Bedfordshire & Luton
mental health and wellbeing services
provided by ELFT

NHS

PROTOCOL FOR THE ASSESSMENT AND MANAGEMENT OF BORDERLINE PERSONALITY DISORDER (BPD) ACROSS PRIMARY AND SECONDARY CARE MENTAL HEALTH SETTINGS

Date issued:	**April 2019**
Lead Authors:	**Dr Micol Ascoli** **Dr Zelpha Kittler** **Dr Helen Donovan**
Next Review date:	**April 2020**

CONTENTS

1. INTRODUCTION

- This protocol was developed using nationally recognised best practice guidelines (NICE, CG78) and expert opinion to support staff to work optimally with service users/patients experiencing clinically significant emotion dysregulation. Service user input was provided by a local Working Together service user led group and a specially convened working group set up to explore optimum care pathways for people suffering from Emotionally Unstable Personality Disorder/Borderline Personality Disorder.

- This protocol uses the term 'Borderline Personality Disorder' rather than 'Emotionally Unstable Personality Disorder'. NICE guidelines also refer to this condition as Borderline Personality Disorder rather than Emotionally Unstable Personality Disorder.

- Over the past two decades, considerable progress has been made in developing specialist psychological treatments for people with Borderline Personality Disorder (BPD). However, the majority of patients with BPD receive treatment within generalist mental health services rather than specialist personality disorder teams. There is increasing evidence that well organised and skillful community mental health teams can deliver effective treatment for patients with BPD.

- Community lifetime prevalence of BPD is 1% (Grant et al., 2008) with prevalence of 11% in community clinics and 20% on inpatient units (Schwartz et al., 1990). Four percent of people aged 16-64 screened positive for BPD, and differences between men and women did not reach a statistical significance (Moran et al., 2016).

- It is estimated that between 40% and 70% of those diagnosed with BPD have a history of past sexual abuse, physical abuse, emotional abuse and neglect. The strongest correlation is between emotional abuse and borderline personality disorder (Kuo et al., 2015).

- Up to 90% of patients with BPD in secondary care settings will have a co-occurring mental health condition (depression, dysthymia, PTSD, bipolar disorder, social phobia, OCD, agoraphobia, drug and alcohol misuse etc), or another personality disorder, such as Avoidant personality disorder, Dependent personality disorder, Paranoid personality disorder and Antisocial Personality Disorder.

- Naturalistic studies show that people with BPD improve over time, with high rates of remission lasting longer than four years and with low rates of relapse at 10 year follow-up. In a study of psycho-social functioning at 10 year follow-up, 78% of subjects with BPD had 'good psychosocial functioning broadly defined' and 50% were diagnostically and psychosocially 'recovered' i.e. in remission for more than 4

years (Zanarini et al., 2010). Improved social functioning was far more achievable than vocational functioning, as vocational deficits account for the overwhelming majority of poor psychosocial functioning, with vocational deficits continuing at 16 years follow-up (Zanarini et al, 2012).

- Clinical implications of impaired vocational functioning are that increased attention should be placed on a recovery model which incorporates support to gain and maintain employment and also improve vocational skills (Bateman & Fonagy, 2012).

2. GENERAL PRINCIPLES OF CLINICAL MANAGEMENT IN THE COMMUNITY MENTAL HEALTH TEAM (Bateman and Krawitz, 2013)

2.1 Organisation of treatment is important. Treatment needs to be well structured, coordinated, and integrated with other services that are available to the patient, to provide understandable and predictable support to the person with BPD.

2.2 Information given to the patients must be clear and unambiguous. Treatment plans are to be written down and given to the patient for ongoing reference.
Written information will include:

- Information about BPD, other comorbid conditions, treatment: including psychological and pharmacological options.
- Dates and times of appointments.
- Access to service details including out of hours services.
- Contacts of self-referral agencies and other third sector organisations.

2.3 Good collaboration and communication between the clinician and other mental health professionals needs to occur about the treatment plan by using a structured and organised approach such as Dialog. Meaningful long term goals broken down into short term goals must underpin the Dialog recovery plan and the care coordinator would use a solution focused approach with the patients to help them gradually move forward in attaining their self-identified goals.

Develop a focus for treatment collaboratively with the patient, e.g. self-harm, relationships, lack of motivation. The treatment goals must be developed with the patient using a problem-solving approach.

2.4 **Avoid changes of staff where possible.** This is of particular relevance to patients with BPD as they can experience this as a re-enactment of earlier loss and abandonment and can be a risk factor for deterioration.

3. ASSESSMENT

3.1 Assessment can take place in primary or secondary care settings. Primary care liaison mental health workers may often be the first point of contact with mental health services. The purpose of the assessment is to aid the understanding of patients' difficulties and collaboratively develop a treatment plan that is aligned to an accurate, compassionate formulation of the patients' problems, including accurate diagnosis of all relevant conditions.

3.2 Patients will be asked to complete a screening checklist for possible presence of a range of disorders prior to the assessment, including a brief screening tool for presence of Borderline Personality Disorder (Self Report Symptom Checklist, Appendix 1). Following the early part of assessment focusing on the patient's story of their difficulties and a thorough history (see below), the clinician will use the checklist later in the assessment to improve diagnostic accuracy and identification of comorbid conditions.

3.3 A comprehensive, detailed assessment will be taken, which includes early childhood experiences and relationships, family history, history of trauma (being mindful not to require detailed discussion of past trauma which may destabilise the patient), pattern of intimate relationships, psychosocial and occupational functioning, including coping strategies, strengths and vulnerabilities (NICE, CG78):

- Detailed exploration of current and past psychiatric history and medical history, including presenting problems, triggering events, onset, fluctuations and checking for coexisting mental health disorders including current or past substance misuse disorders

- Exploration of current and past risk behaviours including harm to self and others and vulnerability to harm from others

- Exploration of relationships and needs of any dependent children including any safeguarding concerns

- Exploration of current social support structures

- Mental State Examination

- Collateral information from relatives or carers, where appropriate, and information from GP. Previous records should be sought if the patient has been in services before

3.4 Thorough assessment should allow the clinician to put together a formulation which makes sense to the patient and includes predisposing, precipitating and maintaining factors as well as protective factors. Thorough assessment should also have picked up indicators of possible borderline personality disorder, such as pattern of instability in interpersonal relationships, emotional regulation, impulse control and unstable self-image/confusion about self - beginning by early adulthood present in a variety of contexts. If the clinician suspects borderline personality disorder from the personal history, then the following common language screening questions should be asked:

A minimum of 5 positive answers are necessary for diagnostic threshold to be met:

a. Are you scared of rejection and abandonment i.e. being left all alone?
b. Are your relationships with your friends and family unstable?
c. Do you see things as either all good or bad, or in absolute terms, e.g.
   Everybody is ….
   All men are….?
d. Do you have trouble knowing who you are and what is important to you?
e. Do you impulsively do things which might damage yourself in some way?
f. Do you self-harm (intentional harm to the body, including overdoses) or behave in a suicidal manner?
g. Do you have emotions that can change quickly?
h. Do you often feel empty inside and feel you need others to distract you or make you feel whole?
i. Do you get excessively angry in a manner that is to your own detriment?
j. Do you 'numb out' or sometimes feel overly suspicious or paranoid when stressed?

The clinician should ensure that before giving a diagnosis which has significant implications for treatment that the criteria is met and documented and that the symptoms **are present from teens or early adulthood for 5 years or more and cause significant impairment.**

3.5 Many experienced clinicians including senior nurses, psychologists and speciality doctors will be competent to make a diagnosis of BPD. However, where the patient presents with a high level complexity and the diagnosis is not clear cut then a referral for specialist personality assessment is recommended.

4. SHARING THE DIAGNOSIS

4.1 How does the clinician share the diagnosis in a way that is beneficial and helpful?
During the assessment process many features of BPD may have become apparent. The task of the clinician is to talk to the patient about the diagnosis in a way that makes sense to the patient and generates coherence of their disparate symptoms and

subjective experiences. It is often best to outline the four main problem areas of BPD to the patient, giving an example from their life to illustrate what is meant by difficulties in interpersonal relationships, emotional regulation, impulse control, sensitivity to others and confusion about self. It can also be useful to use Marsha Linehan's biological vulnerability theory to explain the concept of emotional dysregulation using an example from the patient's own experience. Marsha's theory is that patients with BPD have a constitutional vulnerability that predisposes them to BPD due to:

- High sensitivity (low threshold of emotional response to situations)
- High reactivity (emotional response large)
- Slow return to baseline (emotional distress persists over time)

4.2 It is important to validate the patient's experiences and coping during the explanation. Track collaboratively with the patient the different behaviours arising as a means of coping with emotion, and validate that it is understandable that the patient has developed these unhelpful ways of coping as there is a short term pay off, reducing the emotion intensity. Further explain that in the longer term they end up stuck in a pattern of behaviour that causes further pain and suffering.

4.3 It is VERY important to communicate to the patient that the prognosis for BPD is positive and that the majority of patients recover and have good outcomes over a period of 8-10 years, even without active treatment. However, active treatment can decrease self-harm and suicidal behaviours, reduce distress from other comorbid disorders such as anxiety disorders and depression, and speed up recovery.

4.4 Provide the patient with written information on BPD (such as Mind booklet *'Understanding Borderline Personality Disorder'*) and signpost to NICE guidelines for BPD. Also suggest resources for understanding and reducing self-harm (e.g. Mind booklet *'Understanding Self Harm'*) and suicidal behaviors (e.g. App *'Stay Alive'*, which has advice and tools to identify signs of suicide, how to get help, and dispels misunderstandings about suicide).

5. COMMUNITY CARE PLANNING ACROSS THE SPECTRUM OF BPD SEVERITY

5.1 Some patients referred to secondary care may have features of BPD but neither engage in self-harming behaviours nor have a history of suicidal behaviours. The main problems may relate to impulsivity and problematic interpersonal relationships with comorbid depression or anxiety disorders of a mild to moderate degree. Providing formulation, sensitively explaining the diagnosis, and offering written information on BPD and the comorbid disorders (including self-help resources) may be sufficient provided the risk is low. These patients should be offered the relevant NICE treatment for any co-morbid psychiatric conditions which are likely to be present, and signposted to relevant services to address other psychosocial goals.

5.2 Some patients may requirement treatment in secondary care for comorbid conditions requiring assessment and treatment in secondary care (e.g. Bipolar Disorder type 2, severe depression). Treatment may include stabilisation of medication along with signposting/referral to Wellbeing services (where appropriate) and/or Recovery College. If no significant risk behaviours are present then the patient can be discharged once medication is optimised. It is anticipated that these patients will require only a short period of treatment in an out-patient clinic and be discharged within 6 months. If longer treatment is required, consideration should be given to need for care coordination or discussion with other senior MDT clinicians to avoid patient remaining in an out-patient setting for low level interventions which are not helping the patient. Patients with BPD should not be reviewed by trainees.

5.3 Patients who meet the threshold for secondary care services and are experiencing significant emotional regulation difficulties should be offered assessment for DBT Skills Training groups run within the CMHTs.

These patients may also be supported with input from psychiatry if medication is indicated for comorbid Axis 1 condition which requires follow up appointments to ascertain treatment response. **All medications prescribed should have a clear rationale and outcome measures should be used to evaluate treatment response. This is particularly important in patients with BPD due to the risk of polypharmacy with unstructured approaches to medication management.**

5.4 Some patients with significant personality disorder may present with current low risk, but would not be accepted within Wellbeing Services. They may have a co-morbid condition that would benefit from psychological therapy such as PTSD, and these patients should be discussed with the team psychologist with a view to assessment for individual therapy in secondary care.

5.5 Patients who require a co-ordinated approach and have complex, high risk or multiple problems should be managed under the Care Programme Approach (CPA). Those patients with poor psychosocial functioning, limited social network and young children should also be considered for care coordination so that full multidisciplinary input can be provided and risks to children/others thoroughly assessed.
An Initial CPA meeting should be convened within the first month after the assessment where the level of complexity has been deemed appropriate for care coordination. The roles and responsibilities of all health and social care professionals should be agreed and documented. This group of patients should be offered a range of interventions linked to the initial formulation and their long term goals, including an assessment for DBT Skills Training groups within the CMHT.

5.6 Patients in the Bedfordshire CCG area with the highest level of risk behaviours (i.e. life

threatening suicidal behaviours and/or very frequent/severe self-harming) should be referred for assessment by our Complex Needs service, who offer the full DBT programme of both individual and group treatment.

5.7 Carers' assessments should be offered to those involved in supporting people with BPD where appropriate, and in line with Trust policy. Providing information to carers regarding BPD, and signposting/referral to relevant supports for carers may assist in strengthening the support network and reducing psychosocial crisis for the person with BPD.

5.8 All patients should be signposted to relevant teams or professionals when indicated e.g. addiction services, vocational rehabilitation, employment support, children's safeguarding, and adult safeguarding.

6. CRISIS/SAFETY PLANNING

6.1 Use the Trust RiO risk assessment tool and explore past history of suicide attempts including triggers, severity, level of planning etc, as well as types of current and historical self-harm including frequency, severity and types of self-harm. Enquire about a range of self-harming behaviours including overdosing, cutting, ligaturing, punching self or putting self in high risk situations to elicit harm from others. Explore risk of harm to others as well as safeguarding concerns, self-neglect etc. Explore current relationships and any risk of harm from others as domestic abuse/exploitation is not uncommon.

6.2 Differentiate between acute and chronic risk. Chronic suicidal thoughts are often present and the clinician works with the patient to find safer and more constructive ways of managing distress. Use the Continuum of Suicidal Thoughts to assist in understanding severity and nature of current risk (Appendix 2)

6.3 In acute suicidal crisis, referral to Crisis team or in-patient unit may be necessary as a short term measure to manage an acute increase in risk.

6.4 Safety planning using the Trust RiO Safety Plan should be collaboratively completed with all patients with BPD who have a history of self-harm or suicidal behaviours. This should include working with patient to;

- Identify early warning signs and potential triggers that could lead to a crisis (social, interpersonal, environmental)
- Identify self-management steps a patient can take to reduce the intensity of any suicidal thoughts or urges including drawing up a list of reasons for living, distraction and self-soothing activities

- Who they can contact (informal network and formal support options) and how they would like others including services to respond if they ring in crisis

6.5 The Safety Plan should outline under what circumstances hospital admission would be helpful or necessary and agreed with the patient.

6.6 The Safety Plan, with permission from patient, can involve and/or be shared with carers/relatives and should be accessible to mental health professionals who may come into contact with the patient out of hours.

6.7 The patient should be given a copy of their Safety Plan as part of the CPA process, and at any time it is revised and updated.

7. MANAGING BPD PATIENTS IN CMHT DURING PERIODS OF HIGH RISK/CRISIS

7.1 When a patient is experiencing a crisis (i.e. an increase in risk of harm to self or others) the care coordinator should in the first instance see the patient and explore triggers for the crisis, identify solutions, agree removal of items/means likely to be risky to the patient (e.g. excess medication stored) and involve more senior members of the MDT for advice. The staff member should review the current safety plan with the patient to identify what strategies the patient can use and/or amend the plan. Where the care co-ordinator is unavailable, the team duty worker should provide this contact and support.

7.2 The consultant or most senior psychiatrist should be consulted and, wherever possible, an urgent medical review should be arranged if significant changes in patient presentation indicative of increased risk are present (i.e. suicidal plans, worsening of co-morbid disorder, increased substance misuse, occurrence of other risk taking behaviours, or increased exposure to risk from others).

7.3 If the care coordinator and consultant who have reviewed the situation consider Crisis (CRHT) team input to be required, then the assessment should be 'trusted' and further 'assessments' should be avoided. The impact of not being accepted by another service can be very distressing for the patient with BPD, who may experience this as a rejection and/or invalidation of their distress, and it can create a perception of division between different parts of services. The referral can be made by the care coordinator or the consultant, and the default should be that the patient is taken on unless the Crisis team consider that the risk is too high in the community and wish to refer for hospital admission. Changes to the recommended treatment plan should be discussed with the CMHT consultant i.e. if hospital admission is being recommended instead of CRHT involved. **Close collaborative working across services is particularly important in safe management of patients with BPD.**

7.4 Where another service such as in patient or Crisis team wishes to query a diagnosis given to the patient by the CMHT, there should be a discussion between the consultants of the two services so that there is agreement and clarity for the patient regarding their diagnosis.

8. DISCHARGE FROM CMHT

Once the service user's co-morbid disorders have been treated/managed, the presenting crisis resolved /subsided, and community-based mental health and specialist services do not consider that they are able to offer further intervention that would either significantly reduce risk or improve the well-being of the service user, the patient should be prepared for transition to Primary Care.

A care plan should be agreed beforehand and communicated to the relevant primary care clinicians/services. The care plan should specify:

- Steps for managing distress
- Ways of coping with future crisis
- Information about how to re-engage with community mental health services in times of crisis

Clinicians should anticipate that the **withdrawal and ending of treatment may evoke strong emotions in people with a diagnosis of borderline personality disorder. It is therefore essential that endings and transitions are structured, phased over time and discussed well in advance with the service user and their family and/or carer when appropriate.**

Where the individual does not meet the criteria for service or their agreed treatment plan is complete but they are still vulnerable as defined by the Care Act 2014 (Legislation.gov.uk, 2014), the service still has a duty of care. The individual should be signposted and referred on to the most appropriate service as soon as possible following assessment/completion of treatment. Once the onward service has accepted the referral and assessed the individual the service has discharged its duty of care and may close the case.

9. FURTHER COMMUNITY DEVELOPMENTS

Together with service users and Mind BLMK, we have developed a peer-led support group for people who have completed DBT Skills Training groups in secondary mental health, to support transition and step away from NHS secondary care treatment. This is in a pilot phase in Bedfordshire; outcome and experience measures are being collected, including measures of recovery, use of other services, and satisfaction with the group.

10. SAFETY, CONTAINMENT AND CRISIS MANAGEMENT: ADMISSION AND INPATIENTS PROTOCOL FOR PEOPLE WITH A DIAGNOSIS OF BPD

10.1 Introduction

Patients suffering from BPD frequently present to services in a state of crisis - at onset, during the early stages of treatment and throughout the course of the disorder - which might culminate in an acute inpatients admission.

The role of the inpatients setting for BPD consists in the management and resolution of acute crises that cannot be resolved in the community because of uncontainable risk to self or others.

Crisis management is a crucial feature in the treatment of BPD. However, BPD patients' risk getting caught up in a repeated series of crisis episodes and recurrent admissions which have a negative long term impact on outcomes and reinforce maladaptive ways of coping.

In the context of long term treatment, patient and clinician have to work together again and again on managing recurrent emotional crises in the community whenever possible, rather than avoiding the crises through recurrent hospital admissions.

A conspicuous body of evidence supports the notion that hospital admissions for BPD;

- Are not effective interventions in the long term
- Do not have a lasting effect on improvement
- Are not useful in managing parasuicidal behaviours or suicidal threats
- Have a limited scope within the overall treatment of BPD
- Should be avoided as much as possible
- May have iatrogenic effects (especially in case of BPD in co-morbidity with antisocial personality)

Some notable negative effects of recurrent and prolonged hospital admissions for BPD patients include:

- Reduced mentalising capacity
- Development of passive behaviour and dependence
- Invalidation and reduced ability to cope
- Loss of potentially stabilising factors such as family and social contacts
- Loss of opportunities to build mastery through usual roles, daily activities and employment
- Avoidance of learning and applying adaptive strategies for managing emotional crises
- Patients' psychopathology begins to interact with the ward dynamics

- Learning of maladaptive behaviours from other patients
- Collusion between patients and clinicians in setting unrealistic goals for the admission, given the time and resources available
- The resulting frustration creates opportunities for maladaptive behavioural patterns, leading to new management problems which jeopardise discharge and prolong length of stay

In most cases, a prolonged admission occurs not because it provides any additional therapeutic tools to treat a personality disorder, but because treatment overall has failed and the wider healthcare system is unable to provide a management plan for the serious condition. It is therefore essential to limit the number of admissions and the length of stay for patients with a diagnosis of BPD, by adhering to the following general principles.

10.2 General Principles for Inpatient Care of Patients diagnosed with BPD

When considering a hospital admission, clinicians should adhere to the NICE Guidelines (CG78).

Before considering admission to an acute psychiatric inpatient unit for a person with BPD, first refer them to a crisis resolution and home treatment team or other locally available alternative to admission.

Consider people with a diagnosis of BPD for admission to an acute psychiatric unit for the management of crisis involving significant risk to self or others that cannot be managed within other services, or detention under the Mental Health Act (for any reason).

When considering inpatient care for a person with a diagnosis of BPD, actively involve them in the decision and:

- Ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission
- Agree the length and purpose of the admission in advance
- Ensure that when, in extreme circumstances, compulsory treatment is used, management on a voluntary basis is resumed at the earliest opportunity.

Possible indicators of acute risk, during a crisis, include:

- Significant recent life events (e.g. change in housing, employment, relationship rupture/breakdown)
- Anniversaries, birthdays, and certain times of year
- Deteriorating mental state due to substance misuse
- Escalating risky behaviours or suicide threats/statements
- Increasing symptoms

- Major depression
- Sudden disengagement from, or sudden increase in contact with, community treatment services.

10.3 Key Practice Guidelines for Inpatient Treatment of BPD:

- Inpatient treatment will focus on crisis resolution.
- Develop a therapeutic contract on admission that clarifies expected outcomes (resolution of current crisis) to patients and carers.
- Minimise length of stay (5-7 days) for those with established BPD diagnosis – using a structured approach with the patient to develop treatment goals (see Appendix 3 and 4).
- Keep goals and interventions simple, and limited to those which need to be addressed acutely.
- Aim at containing impulsivity, limiting regression and promoting coping skills in order to return patients to their previous levels of functioning and to treatment in the community.
- For patients with frequent admissions, consider appropriateness of Patients' Controlled Admission Contracts on discharge (see Appendix 5).
- Through effective crisis resolution and the development of good relationships with staff, restore hope and lay the foundations for future work in the community.

10.4 The Realistic Purposes of hospital treatment for BPD patients

a) Maintaining Safety

- Evaluate mental state and assess risk, marking a clear distinction between diagnosis-related chronic suicidality and immediate suicidal intent (using Continuum of Suicidal Thoughts; Appendix 2).
- Consider additional risk factors, such as presence of psychotic symptoms, dissociative states, use of drugs and alcohol, presence of intense affects and emotions, recent life events.
- Ensure safety in ways that do not invalidate patients' ability to cope and continuously encourage patients to apply learned skills.

b) Providing Containment

- Containment includes all general and specific interventions aimed at managing the behavioral disorganization, the emotional instability and the impulsivity.
- Containment measures convey support and understanding, focus on the present rather than the past, and on affect rather than content. In a containing therapeutic milieu, interventions focus on empathy and understanding of the patient's experience and reframing/interpretations are used only to reduce patients' self-invalidation, self-blaming and self-criticism.
- Containments stems from a predictable, stable, consistent and caring hospital

environment and from a set of basic, nursing led supportive and empathetic interventions/interactions.

- The containing environment also offers respite and temporary avoidance of the relational/social difficulties the crisis originates from. Routine activities provide structure and boundaries, helping patients to anchor back to reality.
- The predictable ward schedule counteracts chaotic crisis behaviours.

c) Psychopharmalogical treatment to tackle acute crisis symptoms and reduce psychopathology

- Hospital Admission is an opportunity to reorganise and rationalize psychotropic treatment plans in close collaboration with the community psychiatrist.
- The treatment of BPD is mostly psychotherapeutic in nature. Medications have a limited role to play in a comprehensive treatment plan for BPD and should be used in the context of a broader therapeutic strategy.
- Medications are aimed at targeting specific symptom clusters, rather than the disorder per se. This should be clearly explained to patients, to avoid the development of unrealistic expectations about the likely effects of medications.
- They can be used in the inpatients setting with the aim of alleviating suffering and achieving a symptomatic improvement that will enable patients to return to effective psychotherapeutic interventions.
- Typical and atypical neuroleptics in low doses can be used for the resolution of transient psychotic symptoms, with very little evidence for treatment to continue once these symptoms have settled.
- SSRis can be effective to treat depressed, mood or anxiety disorders. Lithium should be avoided (except in co-morbid BPAD).
- Poly-Pharmacy has no evidence base and should be avoided.
- Benzodiazepines should be avoided and anti-histamines prescribed for short periods only and with specific documented rationale.

d) Diagnostic Assessment and Treating Co-morbid Disorders

- All patients admitted to Bedfordshire and Luton inpatient units will be screened by the Self Report Symptom Checklist (Appendix 1). The questionnaire will be administered within the first week of admission (or when allowed by the remission of acute symptoms), validated by the ward doctor and discussed in ward round.
- When there are preliminary indications that a personality disorder is likely to be diagnosed but there is considerable complexity, the ward can refer for a structured personality disorder assessment. The expectation is that most patients can be diagnosed without the need for a formal PD assessment provided that thorough history and where possible collateral history validate the DSM 4 criteria are met.
- Affective disorders (major depression, BPAD), substance misuse, PTSD, anxiety disorders are the most common co-morbid disorders. Co-morbidity with other personality disorders, most notably narcissistic and Cluster C disorders, is

associated with poorer outcomes and a lower response to treatment.

10.5 Patients' Controlled Admissions (PCA)

Patients controlled admissions offer patients a degree of control and choice in accessing services in times of crisis. Research suggests that PCA's promote and validate patients' autonomy by giving them more responsibility and increased confidence in their coping skills. PCA's are also proven to shorten the length of stay, decrease the number of incidents of violence and aggression (including self-harm) on the ward and reduce the number of involuntary admissions. For patients who have repeated admissions, PCA's may be discussed and offered as part of discharge planning from inpatient services. The PCA contract offers a total of five admissions in 12 months, where patients can access the inpatient wards when they feel a crisis cannot be managed in the community. Each time a bed will be offered in Bedfordshire, Luton or London, for a maximum of 7 days, during which the patients will work with hospital staff on an intensive crisis intervention and distress reduction plan. Re-admission will not be allowed within 21 days from the previous discharge (Appendix 5).

11. INPATIENTS PROTOCOL FOR THE TREATMENT AND MANAGEMENT OF BPD

11.1 Gatekeeping via CRHTT

- The CRHTT will gate-keep all admissions for patients with a known diagnosis of BPD.
- The potential benefits and harm of admission will be discussed with the patient.
- All possible alternatives to admission will be considered, including urgent community medical reviews, intensive CRHTT follow up focused on crisis resolution strategies based on the patient's individualized safety plan, liaison with the CMHT and/or Complex Needs Service (for patients who are already under their care).
- Self-harming behavior, considered as a symptomatic feature of BPD, will not per se constitute an indication to hospital admission.
- Specific indications for admission for patients with a known diagnosis of BPD will be danger to others.
- For patients with an agreed PCA, and where the conditions for PCA are met regarding time since previous discharge and number of admissions, the CRHTT will facilitate requested admissions in line with the contract.

11.2 On Admission

- Patients admitted with a known diagnosis of BPD will be reviewed by the ward consultant within the next working day and will liase with CRHTT.
- If the patient is under the care of the Complex Needs Team and/or CMHT, the team(s) will be notified of the patient's admission within 24 hours.

- Benefits and possible harm of inpatients stay will be discussed with the patient, and harmful consequences of prolonged inpatients admissions reinforced.
- The agreed length of stay will be reiterated and the discharge date set, in collaboration with the patient and the CRHT. All involved parties will be invited to the discharge CPA on the set discharge date. **It is important to bear in mind that discussion of discharge can trigger feelings of abandonment/rejection; therefore this conversation will need to strike a balance between acknowledging the fears of the patient while explaining the rationale and benefits of a defined end date for admission.**
- Carers will be involved with patient consent.
- A discharge plan will be drafted upon the first medical review.
- The Continuum of Suicidal Thoughts (Appendix 2 will be used to collaboratively discuss and ascertain the severity of the suicidal ideation and to develop a safety plan, which will be adhered to on the ward and post-discharge.
- An inpatients care plan will be drawn up in collaboration with the patient using the Trust Dialog online forms in the RiO record.
- Patients will be given a copy of the crisis skills booklet and will be supported to start practicing the skills (See Appendix 6).
- The patient will be asked to commit to crisis-focused work (including attendance at inpatients groups and other available crisis intervention resources).
- For patients detained under the Mental Health Act, the need of continued detention will be reviewed and the patient will be discharged from section if possible.
- The possibility of co-morbid disorders will be considered and patients will be assessed appropriately. Treatment will be started as needed.
- Prescribed medications will be reviewed and rationalized as far as possible.
- Co-morbid substance misuse will be explored and treated appropriately during the admission.
- Appropriate levels of observation will be established.
- Clustering and confirmed diagnosis will be reviewed by the inpatients consultant.
- A referral to the CMHT for care co-ordination under CPA will be made for patients with very poor psychosocial functioning and/or ongoing high risk behaviours including childrens' safeguarding issues.

11.3 Review During Inpatient Stay

Patients will have a medical review every 48 hours for the following purposes:

- Review of Mental State
- Review the need for detention for patients admitted under the Mental Health Act
- Update the risk assessment (staff can use the prompts included in "Understanding and focusing my admission toolkit" – See Appendix 3 & 4)
- Review the implementation of the inpatients care plan and patient's adherence to the agreed use of the available ward therapeutic groups and activities

- Reiterate the agreed discharge date and involve crisis team daily contact with view to engaging and setting up early discharge plan
- Review of observation levels
- Review of the response to and the continued need of psychotropic medications
- Keep the focus on crisis management and the purposes of the current admission
- Redirect any unrealistic expectation on what the current admission can achieve
- Review the use of skills by the patient and generally ensure adherence to the care plan
- If patient's behavior is escalating and putting themselves and/or others at risk a professionals meeting will review the suitability of continued in-patient treatment and discharge may be expedited before the agreed date.

The use of 1:1 observation will be discouraged and kept a minimum. On the contrary, patients will be encouraged to apply the learned skills and to regain control of self-harming behaviours.

If patients identify that the crisis has passed and wish to go home before the agreed discharge date, this will be facilitated.

Patients will be encouraged to engage with therapeutic activities and groups on the ward.

If a patient is not discharged within one week, a professionals meeting will be convened on the ward to discuss and problem solve barriers to discharge. The patient's case should be presented at the Complex Case Panel if no discharge has occurred within four weeks of admission and monthly presentations thereafter.

12. PSYCHOLOGICALLY-BASED ASSESSMENT AND INTERVENTION DURING ADMISSION

The following guidance is based on and adapted from Swenson, Witterholt & Bohus (2007), a chapter on the use of Dialectical Behaviour Therapy in inpatient units. The focus is on re-establishing motivation and responsibility for self –management through collaboration at a time where the patient's skills to manage in the community have been exceeded. This presents a challenge for staff as the patient's behaviour may engender responses of either rescuing (i.e. '*the patient can't cope'*) and/or invalidation (i.e. '*the patient doesn't need to be here'*). Swenson et al describe the following phases, however it is noted that these do not necessarily occur in a linear manner, due to the fluctuating nature of motivation and distress. More detail about how to carry out each of the following phases is described in (Appendix 3 and 4).

12.1 Admission – develop the treatment plan and heighten commitment

a) Assessment:

- Detailed assessment of the specific trigger(s) for current admission
- Understanding increasing vulnerability over time leading up to trigger(s)
- Identifying past strengths/supports which may have broken down
- Be cautious in discussing past trauma in detail as this may destabilize the patient further
- Explain/review the biosocial model to increase understanding of dysregulation and emotional vulnerability

b) Agree the plan, with focus on the following:

- Reducing arousal and gaining control of unhelpful behaviors that led to admission (e.g. self-harm, suicidal behavior, harm to others, substance misuse)
- Improving routine day/night structure – focus on self-care
- Identifying external and internal targets for problem (e.g. housing, financial, relationship, safety planning)
- Building/maintaining/repairing links with community based treatment/care

c) Heighten commitment to the plan, as many patients will find it difficult to connect with sense of agency and ability for management and change:

- Use of pros/cons to consider outcomes of committing and not committing to change
- Notice and name willfulness and work at increasing willingness

12.2 Skills for engagement and collaborative community care plan

Increase skills for behavioral control – distress tolerance skills, mindfulness (delivery of groups, prompting/coaching for individuals, making resources accessible on the ward for use by staff and patients), and routine for self-care.

12.3 Develop and implement discharge plan

a) Teach and use skills for getting and staying out of hospital:

- Safety Planning and use of Dialog to build or review ongoing care plan
- Continued support of distress tolerance, mindfulness and self-care

b) Identify, build and maintain links during stay with sources of support post-discharge:

- Agree and make referrals to services
- Introduce and build relationships during admission to facilitate smooth discharge
- Reinforce existing interpersonal supports and consider carer needs

c) Safety Plan:

- Review with nursing team day before discharge and consider usefulness of PCA or unhelpful admission avoidance plan before discharge for relevant patients.

13. PATIENTS WITH CO-MORBID SUBSTANCE MISUSE

13.1 Assessment on admission:

- Establish level of support already provided through substance misuse services/background information
- Establish whether the service user is meeting criteria for alcohol dependence or dependence on other CNS depressants as timely interventions may be required to manage clinical risk
- If already in treatment, establish whether safe and timely introduction/continuation of community treatment can be arranged as per ELFT policies

13.2 Following admission (Day 2)

- On day 2 of admission, consider a more comprehensive assessment of substance misuse history if not already done.
- Establish types of substances used (illicit substances, alcohol, prescribed medications used outside the intended prescription patterns, over the counter medications)
- Identify routes of administration (oral, parenteral)
- Identify frequency of consumption (daily, regular but not daily, intermittent use, evidence of withdrawal symptoms when not using and possible triggers).
- Focus on current use but also establish past use
- Establish presence of physical health and mental health complications associated with substance use. DO NOT automatically assume causation on evidence of substance use. DO NOT exclude service users from accessing mental health treatment on the basis of their substance use history.
- Establish effects of substance use on social functioning
- Alcohol use:
  Follow the relevant “inpatient alcohol detoxification” guideline. Establish possible presence (AUDIT score) and severity of alcohol dependence (daily alcohol units, SADQ score). Monitor withdrawal symptoms (CIWA-Ar score). Consider use of prophylactic parenteral Thiamine. Arrange immediate treatment in an acute medical ward for presumptive diagnosis of Wernicke’s
- Opioid use:
  Follow the relevant “inpatient treatment for opioid service users” guideline. Opioid withdrawal can be unpleasant but is not commonly life threatening. Opioid toxicity can be life threatening. Use scales for monitoring of symptoms (OOWS, SOWS,

COWS). Use urine drug testing for screening purposes. Ensure availability of Naloxone in all inpatient wards.

13.3 Discharge Planning:

- Liaise with community drug services and involve them in discharge planning.
- Ensure appropriate medication can continue getting prescribed following discharge.
- Provide alcohol relapse prevention medication with TTOs (Acamprosate, Disulfiram, Naltrexone).
- Do not provide opioids (Methadone or Buprenorphine) as TTOs. Make timely arrangements so that they can continue getting prescribed by drug services following discharge.
- A diagnosis of personality disorder does not necessarily predict poor outcome (PIG Dual Diagnosis DoH, 2002). Service users with personality disorder and co-occurring substance misuse should be considered for treatment under CPA (PHE 2017).

14. HOUSING

Upon admission ascertain patients' accommodation status. If the patient already has accommodation, the expectation is that the patient will return to this place and any moves required will be facilitated in the community as it is not the role of the inpatient team. Only in exceptional circumstances (e.g. the identified accommodation is no longer clinically safe for patient to return to) would the move be arranged whilst an in-patient.

If the patient is homeless establish where they usually reside. If they are of No Fixed Abode upon admission, then contact the area they were admitted from and involve that Local Council.

Where housing is not in place at the point where discharge is clinically indicated, patients may be discharged to temporary options and ongoing housing needs will be addressed as part of community-based support and treatment.

ELFT work closely in partnership with each Council and have a number of protocols and Housing Forums in place:-

- **Luton** – Penrose Steps are commissioned by Luton Borough Council to provide an in reach worker who can offer a service to all Luton residents on our inpatients unit. This worker visits the units on a daily basis making sure all patients with housing need/homeless are seen promptly and work starts in partnership with ward staff and the relevant community team to address needs. Luton holds a fortnightly Mental Health and Housing forum where cases can be taken to seek solutions. A

housing officer attends each time and any mental health worker can attend to present; third sector partners attend as appropriate. There is a quarterly business meeting to enhance partnerships further by information sharing/service updates and an annual conference.

- **Central Bedfordshire** – there is a discharge protocol signed off by CBC and ELFT and a direct access referral form into housing options to complete as early as possible. CBC holds a monthly housing forum and a quarterly homelessness form.
- **Bedford** – there is a direct access referral form into Housing options. There is a new third sector organization in Bedford called Justus, working to address homelessness to include people on inpatients units. There is also a tenancy sustainment post in the CMHT.

For all 3 councils, there is an ability to escalate cases if urgent through the housing options/solutions teams. There is also now a Rough Sleepers Project across the county with ELFT nurses working alongside homeless outreach workers enhancing partnerships to address homelessness.

15. DISCHARGE FROM INPATIENT WARDS

- Patients will be discharged on the agreed date.
- The use of extended periods of leave prior to discharge will be discouraged.
- The CRHTT and care co-ordinator involved in the care of the patient will be involved in discharge planning discussions and in attendance at discharge where possible.
- The patient will be encouraged to share any achievement during the inpatients stay and to identify any further area of need to be addressed in the community.
- The Continuum of Suicidal Thoughts will be reviewed and any changes in presentation recorded.
- The safety plan drawn during the inpatients stay will be included in the discharge plan.
- The crisis plan will be updated.
- The Trust in-line risk assessment will be updated.
- Any agreed PCA contract will be finalised and signed off at discharge, with a copy of the contract highlighted/sent to other relevant teams/services.
- 72 hour follow up to be arranged and patient informed.
- On leaving the ward, patients will receive a copy of the discharge plan, their safety plan, follow up appointment, and any relevant information/advice relevant to their admission and future planning (diagnosis, medication, coping skills, community resources).

16. REFERENCES

Bateman, A. and Fonagy, P. (2012). Handbook of mentalizing in mental health practice. Washington DC: American Psychiatric Press.

Bateman, A and Krawitz, R. (2013). Borderline Personality Disorder. An evidence based guide for generalist mental health professionals. Oxford University Press.

Grant, B.F., Chous, S.P., Goldstein, R.B., Huang, B., Stinson, F.S., Saha, T.D., Smith, S.M., Dawson, D.A., Pulay A.J., Pickering, R.P. and Ruan, W.J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-1 V borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. Journal of Clinical Psychiatry, 69, 533-545.

Legislation.gov.uk. (2014). Care Act 2014. (online) Available at: http:www.legislation.gov.uk/ukpga/2014

Kuo, J.R., Khoury, J.E., Metcalfe, R. Fitzpatrick, S and Goodwill, A. (2015) An examination of the relationship between childhood emotional abuse and borderline personality disorder features: the role of difficulties with emotion regulation. Childhood Abuse and Neglect, 39, p. 147-155.

Moran, P., Leese, M., Lee, T., Walters, P., Thornicroft, G., & Mann, A. (2003). Standardised Assessment of Personality- Abbreviated Scale (SAPAS): preliminary validation of a brief screen for personality disorder. British Journal of Psychiatry, 183, 228-232

Moran P, Rooney K, Tyrer P, Cold J. {2016). 'Chapter 7: Personality disorder' in McManus S, Bebbington P,Jenkins R, Brugha T. (eds.) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital

Schwartz, M., Balzer, D., George, L., and Winfield, I. (1990). Estimating the prevalence of Borderline Personality Disorder in the community. Journal of Personality Disorders, 4, 257- 272.

Zanarini, M.C., Frankenburg, F.R., Reich, D.B. and Fitzmaurice, G. (2010). The 10year course of psychosocial functioning among patients with borderline personality disorder and Axis 11 comparison subjects. Acta Psychiatric a Scandinavia, 122{2}, 103-109

Zanarini, M.C., Frankenburgm F.R., Reich, D.B. and Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with Borderline Personality Disorder and Axis II comparison subjects: A 16-year prospective follow-up study. American Journal of Psychiatry, 169, 486-483.

17. APPENDICES

Appendix 1. Self Report Symptom Checklist	 Appendix 1. Self Report Symptom Che
Appendix 2. Continuum of Suicidal Thoughts	 Appendix 2. Continuum of Suicidal
Appendix 3. Understanding and Focusing my Admission	 Appendix 3. Understanding and Fo
Appendix 4. Staff Prompts for Understanding and Focusing my Admission	 Appendix 4. Staff Prompts for Understa
Appendix 5. Patient Controlled Admission (PCA) Contract Proforma	 Appendix 5. PCA contract pro forma.do
Appendix 6. Crisis Skills Booklet	 Appendix 6. Crisis Skills Booklet.pub