Livewell Southwest

Personality Disorder Service Operational Policy

Version No.1
Review: November 2016

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The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Personality Disorder Service Lead**

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0.1	New policy	July 2014	Specialist Personality Disorder Practitioner	New policy
1	Ratified	September 2014	PRG	Ratified with minor amends.

Personality Disorder Service Operational Policy

1 Introduction

1.1 The Personality Disorder Service has been established within Livewell Southwest (LSW) to provide five aspects of service:

- It will offer a specialist psychotherapy assessment and treatment service for this client group in line with National Institute for Health and Care Excellence (NICE) guidelines and recommendations (2009).

- It will also provide teaching and training for staff who work directly and indirectly with those who may attract a diagnosis of Personality Disorder.

- The newly established service will undertake consultation with staff working who may wish to discuss a range of issues related to their client's presentation.

- The Personality Disorder Service will provide consultation to the organisation regarding service development and provision for those diagnosed with a personality disorder. It will promote current best practice, encourage audit and research and oversee the implementation of NICE guidance.

- The service will promote an ethos that contributes to better understanding of Personality Disorder across the organisation and to the reduction of stigma associated with the diagnosis. It will embrace the values of good practice and adopt a positive approach to service provision.

1.2 NICE recommends that a dedicated Personality Disorder Service be available and be informed by a psychological approach, offering psychological treatment to clients with this diagnosis. http://www.nice.org.uk/nicemedia/pdf/CG78NICEGuideline.pdf

1.3 NICE states that the prevalence of clients diagnosed with a personality disorder in mental health settings can be over 50%. Research has also shown that those with a diagnosis of personality disorder have nearly 50% more contacts with secondary health care workers. The client group are also more emotionally demanding of staff because of the nature of their relationship difficulties and often present with high risks.

1.4 The service will provide a Dialectical Behaviour Therapy (DBT) programme as the core component of its psychotherapy treatment.

1.5 DBT is one of the few psychological interventions for Borderline Personality Disorder (BPD) that has controlled empirical evidence for its effectiveness. http://blogs.uw.edu/brtc/publications-articles-on-dialectical-behavior-therapy-dbt/

1.6 This growing body of evidence indicates that BPD clients have shown greater improvement on a number of measures following DBT when compared to BPD clients receiving treatment as usual. Improvements have been found on measures of suicide and self-harm behaviour, suicidal ideation, depression, anger, global psychological functioning and a reduction in hospital ward stays.

2 Purpose

2.1 The purpose of this policy is to provide a unified operational policy for the Personality Disorder Service and outline how the core components of effective practice are to be delivered across LSW. It is a working document that will be continually reviewed and updated in line with local need.

2.2 This policy will provide clarity to our stakeholders within LSW to encourage collaborative working and the development of smooth processes between services.

2.3 The Service has been developed to work towards meeting NICE guidelines and recommendations for working with clients with a diagnosis of Borderline Personality Disorder (NICE 2009). The chosen model of treatment (DBT) is comparatively well researched and originated from work by Marsha Linehan in America in the late 1990s. This policy will reflect how the service will maintain fidelity to the model of treatment whilst recognizing the specific needs of our client group in LSW.

2.4 It will provide an operational framework within which team members operate and provide guidance for other teams on procedures for referral, treatment and discharge.

2.5 This policy will also promote the need for a cohesive model of support and supervision for the team members working within the Personality Disorder Service. It is recognised that this work can place considerable emotional demands on therapists. With this in mind it is important that the team have a stable base and strong collaborative ethos.

3 Guiding Values and Principles

The service will:

3.1 Provide a service that respects the privacy, dignity, choices and confidentiality of each individual service user acknowledging their culture, ethnicity, physical ability, gender, sexual orientation and religious beliefs.

3.2 Develop and sustain trusting relationships as a key to effecting change.

3.3 Be respectful towards individuals, carers and families.

3.4 Recognise and respect individual strengths.

3.5 Remain hopeful and optimistic.

3.6 Balance efforts to be consistent and reliable with the understanding that the environment is in a constant state of change.

3.7 Employ staff that are committed to working with the target group and who are suitably qualified, trained and supported to provide high quality interventions.

3.8 Recognise that 'Personality Disorder is everybody's business' and support the development of understanding and capability in the wider health and social care community.

3.9 Attend to team member's ongoing learning and consultation needs through reflective practice and the prioritising of team consultation meetings as described within the treatment model.

3.10 Act to promote long-term physical and emotional safety for staff, service users, carers and the wider public.

3.11 Promote best practice by exemplifying a structured, positive and compassionate approach to helping people with severe emotional and behavioural difficulties.

4 Definitions

4.1 BPD – Borderline Personality Disorder

DBT – Dialectical Behaviour Therapy

NICE – National Institute for Health and Clinical Excellence

CMHT – Community Mental Health Teams

CFT – Community Forensic Team

ASR – Asylum Seeker and Refugee Team

MHM – Mental Health Matters

HTT – Home Treatment Team

LSW – Livewell Southwest

AOS – Assertive Outreach Service

KUF – Knowledge and Understanding Framework

5 Operational Criteria for Dialectical Behaviour Therapy Component of Service

5.1 Target Group

5.1.1 The therapy offered by the team has been developed and evaluated for use with clients who meet the diagnostic criteria for Borderline Personality Disorder (DSM IV), particularly those with histories of multiple self-harm and suicidal behaviours.

5.1.2 These clients also often present with marked emotional instability; difficulties with chaotic or unstable relationships; fear of abandonment; unstable self-image; impulsive self-damaging behaviours (e.g. substance abuse, binge eating); chronic feelings of emptiness; difficulties with anger; and transient psychotic or severe dissociative experiences.

5.1.3 These difficulties can lead to clients having multiple contacts with primary and secondary care services, often including emergency and crisis services, and to being frequent users of unscheduled care.

5.1.4 The overall aim of the DBT service is to successfully engage with this client group to help diminish their distress and help them achieve a better quality of life. For most clients this will involve the reduction of self-harm/suicidal behaviours and learning skills necessary for surviving emotional crises, regulating emotions and improving interpersonal effectiveness.

5.1.5 The service aims to promote best practice by exemplifying a structured, positive and compassionate approach to this client group.

5.2 Philosophy

5.2.1 The dialectical philosophy upon which the treatment is based ensures the balance of acceptance and change within the treatment as a whole and within each individual interaction. The treatment is structured around the following assumptions about clients and therapy:

5.2.2 DBT assumptions about clients:

- Clients are doing the best they can.
- Clients want to improve.
- Clients must learn new behaviours in all relevant contexts.
- Clients cannot fail in DBT.
- Clients may not have caused all of their own problems but they have to solve them anyway.
- Clients need to do better, try harder, and/or be more motivated to change.

- The lives of suicidal, borderline individuals are experienced as being unbearable as they are currently being lived.

5.2.3 DBT assumptions about therapy:

- The most caring thing a therapist can do is to help clients change in ways that bring them closer to their ultimate goals.
- Clarity, precision and compassion are of the utmost importance in the conduct of DBT.
- The therapeutic relationship is a real relationship between equals.
- Principles of behaviour are universal, affecting therapists no less than clients.
- Therapists treating borderline clients need support.
- DBT therapists can fail.
- DBT can fail even when therapists do not.

5.3 Referral Criteria

5.3.1 It is important that staff do not make a referral until they have spoken with a member of the Personality Disorders team about the client concerned. The team is based at Riverview, Mount Gould Hospital and can be contacted on (01752) 435179.

5.3.2 People referred for DBT should have a diagnosis of borderline personality disorder or present with difficulties consistent with this diagnosis.

5.3.3 They must be known to secondary mental health services and have a care co-ordinator external to the DBT team.

5.3.4 They are likely to present with repeated serious self harm and/or suicidal behaviours/gestures.

5.3.5 They have multiple contacts with primary and secondary care staff including emergency/crisis services and high use of unscheduled care.

5.3.6 They will have an awareness of the referral and should have a general idea of what the therapy they are being referred to involves :

- They will know that self harm and suicidal behaviours are target behaviours in therapy and that emotional regulation and interpersonal skills are also a focus.
- They will be motivated to work in a collaborative manner and be able to tolerate working in both an individual and group setting.
- That therapy is time limited and will last for 12 months.

5.3.7 The following exclusion criteria may also apply:

- Diagnosis of Anti-social Personality Disorder and/or history of dangerousness to others.

- Alcohol/Drug dependancy to a level which is likely to interefere with therapeutic engagement.
- Current court disposals.
- DBT treats individuals as having capacity and being responsible for their actions. It is therefore not suitable for individuals who are deemed to lack capacity, including those currently detained under the Mental Health Act.

5.4 Referral Process

5.4.1 It is requested that all referrals are discussed with the team prior to completing the paperwork. We are happy to discuss any potential referrals and answer any questions regarding the treatment or the process.

5.4.2 Referrals for assessment will be accepted from care coordinators within established mental health teams (CMHTs, AOS, CFT, ASR) or complex needs teams for individuals who meet the referral criteria.

5.4.3 Referrers should complete a referral form and consult the guidelines for considering the client's suitability for DBT.

5.5 Assessment

5.5.1 An assessment will be undertaken by a member or members of the DBT team and will include:

- Clarification of presenting problems and goals.
- Social and family history; current support network; details of previous therapeutic input; details of past and current risk behaviours.
- A range of diagnostic and outcome measures.
- Assessment of capacity for recommended treatment.
- Analysis of impediments to recommended treatment.

5.5.2 The client will be given verbal feedback from the assessment and this will be followed up in writing with a copy to the care coordinator and other relevant professionals.

5.6 Pre-Treatment Sessions

5.6.1 If the client is accepted for treatment following assessment they will commence pre-treatment sessions. During this phase, the therapist orientates the client to the treatment and assists the client to make an informed decision about committing to therapy.

5.6.2 Before therapy can begin the client must agree to work on decreasing para-suicidal behaviours and interpersonal styles that interfere with therapy and on increasing behavioural skills.

5.6.3 If DBT is not felt to be suitable for the client at the present time or they are unable to commit to therapy, the therapist will endeavour to provide useful feedback and suggestions to the client and to the referring team.

5.7 Modes of Treatment

- **Individual Psychotherapy:** The client will be allocated a primary therapist from the DBT team who will undertake individual psychotherapy, working collaboratively with the patient. Individual therapy takes place on a weekly basis.

- **Group Skills Training:** This is an integral and essential part of the DBT programme and focuses on the acquisition of new skills. It is taught on a modular basis with the four elements of skills training being: Core Mindfulness Skills; Interpersonal Effectiveness; Emotion Regulation; Distress Tolerance.

- **Telephone Consultation:** Individual therapists will provide their clients with clear, written instructions on how and in what circumstances they could be contacted. Telephone contact is primarily around skills coaching when clients may be struggling between sessions.

- **Therapist's Consultation Meetings:** This meeting takes place on a weekly basis and includes all members of the DBT team. It runs according to a set format and is based on dialectical principles and agreements between members. The meeting provides a formal process of support and supervision that enables practitioners to develop knowledge and competence and assume responsibility for their own practice.

5.8 Liaison

5.8.1 Therapists will work with clients to take responsibility for their own interactions with others and will not intervene or act on the clients behalf.

5.8.2 The team will provide other professionals with general information, consultation and training about the treatment program. As a general principle, they will not tell other professionals how to treat the client. Therapists will not discuss their clients with other professionals outside of the treatment team unless the client is present. However, documentation regarding therapeutic progress will be maintained in accordance with LSW policy and good practice guidance.

5.8.3 Therapists will not intervene to solve problems for the client with other professionals nor will they defend other professionals.

5.8.4 The therapist will only liaise directly with other professionals in specific situations where there is an increased risk to self or others and the client is unable to communicate this themselves or it is not appropriate for them to do so.

5.8.5 During in-patient stays, voluntary or involuntary, the role of the therapist becomes to consult with the client to achieve a safe and early discharge from hospital in order to continue with the DBT programme.

5.9 Discharge

5.9.1 The client will usually stay in therapy for a period of 12 months. On reaching the point when they are ready to leave the DBT programme, discharge will be planned and the relevant professionals will be informed. Some clients will continue to be supported by CMHT, some may seek further therapy and some may be discharged from secondary care.

5.9.2 DBT has lower attrition rates than other forms of psychotherapy with this client group but the client may decide to terminate treatment at any time. It is expected that this will be discussed in session with the therapist.

5.9.3 During pre-treatment the client will be made aware that if they miss four weeks of scheduled therapy in a row, either group skills training or individual therapy, they will automatically leave the programme. Return to therapy is then a matter of negotiation after the agreed contract time has elapsed.

5.9.4 There may be exceptional circumstances when missing four weeks of scheduled therapy is unavoidable. In these circumstances a DBT fall back strategy is to put a client “on vacation”. This is the cessation of therapy for a specified period of time or until a particular condition is met or change is made. The therapist will advise the care coordinator regarding any significant breaks or termination of therapy.

5.10 Evaluation and Outcome Measures

5.10.1 The treatment adherence of the therapists and their ability to self-regulate will be maintained through the consultation meetings. Participation within the bounds of the consultation agreements will help therapists remain dialectical. Contributing to regular teaching and discussion will also advance DBT practice.

5.10.2 The team will initially have access to expert external supervision and avenues for further training and development will be explored.

5.10.3 A range of clinical outcome and quality of life measures may be taken at points before, during and/or after treatment to evaluate the effectiveness of the service.

5.10.4 Dependent on the clinical information available, the team also aims to audit episodes of self-harm by clients, inpatient hospital stays and Emergency Department attendance to monitor the effectiveness of treatment.

5.10.5 Links will be made with Service User Groups, and in particular with the current

Personality Disorders Peer Support Group, in order to engage clients in service development and also to provide feedback on services.

5.10.6 The service may use such tools as the Millon Multi-Axial Inventory, BEST, IIP-32 and CORE to monitor the diagnostic criteria and quality of life indicators for clients in treatment.

5.10.7 These measures may be collated at points pre, during and post treatment to review the efficacy of treatment and inform future practice.

5.10.8 The service will also use the Meridian service user questionnaire/feedback.

6 Training and Staff Development

6.1 Team Structure

6.1.1 The Personality Disorder Service will be led by a Consultant Counselling Psychologist with three further Specialist Practitioners acting as Primary Therapists for the DBT component of the service. These Practitioners will have a core professional registration in psychology, mental health nursing, occupational therapy or social work. The team may also consist of and supervise Psychology Assistants/Trainees and/or Psychology Placement Students.

6.2 Provision of Supervision and Consultation

6.2.1 As well as providing DBT, a core function of the Personality Disorder Service will be the provision of supervision and consultation to LSW staff working with clients with a diagnosis of Personality Disorder.

6.2.2 This can be provided on a team, individual or case by case basis. It may also include attendance at risk management and care planning meetings.

6.3 Provision of Training

6.3.1 The Personality Disorder Service will also develop and provide training programmes on the diagnosis and management of Personality Disorder and the provision of Dialectical Behaviour Therapy.

6.3.2 Links will be made with the newly developed training department, the psychotherapy department and with CMHT psychologists. The latter already provide a range of therapeutic treatments as well as teaching and training opportunities.

6.3.3 The Knowledge and Understanding Framework (KUF) offers a nationally-recognised training on the understanding of Personality Disorder which is already on offer within LSW. The Personality Disorders Service will promote the values embraced within this training and encourage take up of the training across all levels of the organisation.

7 Monitoring Compliance and Effectiveness

7.1 The Personality Disorder Service will provide a quality evidence based service. The service will undertake regular reviews and evaluate the effectiveness of its treatment provision using a range of audit tools. Through the use of robust supervision and consultation arrangements it will strive to maintain fidelity to the model of treatment.

7.2 The team will audit the following information regarding clients in treatment:

- Episodes of self-harm.
- Inpatient hospital stays.
- Mental Health Act Assessments.
- Emergency Department attendance.

7.3 The service may use such tools as detailed in section 5.10 above, to monitor the efficacy of practice and inform future practice.

7.4 The Personality Disorder Service will steer service development through the Personality Disorder Working Group. This group ensures that strong links are maintained between services within the organisation and with relevant stakeholders and that services are developed through a broad consensus on need.

All policies are required to be electronically signed by the Lead Director. Proof of the e-signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

Signed: **Sara Mitchell**
Plym Locality Manager

Date: 13.11.14

Referral Form

Patient	
Name: _____	NHS Number: _____
Address: _____	Date of Birth: _____
_____	
_____	
Telephone: _____	Mobile Tel.: _____
Done By	
Name: _____	Date: _____

Referral Form

Created by Sarah Woolley

All questions marked with a * should be answered.

1. Referral

1.1. Reason for Referral

1. Reason for referral

2. Staff/Service concerns (eg. Why specialist support is needed, difficulties with engagement, staff or service user unable to move forward with current treatment)

3. Are you referring to the Personality Disorder Service?
   - ◯ Yes
   - ◯ No

Patient

Name: _____ NHS Number: _____

1.2. Summarised mental health history

1. Any diagnosis and/or mental health difficulties

2. Brief details of previous/current contact with mental health services (eg. contact with community mental health team, crisis services and A+E, in-patient and psychological services). Provide chronology if possible, or give indication of frequency of contacts.

1.3. Substance Misuse

1. Any substance misuse?
   - ◯ Yes
   - ◯ No

2. Details

Patient

Name: _____ NHS Number: _____

2. Summarised risk information

2.1. Vulnerability (eg. being taken advantage of and/or being harmed by others, please include any safeguarding adult concerns)

1. Current

2. Past

2.2. Self harm/ Suicide (eg. cutting, misuse of medication/ overdosing and eating difficulties)

1. Current

2. Past

Patient

Name: _____ NHS Number: _____

2.3. Risk to others (eg. violence or aggression, please include any safeguaring children concerns)

1. Current

2. Past

3. Occupational Activity

1. Please describe how time is spent and any difficulties relating to activities of daily living, education, work and leisure.

4. Medication

1. Current Medication

5. Any other relavent information to this referral

1. Details

Have you reviewed and updated relevant Risk assessment

6. Personality Disorder Service Questionaire

Remember to detail information within the referral form when answering 'yes' to the below questions.
Please ensure you have discussed this referral with the Personality Disorder Service. (01752 435179)

1*. Are you the person's care co-ordinator, or have you discussed andagreed this referral with their care co-ordinator?

- ◯ Yes
- ◯ No

Please be aware a person MUST have a care co-ordinator for consideration of acceptance to the Personality Disorder Service

2. Does the person have a history of risk to others or could they be a risk to other group members (eg. predatory sexual behaviour, exploitation)?

- ◯ Yes
- ◯ No

Referral Form

Patient

Name: _____ NHS Number: _____

This will be discussed in Consultation

3. Does the person have anti-social traits?
   - ◯ Yes
   - ◯ No

This will be discussed in Consultation

4. In your view does the person have the capacity to engage in a year long programme of group or individual therapy sessions?
   - ◯ Yes
   - ◯ No

5. Is the person aware that a reduction in suicide attempts and self-harm will be a priority in therapy?
   - ◯ Yes
   - ◯ No

6. Are the person's closest relationships often troubled by a lot of arguements or repeated break ups?
   - ◯ Yes
   - ◯ No

7. Does the person deliberately hurt himself/herself physically? (eg. punch themself, cut themself, burn themself)
   - ◯ Yes
   - ◯ No

8. Does the person have a history of suicide attempts?
   - ◯ Yes
   - ◯ No

9. Does the person have multiple problems with impulsivity? (eg. eating binges, spending sprees, drinking too much, verbal outbursts)
   - ◯ Yes
   - ◯ No

10. Does the person have very changeable moods?
    - ◯ Yes
    - ◯ No

11. Does the person feel very angry alot of the time or often act in an angry or sarcastic manner?
    - ◯ Yes
    - ◯ No

12. Is the person often distrustful of other people?
    - ◯ Yes
    - ◯ No

13. Does the person frequently feel unreal or as if things around them are unreal?
    - ◯ Yes
    - ◯ No

14. Does the person describe chronic feelings of emptiness?
    - ◯ Yes
    - ◯ No

Referral Form

Patient

Name: _____ NHS Number: _____

15. Does the person often feel they have no idea who they are or that they have no sense of identity?
    - ◯ Yes
    - ◯ No

16. Does the person go to lengths to avoid feeling abandoned? (eg. repeatedly calling someone to reassure themselves that he or she still cares, begging them not to leave, clinging to them physically)
    - ◯ Yes
    - ◯ No

17. Does the person have children, dependents or care giving responsibilities?
    - ◯ Yes
    - ◯ No

18. Have other treatments/therapies been tried or are they unavailable, failing or not suitable?
    - ◯ Yes
    - ◯ No

19. Is the person a frequent user of emergency health services or unplanned care?
    - ◯ Yes
    - ◯ No

20. Please specify:

21. Is the person currently an inpatient or detained under teh Mental Health Act?
    - ◯ Yes
    - ◯ No

22. Does the person have multiple agencies involved?
    - ◯ Yes
    - ◯ No

23. Have other co-morbid difficulties been identified? eg. psychosis, eating disorder etc.
    - ◯ Yes
    - ◯ No

24. What is the person's formal diagnosis?

25. Any other comments

Appendix B

Useful References and Resources

Personality Disorder: No longer a diagnosis of exclusion. NIMHE(2003)
http://www.personalitydisorder.org.uk/assets/resources/56.pdf

Breaking the Cycle of Rejection. The Personality Disorder Capabilities Framework. NIMHE(2003)
http://www.spn.org.uk/fileadmin/spn/user/*.pdf/Papers/personalitydisorders.pdf

The Personality Disorder Knowledge and Understanding Framework.
KUF - Personality disorder programme

No Health Without Mental Health. DoH(2011)
The mental health strategy for England - Publications - GOV.UK

Royal College of Psychiatrists website – Personality Disorders
http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/personalitydisorders.aspx

Emergence – a website providing advice and support to those affected by personality disorder.
http://www.emergenceplus.org.uk/

Information on DBT:
http://priory.com/dbt.htm

http://www.behavioraltech.com/downloads/dbtFaq_Cons.pdf