement in ongoing community treatment.

Key principles of brief intervention treatment for people with personality disorders include:

- Engage the person in crisis (within 72 hours of presentation) in a treatment program
- Stabilise and support the person after a crisis
- Provide an integrated, planned approach to managing problems
- Provide time-limited psychological treatment options irrespective of the reason for presentation
- Provide present-focused supportive psychosocial assessment (including risk assessment and comorbidity)
- Provide brief, time-limited treatment with a primary focus on psychoeducation and crisis survival skills
- Develop a Care Plan. See *Guidelines for Developing a Care Plan*
- Reinforce the importance of developing strong links to available services
- Actively encourage the person to engage in further social and psychiatric assessment and longer-term psychological treatment.

Users' Experience of Services

People with personality disorders may experience little or no follow-up care following a crisis. This may be due to a number of factors including limited resources, staffing constraints, difficulties knowing where to refer and who to refer to, and/or failure to identify the benefits of follow-up treatment.

A predictable, coordinated and structured brief treatment program provides clients in crisis with follow-up care. Assertive and proactive follow-up also encourages engagement, particularly in longer-term psychological treatment.

Guidelines

The aim of this guideline is to support the person to engage with services when they first encounter difficulties and encourage the development of strong links to ongoing community treatment. A brief intervention typically follows a presentation to an emergency department or a hospital admission. It has been important in integrating a brief intervention program into the mental health service to be flexible in approach and adapt the program to the needs and policies of the local mental health service. See the Project Air Strategy *Brief Intervention Manual for Personality Disorders* and *Guidelines for Commissioning a Personality Disorder Service* for more specific details.

Initial Steps

The following steps are recommended during the initial phase:

- ENGAGE: As soon as the referral has been received, make contact with the person to schedule their first appointment. Attempt to ensure this appointment is within 72 hours of receiving the referral
- PROVIDE INFORMATION: Clearly describe the service you can offer. People with personality disorders may be unaware of their treatment options
- REMIND: Make a reminder telephone call in the 24 hours leading up to the first scheduled appointment
- BE FLEXIBLE: If the person is unable to attend, or does not show for their first appointment, offer an alternative time.

Consultation

The following steps are recommended during the consultations:

- PROVIDE INFORMATION: Include an overview of the structure and content of the sessions
- ASSESS: Conduct a focused, supportive psychosocial assessment
- LISTEN: to the person's current experience. Provide the person with practical crisis survival skills that relate to their current experience, validate their current situation and focus on the here and now, rather than past trauma's
- PSYCHOEDUCATION: Provide information about personality disorders. Describe experiences that are common to people with a personality disorder
- CRISIS SURVIVAL SKILLS: Develop a Care Plan with the person. See *Guidelines for Developing a Care Plan*
- REVIEW: the Care Plan with the person at each appointment. Review progress prior to their termination or referral to ongoing community treatment
- ENCOURAGE: the person to engage in longer-term treatment if necessary. Inform the person of research outcomes for people with personality disorders who engage in longer-term treatment - this will provide hope and motivation
- REMAIN SUPPORTIVE: See *The Relational Model of Treatment, Key Principles for Working with People with Personality Disorders*.

Referral

Points to consider:

- REFER: Support the person to engage in ongoing treatment. Discuss the benefits of treatment and refer the person to a service or health care provider (e.g. local Community Mental Health Team, private psychologist)
- INFORM: Let the person know about the outcome of the referral, including waiting periods or timeframes. Encourage the person to utilise their Care Plan in the meantime
- LINK: the person in with other support groups or clinical services as appropriate.

Information for Clinicians:

- Time-limited: Presentation to emergency departments should be followed by a structured brief time-limited program. Be clear about the number of sessions you can offer
- Care Plan: Support the person's effective collaboration with other care providers during times of crisis. A collaborative and integrative approach for managing a crisis and setting goals is recommended
- Session content: Inform the person about the content of the sessions
- Assessment: Conduct a focused, supportive psychosocial assessment
- Listen to the person's current experience: Avoid re-visiting past experiences. Provide the person with practical skills that relate to their current experience
- Psychoeducation: Educate the person about personality disorders. Describe experiences that are common to those with a personality disorder and be supportive in your approach
- Care Plan: Develop an individualised Care Plan with the person. See *Guidelines for Developing a Care Plan*. This should be done collaboratively with

the person to ensure they feel comfortable utilising the advised techniques. It will also help the person to engage with treatment services in the future and utilise crisis survival skills

- Referral for ongoing treatment: Support the person to engage in longer-term treatment by discussing treatment options with them and referring them on to an appropriate treatment service
- 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 a personality disorder. It is important to discuss such issues in an open and honest manner
- Review: Ideally the service should review the outcomes of brief intervention to identify potential areas for improvement in clinical practice
- Service Evaluation: Ongoing meetings for service evaluation and development attended by key staff including clinicians from psychiatry, Emergency Departments and acute care teams, psychology, nursing, social work, occupational therapy, clinical pharmacology and drug and alcohol services are recommended.

Guidelines for Ongoing Community Treatment

Psychological therapy is the treatment of choice for personality disorder. People with personality disorder often have long treatment histories. The current episode needs to be understood within the broader treatment history and future treatment needs.

A coordinated ongoing community treatment model, which supports continuity of care and is understood within a relational model, is essential to the effective treatment of personality disorders. This is to prevent experiences of treatment as limited, fragmented and episodic.

Key considerations of ongoing community treatment for personality disorder include:

- The **primary clinician** is responsible for taking the lead role in developing the Care Plan. See *Guidelines for Developing a Care Plan*
- The person's autonomy and choice in developing their plan for treatment should be fostered
- Treatment objectives should be clearly defined with short- and longer-term goals identified
- It is to be expected that progress may be slow or varied in the earlier stages of treatment and it can be helpful to communicate this to the person. It is important to acknowledge and celebrate minor achievements that are consistent with the agreed goals for treatment
- The Care Plan should be distributed to all services involved including Emergency Department, Mental Health Inpatient Units, general practitioners, private psychologists or psychiatrists, and other involved health professionals or services
- Primary clinicians should not work in isolation and should seek peer consultation and clinical supervision on a regular basis.

Eligibility Criteria

Each service should develop eligibility criteria for the ongoing community treatment of people with personality disorder. The following criteria are recommended:

- The person has a primary or secondary diagnosis of personality disorder
- The person is at significant risk of self-harm
- The person has marked low psychological, social or occupational functioning
- The person has high usage of community services without positive outcomes.

Local Protocols

Each service should develop protocols for accepting referrals of people with personality disorders. The following guidelines are recommended:

- Eligibility criteria should be dynamic
- Decisions to accept a referral should be made by a clinical team and not by any one individual
- If a referral is not accepted, alternatives for care should be discussed with the referring person or agency.

Provision of Psychological Treatment

Effective treatment of personality disorder involves a coordinated care approach, which underpins the many and varied treatment modalities. See *The Relational Model of Treatment*. When considering a psychological treatment for a person with personality disorder, the service should take into account:

- The diagnostic assessment, case formulation and treatment plan – this provides treatment direction
- The severity of the disorder
- The person's willingness to engage in therapy and their motivation to change
- The person's ability to remain within the boundaries of a therapeutic relationship
- The availability of treatment and professional support
- Involvement and support of families and carers. If the family are not supportive of

treatment, it may be difficult for the person to sustain care.

When providing psychological treatment for people with personality disorder, especially those with multiple comorbidities, the following service priorities are recommended:

- A coordinated treatment approach in accordance with the *Guidelines for Developing a Care Plan*
- A trusting, open, consistent and reliable approach to treatment
- The frequency of treatment sessions should be adapted to the person's needs (e.g. offering twice-weekly sessions if deemed necessary)
- Personality disorders can be difficult to change. Evidence based treatments are all long-term - up to 12 months or more. Psychological interventions should be provided for a minimum of 6 months with the option to continue if helpful. This does not include brief interventions that engage the person and provide a conduit into longer-term treatment. See *Guidelines for Brief Intervention*
- Monitor the effects of treatment on a broad range of outcomes including personal, social and occupational functioning, drug and alcohol use, self-harm, depression and the symptoms of personality disorder
- Treatment of comorbid conditions should be integrated within the overall treatment, using structured and well-established interventions.

Retention

People with personality disorder may miss appointments, demand immediate support at unscheduled times, appear ambivalent about treatment progress and, at various times, disengage from the service. Challenges in engaging the person and building a therapeutic relationship are inevitable as relationships may be experienced as threatening or unsafe. It is important that the primary clinician seeks support and clinical supervision to work through these difficulties and ensure longevity of treatment.

Continuity of care can also support retention in treatment. It should begin during the assessment phase with the clinician who takes the lead role in the initial assessment and is providing ongoing treatment. If the clinician and the treating team believe the person is better matched with a different clinician, a joint session with the assessor and new clinician may support engagement in treatment.

A reminder phone call or text message about an appointment may be appropriate for some clients, and further support retention in treatment. However, messages should be sent from a general work number rather than a private number. Boundary and risk management issues should also be discussed with the treating team and the person before this service is offered.

The Role of Medication

Medication is not considered a primary treatment for personality disorders. Medication can occasionally be used to target specific personality disorder symptoms or, where there is an evidence base, for the treatment of comorbid conditions. See *Guidelines for Medical Practitioners*.

Antipsychotic medications should not be used for the medium or long-term treatment of personality disorder. Reduction or cessation of unnecessary prescription drugs should be a priority.

Psychological Treatment

There are a number of psychological treatments available for people with personality disorders. There are common factors across all evidence-based treatments (Weinberg et al 2011). Individual therapies for personality disorder all have:

1. a focus on the treatment relationship
2. an active therapist
3. attention to affect
4. emphasis on exploratory change-oriented interventions

A number of different manualised approaches have been investigated using randomised controlled trials including

Dialectical Behaviour Therapy, Mentalisation Based Therapy, Transference Focused Psychotherapy, Cognitive Analytic Therapy, Schema-Focused Therapy and General Psychiatric Management. Among these, research suggests that no one treatment is superior for personality disorders.

The relational model to treatment incorporates aspects of Gunderson's General Psychiatric Management, which is easily applicable to health services and the wider community network, and is compatible with most other psychotherapies. The relational model emphasises relationship management skills and understanding core conflicts, and treatment focuses on the here and now.

Psychotherapy is the treatment of choice for people with personality disorders. The duration of treatment will depend on the person's willingness to engage in treatment and their motivation for change. The expected duration of treatment is a minimum of one year (usually weekly appointments) although this may vary across services.

Aspects of Treatment

Case management or a care coordination role is the basis for psychotherapy:

- Care coordination is a collaborative process of assessment, planning, facilitation and advocacy to meet an individual's mental health needs through communication and available resources to promote the best possible outcome of the consumer
- Care coordination is a mix of specialist clinical interventions, coordination of services, monitoring of the person's progress and supporting the person's recovery.

Readiness for longer-term psychological treatment

Readiness for psychotherapy needs to be established before treatment commences and is dependent upon the person:

- Seeking change
- Attempting to take responsibility for safety
- Identifying their role in interpersonal difficulties and problems.

Care coordination must recognise fluctuating treatment needs where 40-60% of clients will drop out of treatment in the first six months, 30-50% will stay long enough to benefit and others will have episodic occasions of service. Actively engaging and encouraging the person to continue in treatment is essential, whilst understanding that some people may drop-out, despite best efforts on part of the therapist.

NOTE: Psychotherapy may be contraindicated for people with antisocial personality disorder with severe psychopathology.

Core Tasks of Psychotherapy

The core tasks of psychotherapy include (Gunderson, 2000):

1. Building a contractual alliance – focus on engagement, setting the frame, establishing goals and frequency of sessions
2. Building relationship alliance - developing a supportive and trusting relationship, discovering unhelpful relational patterns starting at the surface
3. Focusing on the relationship - establishing trust, tolerating strong feelings, and enhancing disclosure
4. Providing effective psychotherapy - reducing problems and improving adaptation and functioning.

Four phases of treatment:

Phase 1: Getting Started

- Develop a therapeutic contract on the practicalities of therapy (attendance, missed appointments, schedule of visits, holidays and other leave dates, crisis management)
- Identify the person's goals across a range of areas (insight into self, change maladaptive behaviours and attitudes, improve relationships, new cognitive abilities such as perspective taking)
- Be active and interactive, honest, fair and reasonable
- Provide structure and safety
- Take a developmental (child-adolescent-adult) focus – understand emotional and skills deficits, focus on relationship health (to self and others)
- Foster engagement by invoking the person's attachment to the clinician,

hopes for change, interest in the process of self-disclosure and self-examination.

Phase 2: A Relational Alliance

Relationships are the focus of treatment in the relational model. Focus on the relationship between the person with personality disorder and:

- themselves
- you
- carers
- health service
- other health professionals involved in their care
- workplace
- social environment.

Phase 3: Positive Dependency

In this phase of treatment the therapeutic work focuses on connecting feelings to situations and behaviours. Much repetition may be required at this phase and therapeutic work may be intense with the clinician needing to provide a lot of containment and holding of the person in a calm and composed manner. During this phase, the person may be particularly sensitive to the clinician's moods, attitudes and absences.

Phase 4: Secure Attachment, the Working Alliance, and Consolidation of Self

- Set the therapeutic tone - be active and engaged, focus on the here and now, maintain neutrality but be emotionally engaged
- Listen to three channels of communication – verbal, non-verbal, felt experience
- Identify core conflictual relationship themes (e.g. abandonment)
- Respond to promote understanding and control – be calm, simple, warm, consistent, supportive; not over-reactive
- Value talking, listening and understanding
- Reinforce strengths and what is valid
- See *The Relational Model of Treatment, Key Principles for Working with People with Personality Disorders*.

Termination and Discharge

People with personality disorders are sensitive to loss, aloneness and rejection. Termination needs to be well planned and handled with great care. Consider termination issues from the start of therapy. When planning for discharge:

- Emphasise any progress the person has made
- Express confidence in the person's ability to manage their life both now and after termination
- Encourage the person to think about possible future goals or challenges and how to approach these
- Support the person to identify other resources available within the community
- Discuss plans for termination with the person's carers. See *Guidelines for Involving Family Members and Carers*.

Managing Endings

It is common for the client and therapist to be anxious about endings. Considerations for managing endings:

- Preparation – from the first session, talk with the client about the end
- Discuss the final session well in advance
- Consider using a therapeutic letter, card or symbolic ending
- Summarise the therapy. Invite the client to write or verbalise a summary.

Unplanned Termination

Unplanned termination can happen for many reasons, such as the person moving house or the clinician changing jobs. It is crucial that, no matter what the stage of therapy, this is handled with great care and sensitivity. If termination is so sudden that further sessions are impossible, the clinician should find creative ways to ease the transition, such as a telephone call or letter.

Termination is a crucial part of treatment and recovery for a person with a personality disorder. When well-managed, people will have a new and helpful experience of a relationship ending. Discharge plans should be discussed with the treating team and discussed in clinical supervision.

Guidelines for Clinical Supervision and Consultation

Peer consultation and clinical supervision are essential components of evidence-based therapy. There are many challenges associated with working with people with personality disorders. Recurring crises, repeated self-harm or suicide attempts, problems with discharge and slow treatment progress can flummox even the most experienced clinician.

Given these challenges, it is essential that clinicians are supported to work effectively with people with personality disorders. Crucial components of this support include the provision of specific skills and training and specific time for debriefing, processing, clinical supervision and consultation. It is well established that clinical supervision supports clinicians to provide effective treatment for people with personality disorders.

The following points differentiate between clinical supervision and consultation. They support the many theoretical approaches used to treat people with personality disorders.

Clinical Supervision and Consultation

Clinical supervision involves the support and discussion of a clinicians work in order to develop and consolidate their knowledge and skills. It can also include debriefing.

Clinical supervision is recommended for all clinicians irrespective of their level of experience, but is particularly beneficial for the beginning or intermediate therapist. It is also helpful for the treating team to develop and maintain a consistent approach to treatment.

- CLINICAL SUPERVISION AND CONSULTATION ARE ESSENTIAL for working effectively with people with personality disorders, no matter what the theoretical orientation of the service or the clinician
- REGULAR weekly or, at the very least, fortnightly clinical supervision is recommended to master the many complex clinical skills associated with working with people with personality disorders. Although consultation may occur less frequently than clinical supervision and may be used by more experienced clinicians, even an experienced clinician who has a sophisticated theoretical understanding encounters occasional difficulties in responding professionally
- EXTERNAL clinical supervision is recommended to help the clinician view the clinical situation with greater clarity
- PURPOSE: A primary goal of clinical supervision is to increase the clinician's ability to respond thoughtfully, rather than reactively
- CONTAINMENT: Clinical supervision should provide effective containment for the clinician. The supervisor can function as a historian of the clinical process and act as an anchor when the clinician is caught off guard
- RESPONSIBILITY: Responsibility for the treatment of the person with personality disorder rests with the clinician, treating team, manager and clinical director
- REVIEW: If not engaged in supervision, it is recommended that clinicians seek consultation at least once a year regarding their tolerance and sensitivity towards complex and chronic clients
- SHARED RISK: Decisions made are not just based upon one person's decision making process.

Conflicts Within Treating Teams

Treating teams may also find the team experiences conflicts and disagreements. These disagreements are the team's reaction to the person's behaviour and not necessarily something the person is doing to the team. The team's disagreements may, however, represent the person with personality disorder's own experience of him or herself as either good or bad. Alternatively, different staff member's experiences of the person with personality

disorder may lead to differences in opinion among a team struggling to understand the person's primary issues. They may also reflect the person's fragile sense of self, their own internal chaos, and ongoing problems in sustaining relationships.

Treatment of personality disorder is most effective when members of treating teams learn to manage their reactions and communicate with each other. Group clinical supervision and peer consultation is recommended for all team members to assist with this.

Team Leaders and Managers

Team leaders can play an important role in modelling adaptive and constructive responses to people with personality disorder. Support from management is also vital in acknowledging that clinical supervision and consultation is a legitimate part of the clinician's role and does not signify weakness or ineffectiveness.

Common Clinician Reactions

A clinician's personal reactions toward the person they are treating can be influential in the treatment process. These personal reactions can provide:

- A helpful process that allows the clinician to better understand the way the person may influence others. Through noticing the way the person affects the clinician, the clinician can see how the person affects other people in their life
- An unhelpful process when the clinician reacts negatively toward the person. NOTE: this can result from issues in the clinician's own life or from aspects of the person's presentation that are not understood or able to be tolerated by the clinician.

Clinical supervision provides a context for examining these issues. It can facilitate insight into personal reactions and develop skills to enable these reactions to progress treatment.

One way of enhancing the clinician's capacity for thoughtful intervention is to identify the function of the feelings the clinician is having (for example, the clinician may feel guilty about not being able to solve their client's problems and may do more for their client to compensate for these feelings – by understanding the function of these guilty feelings, the clinician can step back and encourage the client do take more responsibility for his/her own life.

Many clinicians, particularly those early in their career, are reluctant to share intense feelings in clinical supervision. To help overcome this, the optimal approach to clinical supervision is to steer a middle course between analyses of the clinician's reactions toward the person they are treating with an educative focus on aspects of treatment.

Guidelines for Commissioning a Personality Disorder Service

This guideline outlines the steps to follow when commissioning a personality disorder service. The evidence base for the treatment of personality disorders provides confidence in the value and efficacy of implementing a specific personality disorders service. Good implementation and careful commissioning is needed to ensure that the other guidelines provided here are implemented fully with high adherence and competence in their use with the target health population.

Develop a plan and a strategy to implement the change, assessing critical factors for success including the readiness for change in the organisation. Use the principles of implementation science, that is, the transfer of discoveries in the health sciences research into implementation in routine clinical practice.

Develop a partnership between the service funding agency, the service managers, and a research team to allow the development of effectiveness studies contributing to evidence, bridging the evidence-base and clinician training gap, and fostering innovation.

Commission first with managers: Those in leadership and management positions who have authority and power must be approached first to obtain support for the project. There must be an active transfer of this support from the leaders to the rest of the organisation to broaden consensus that the service should be implemented as a priority. Leaders need to promote an organisation that is open to change and innovation and that is flexible in responding to new ideas.

Address resistance: Recognise resistance to practice change across different nodes of the service, from leaders to practitioners to consumers, and address this resistance.

Work with resistance: Discover the barriers to change based on scepticism, and prepare specific educational points to counteract fears and misconceptions.

Face to face: Present the guidelines and the treatment approach to managers and staff directly to allow both a formal presentation of facts and for implicit knowledge to be communicated.

Active presentation: Get the group actively involved in the presentation to develop allegiance and foster shared ownership in the ideas of the project.

Recognise all the levers of change: Developing guidelines and disseminating them will not lead to practice change without demonstrating the advantages and benefits of the approach and providing adequate supportive resources, leadership and training.

Identify supporters: Recognise the need to have 'champions' who are prepared to support the change at different levels of the organisation. Recognise that only focusing on changing each individual's practice will be difficult and slow, compared to system-wide implementation projects. Ensure that the ‘champions’ approached are motivated and committed to the project and are willing to take a lead role in championing change throughout the service. Where possible, allow ‘champions’ to self-identify within the service.

Develop a long-term view: Understand that sustaining changes in the long-term requires maintenance and monitoring programs to identify barriers and capitalise on strengths helping to support change.

Educate consumers: About making informed choices in favour of evidence-based options. This can help reinforce system changes and implementation of new approaches.

Weigh up the advantages of program implementation: Recognise that immediate needs in terms of waiting lists, staffing problems and immediate clinical management issues needs to be balanced with the advantages of taking time out to plan change and develop systemic innovative solutions.

Build in cost-benefit analyses: The cost of not adopting the approach versus cost of adopting it; the value and added benefit of change. The cost of not-treating properly on the person with personality disorder and on society outweighs cost of treatment. Cost of training must be compared to cost to staff without the program. Consider measuring staff satisfaction, reductions in use of expensive emergency and mental health inpatient services, and the overall value of the investment.

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