BORDERLINE PERSONALITY DISORDER:
PATHWAYS TO EFFECTIVE SERVICE DELIVERY
AND CLINICAL TREATMENT OPTIONS

ROY KRAWITZ with CHRISTINE WATSON

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Commission's Foreword

Early in the life of the Mental Health Commission we became aware of the diversity of views within the mental health sector on how best to provide for people who meet a diagnosis for borderline personality disorder.

Some people with this diagnosis have been denied service, and for many others the treatment they have received has not reduced their symptoms or distress. All services recognise the risks in not having effective and sound treatment and support pathways for themselves and the individuals with this diagnosis.

This discussion paper draws together the available evidence on treatment and approaches. It explores the complex territory traversed by mental health workers, consumers and their families.

The Commission shares Roy Krawitz' and Christine Watson's concerns about the words borderline personality disorder. We agree that a diagnostic category couched in this language is unsuitable and leads to discrimination both within mental health services and communities. Some people who use mental health services are also very uncomfortable with this terminology. However, because there is currently no agreed alternative, we have, with regret used the widely recognised, though inappropriate title for this diagnostic category.

The discussion paper is being widely distributed by the Commission to provide some guidance to the sector; we anticipate it will evoke discussion and debate, and hope that it will be the stimulus for much needed action in all levels of mental health service provision.

The Commission thanks Roy Krawitz and Christine Watson for this contribution towards better treatment and support for people with a diagnosis of borderline personality disorder.

Dr Barbara Disley
Chair
Author’s Apologies

The term borderline personality disorder is experienced as offensive and unhelpful by many. Whilst there is exploration of more meaningful and useful terminology, it seemed best to use a term that will be clearly understood by readers. The terminology “case management” is used for the same reasons.

Maori and Pacific Island people are only briefly commented on because it seemed inappropriate for Pakeha to do more. Authorities on Maori and Pacific Island peoples who are also knowledgeable about borderline personality disorder and its relevance within these cultures need to be identified.

Gender and sexual abuse issues are important as 75 percent of people meeting diagnostic criteria for this disorder are female and 70 percent have a history of sexual abuse. These issues have not been addressed in this paper, as there are ongoing forums available where they have been and will continue to be explored.

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Author

Roy Krawitz is a psychiatrist and psychotherapist working for Waitemata Health’s RREAL team (Resource for Regulating of Emotions and Living), runs private training workshops on borderline personality disorder and has just started employment with Spectrum, the Personality Disorder Service for Victoria, Australia.

Assisting Author

Christine Watson is a policy analyst and psychotherapist who moved from New Zealand in 1998 to take up the position of Director, Spectrum, the Personality Disorder Service for Victoria.
Methodology

Literature Review

A MEDLINE and PSYCLIT search for the years 1980-1998 and a Cochrane Library search of The Database of Reviews of Effectiveness (DARE) were performed. References from selected articles were examined as well as literature suggested by key informants.

Key Informants

Krawitz had personal contact with a number of international professional authorities (incl. Clarkin, Dawson, Gunderson, Guthiel, Herman, Linehan, Links, Maltzberger, Marziali, Nehls, Paris, Perry, Waldinger and Young) and consumer groups (SAFE – Self-Abuse Finally Ends and The Cutting Edge Newsletter) in the US and Canada in 1997. Krawitz gathered information on the New Zealand context in the process of running 36 two-day workshops in 10 different New Zealand centres in 1997 and 1998. Information was gathered from key professional and consumer informants throughout New Zealand who provided feedback as the concepts evolved.

Peer Review

A draft paper was produced which was peer reviewed by people actively involved and knowledgeable in the area and the paper updated accordingly.

Best Practice

There is a paucity of evidence-based research and an absence of internationally recognised guidelines and clinical pathways. The limited evidence-based research is highlighted. Thereafter, methodology has relied heavily on local and international opinion of best practice and identification of gaps in knowledge.

Abbreviation

Dialectical behavior therapy is abbreviated throughout as DBT.
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When people meeting diagnostic criteria for borderline personality disorder are valued, they will be seen as having a legitimate clinical condition (with proven treatment methods) and will have an opportunity to receive effective, appropriate treatment.
Summary

Effective and efficient services will be developed when resourcing and professionally indicated risk taking issues are addressed, but not before.

Contextual information

- Mental health services are poorly equipped to address the needs of people with borderline personality disorder who are highly represented in mental health facilities.
- The diagnosis of borderline personality disorder is dimensional with considerable overlap and comorbidity with other diagnoses.
- 75 percent of those diagnosed are female and 70 percent have a sexual abuse history.
- The long-term prognosis is reasonably good, provided people do not suicide.
- The mortality ranges from 10-45 percent, depending on severity.
- Health resource usage is high.

Treatment issues and clinical pathways

- Risk assessment and general assessment need to be highly individualised.
- An identified key clinician will be at the core of the team.
- A clinical plan created by client and key clinician is at the core of treatment.
- There is a paucity of treatment research to recommend evidence based practice, so clinician focus has to be on best practice recommendations.
- The best researched psychosocial treatments for people with severe forms of the disorder are DBT (dialectical behaviour therapy) and self psychology as carried out by Stevenson/Mears.
- Taking what is similar in different models can guide clinicians in their practice.
- Pharmacological treatment can have an adjunctive role to psychosocial treatments.
- A long-term perspective (years) needs to be held with regard to treatment.
- Treatment is prioritised to that which will achieve greatest client stability.
- The goal of crisis work is to assist the client’s return to their pre-crisis level of function and will include a hierarchy of actions which may include anti-suicide interventions.
- Distinguishing self-harm intended to suicide from that intended for other reasons will critically influence treatment pathways.
- The commonest reason for self-harm is relief of internal emotional distress especially anxiety and anger.
• Limit setting to enable the clinician to retain positivity for the client is legitimate.

• Acute inpatient stays should, wherever possible, be brief (measured in hours).

• Acute hospitalisation is avoided, where possible, by use of resourced alternatives.

• Lengthy hospitalisation should be subject to routine, local peer review.

• Client controlled brief acute hospitalisation holds considerable promise.

• Often public mental health services only respond to this client group when they are suicidal. This encourages the very behaviour clinicians are trying to decrease.

• Authorities on Maori and Pacific Island peoples who are also knowledgeable about borderline personality disorder and its relevance within these cultures need to be identified and encouraged.

Discrimination and Clinicians’ feelings

• Clinician values and feelings are critical determinants for effective treatment.

• Stigmatisation has led to discrimination, most evident in the paucity of intensive, proactive treatment for those people most severely affected.

• Individual and institutional avoidance of proactively treating this group is the single most important impediment to effective service provision.

Resourcing

• Funding for training of 65 clinician positions in the community is likely to be both cost effective (due to a decrease in hospitalisation), and have better results for people with a borderline personality disorder diagnosis.

• Resources for treatment need to be on a par with other disorders with similar mortality, morbidity, disability and health resource usage.

• Money not specifically allocated and monitored for borderline personality disorder is likely to end up in other areas.

Legal Issues

• New Zealand Mental health legislation can be legally used.

• Mental health legislation should be considered an unusual part of treatment and be subject to routine, local peer review.

• If the client is and has been chronically suicidal (without an acute exacerbation), there is no more the clinician can do to prevent such a suicide apart from setting up a satisfactory, comprehensive treatment plan.

• Effective treatment of people with this diagnosis requires decision making which entails risk, including that of suicide. There is an absence of clearly defined guidelines on how active a clinician should be and how much responsibility a clinician should take.
Workforce Issues

Addressing the Culture of Fear

- There has been an increase in consumer complaints and heightened media visibility. Clinicians have responded by increasing their concern about the quality of their work. This constructive concern is now being replaced, in the treatment of people meeting diagnostic criteria for this disorder, by a “culture of fear” which is leading to defensive practices which are destructive in many ways, particularly to client outcome.
- National leaders need to address the factors creating this “culture of fear”, attempting to create an environment for clinicians to take appropriate professional risks.
- Local systems can be set up providing peer advice and support, and thereby medico-legal protection, for clinicians to take professionally indicated risks.

Key Clinician’s Role

- The key clinician role is probably the most important staff role in the treatment and needs to be invested with accordingly high value and status.
- Key features of local systems are: clear policies, procedures and guidelines, focused, coherent and skilled supervision, senior clinical staff and management support, a confident, calm, clear environment and a capacity to resolve conflict and difference.
- Key clinicians need to be empowered to determine treatment.
- A number of acceptable treatment models exist. Individual outpatient clinicians should be supported to practice in the model that best matches their training and experience.

Service Development

- If there is to be a local or nationally coordinated initiative, the model that currently suits the public mental health New Zealand context best is DBT. DBT is evidence based, been shown to be effective with people meeting diagnostic criteria for severe forms of borderline personality disorder, been used in outpatient and acute and longer-term inpatient settings, been well received throughout the country, requires modest additional training and a receptive workforce is available.
- Residential services should be developed after the establishment of comprehensive outpatient services and with considerable planning to avoid some inherent dangers.
- Workforce training recommended:
  Foundation training - 40 percent of all mental health staff;
  Additional training for specific work areas (eg crisis) - 20 percent of staff in that area;
Therapists and key clinicians - 132 nationally.

- National leadership tasks are numerous and need to be given time and importance.

**Recommendations**

- Ring-fenced funding for 65 FTE key clinician positions in the community. These key clinicians will have a client:clinician ratio of 10:1 and will work exclusively with people meeting diagnostic criteria for the severest forms of borderline personality disorder (estimated at 650 people, who are the 1 percent of all people meeting diagnostic criteria for borderline personality disorder nationwide).

- National leaders address the factors creating the “culture of fear”, attempting to create an environment for clinicians to take professionally indicated risks.

- Part-time professional/consumers (totalling two FTEs) be appointed to leadership positions across the country to integrate and further this work locally and nationally.
Vignette

“Molly suffered repeated severe physical, sexual and emotional abuse at the hands of several family members throughout her childhood and adolescence. Even as a young adult, she remained at risk whenever she had any contact with her family. She was removed from the care of her parents several times during childhood, but on each occasion was eventually returned to their care. Frustrated, ashamed, and convinced that she was responsible for all the problems in her family, Molly began to hit herself with belts, cords, and sticks when she was 12 years old. She described how she learned “cutting” from another patient while in a psychiatric hospital. By the time we met, she had a history of more than 50 overdoses, using medications prescribed by different physicians as well as those available over the counter. She had added burning her limbs and alcohol abuse to her repertoire of self-injury. None of this self-abuse caused physical pain, but each episode was temporarily effective in relieving her frustration. Massively obese, constantly starving and overeating, she spent more time in hospital than in the community. No treatment programmes helped; borderline personality disorder was diagnosed, and she began to feel and fear the inevitable rejection of her caretakers”.[1]
Introduction

The Mental Health Commission requested this paper, stating in the project specification, “Currently mental health services do not adequately address the needs of people with borderline personality disorder. Often many of the negative, critical incidents that impact on the whole of the mental health sector involve people that have a diagnosis of borderline personality disorder. In addition, there is evidence that this group of people are intensive users of mental health services. It would seem useful if we were able to provide some clearer direction to service providers about more effective ways of treating this group” [Project Specification, Mental Health Commission]. People meeting criteria for a diagnosis of other personality disorders, especially antisocial personality disorder, are also of considerable national concern but are not the focus of this paper.

A growing number of authors, over the last five years, have expressed concerns about services in Australia and New Zealand for people meeting diagnostic criteria for borderline personality disorder. Sara et al[2] have raised concerns as to the adequacy of current funding for treatment. Leonard[3] has noted that, despite associated morbidity, little attention has been given to services delivered in both public and private settings. Clarke et al[4] describe treatment as being “generally haphazard and ineffectual”. Morton and Buckingham have extensively documented the inadequacy of service provision in Victoria, Australia, stating “Service provision is ‘penny wise and pound foolish’. Very little is spent on early intervention and treatment and relatively large amounts are spent on containment”.[5] Miles states, “It is a frequent experience of acute services that considerable time and expense is exhausted in the provision of acute and crisis responding care for individuals who have severe personality disorders and who currently present their distress with some form of self-harm or threat. The acute services are not well geared to provide the kind of enduring care that such individuals require but when they turn to find such supporting services they are not available”.[6] O’Brien and Flote state, “The failure to develop appropriate comprehensive programmes within public mental health services for patients with BPD means that, despite considerable evidence that inpatient care is neither economically nor clinically effective, patients are treated within this sub-optimal alternative”.[7]

The demand on mental health services has increased dramatically over the last 20 years and services are currently stretched despite increased funding and more efficient management and clinical practice. There is strong competition for resources. People meeting diagnostic criteria for this disorder are competing with outpatient services for people who are usually better liked and who have diagnoses considered more legitimate. Consequently services are short of best practice, resulting in clients being inappropriately treated in crisis and acute inpatient services (where resource usage is high) with poor outcomes. This compounds the negativity, and individual and institutional avoidance of providing treatment for people meeting diagnostic criteria for this disorder, that already exists. Mental health services are poorly equipped to deal with the challenges presented. However, people meeting diagnostic criteria for this disorder are treatable.
Contextual Information

Epidemiology

The point prevalence in North America of people meeting diagnostic criteria for borderline personality disorder is 1 percent–2 percent, with the Swartz et al[8] figure of 1.8 percent of 19-55 year-olds often being used as a benchmark. There are no prevalence rates available for New Zealand.

- People meeting criteria are well represented in mental health facilities, with estimates of 11 percent at community clinics and 20 percent in inpatient units.[8]
- A high percentage of those attending drug and alcohol services meet criteria.[9,10]
- Swartz et al found that of those people meeting diagnostic criteria for borderline personality disorder, 22 percent had a diagnosis of alcohol abuse and dependence and 50 percent had a lifetime history of drug problems.[8]
- In psychiatrically hospitalized young adults with substance use disorders, 58-65 percent met diagnostic criteria for this disorder.[9]
- 75 percent of those diagnosed as having borderline personality disorder are female.[8]
- Many authors believe males are under-represented and under-diagnosed in mental health settings and more likely to be found (but not diagnosed) in substance use centres and in the justice system.
- 75 percent of those diagnosed as having borderline personality disorder have a history of sexual abuse.[11]
- There are suggestions that the prevalence and severity are increasing in western cultures.[12,13,14] This view is supported by evidence of an increase in suicide, youth suicide and people meeting criteria for diagnoses of antisocial personality disorder and substance use disorder, all of which are correlated with borderline personality disorder.[12]

Diagnosis

DSM 4 describes “personality disorder” as “An emotional pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment”.[15]

DSM 4 classifies personality disorder into Cluster A, B and C.

Cluster A:

- Schizoid personality disorder
- Schizotypal personality disorder
- Paranoid personality disorder
Cluster B:
- Histrionic personality disorder
- Narcissistic personality disorder
- Borderline personality disorder
- Antisocial personality disorder

Cluster C:
- Dependent personality disorder
- Obsessive-compulsive personality disorder
- Avoidant personality disorder

People meeting criteria for a diagnosis in the Cluster C group are generally less impaired than those meeting criteria for a diagnosis in the Cluster B group and are not the group of most concern to mental health providers. People meeting criteria for a diagnosis in the Cluster A group can have significant impairment but relatively infrequently seek out mental health services. People meeting criteria for a diagnosis in the Cluster B group are generally significantly impaired and of considerable concern to mental health providers.

Whilst questions remain about the validity of the diagnosis of borderline personality disorder, the behaviours described in DSM 4 criteria are well recognised by clinicians. Borderline personality disorder, as defined, is a dimensional disorder with varying degrees of severity and with a considerable percentage of the population having some traits. Having traits associated with this disorder is probably a normal feature of adolescence. When the traits are of sufficient severity a DSM 4 diagnosis can be made. To meet diagnostic criteria, DSM 4 states that the person must have “a pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsiveness beginning by early adulthood and present in a variety of contexts ...” and must have five or more of the nine listed features (see appendices). Borderline personality disorder is best understood as a collection of symptoms and behaviours, which are present in a range of diagnoses and with considerable Axis 1 and Axis 2 co-morbidity. Persistently unstable or chaotic life-circumstances may alert to the possibility of the diagnosis. Persistent self-harm and severe dissociation are well correlated with a diagnosis of borderline personality disorder. Of course, neither self-harm nor severe dissociation is sufficient for the diagnosis. Gunderson states that self-harm comes closest to being the “behavioral specialty” of people meeting diagnostic criteria for borderline personality disorder. Seventy to seventy five percent of people meeting diagnostic criteria for this disorder have a history of at least one episode of self-harm. The literature is less clear about what percentage of people who engage in an episode of self-harm meet diagnostic criteria for this disorder as most studies of suicidal behaviour have not reported on Axis 2 diagnoses.

The very high comorbidity with Axis 1 and 2 diagnoses and the unclear relationship with affective disorders lead to legitimate concerns about the unsatisfactory nature and validity of the diagnosis. While all these concerns are important and worthy of further research, it is critical that they do not distract from the need to treat people living in misery.
Co-morbidity

- Stone's study found only 37 percent had a “pure” diagnosis of borderline personality disorder, that is, no co-morbid diagnosis.\(^{[17]}\)
- There is considerable overlap between borderline personality disorder and affective disorders. The relationship remains one vigorously debated but not resolved.\(^{[8]}\)
- Linehan found 71 percent of people meeting diagnostic criteria for borderline personality disorder also met criteria for major affective disorder and 24 percent also met criteria for dysthymia.\(^{[11]}\)
- There is an overlap with other disorders related to impulsiveness (bulimia, substance abuse).
- A majority of people meeting diagnostic criteria for borderline personality disorder also meet diagnostic criteria for another personality disorder.
- Swartz et al found the following concurrent diagnoses if a borderline personality disorder diagnosis is made:
  - generalised anxiety disorder (56 percent)
  - simple phobia (41 percent)
  - major depression (41 percent)
  - agoraphobia (37 percent)
  - social phobia (35 percent)
  - alcohol abuse and dependence (22 percent)
  - bipolar disorder (14 percent), panic disorder (13 percent)
  - schizophrenia/schizotypal (13 percent)
  - mania (10 percent)
  - somatization disorder (8 percent)
  - obsessive compulsive disorder (6 percent)\(^{[8]}\)
- There are suggestions of an overlap with a variety of organic brain disorders.\(^{[8]}\)

To assist understanding and to guide treatment initiatives, Hurt et al have broken down the symptoms and behaviours into identity, affective and impulse clusters:\(^{[18]}\)

**Identity cluster:**
- chronic feelings of emptiness and boredom, identity disturbance, intolerance of being alone.

**Affective cluster:**
- labile affect, unstable interpersonal relationships intense, inappropriate anger.

**Impulse cluster:**
- self damaging acts and impulsiveness.\(^{[18]}\)
Beck provides a view of the cognitive schema of people meeting diagnostic criteria for borderline personality disorder that also assists aetiological understandings and underpinnings of treatment:

“\text{The world is dangerous and malevolent.}”

“I am powerless and vulnerable.”

“I am inherently unacceptable.” \[19\]

\section*{Clinical Boundaries}

The histrionic, narcissistic and borderline diagnoses have a lot in common, with the borderline diagnosis being the most frequently made diagnosis in New Zealand. There is considerable overlap between borderline personality disorder and antisocial personality disorder. A pervasive failure of empathy is not a criteria in the DSM 4 diagnosis of antisocial personality disorder, but it was a clinically meaningful part of the old diagnostic terminology of psychopathy. People meeting diagnostic criteria for this disorder frequently have significant antisocial traits, but are able to be empathic to another’s experience, sometimes exquisitely so, at least for short periods. People who are currently abusing drugs frequently have features of borderline personality disorder, especially if they are engaging in criminal activities to finance their drug use. In these circumstances, a diagnosis needs to be made cautiously, preferably after illegal drug use has stopped.

There is overlap between the diagnoses of personality borderline personality disorder and bipolar affective disorder.\cite{20,21,22} When the differential diagnosis includes borderline personality disorder and bipolar affective disorder, accurate diagnosis where possible will greatly improve outcome. An incorrect diagnosis of bipolar affective disorder encourages the clinician to overuse medication and to take too much responsibility. Once such a treatment culture has evolved, staff, client and family expectations have developed and shifting diagnosis and treatment can be a very difficult process. An incorrect diagnosis of borderline personality disorder deprives the client of rapidly effective and relatively easy to institute pharmacological treatment. The presenting symptoms of borderline personality disorder can be remarkably similar to those of a brittle, rapidly fluctuating form of bipolar disorder. People meeting diagnostic criteria for borderline personality disorder have affective shifts which tend to be of shorter duration, of more rapid onset and termination and more immediately linked to an identifiable stressor.

The presence of psychotic symptoms whilst inviting consideration of an Axis 1 diagnosis of schizophrenia, is not sufficient for the diagnosis. DSM 4 makes place for a person to have transient paranoid ideation and still meet diagnostic criteria for borderline personality disorder. The presence of hallucinations, pseudo hallucinations and brief psychotic episodes is not unusual in people meeting diagnostic criteria for borderline personality disorder without them meeting any of the other diagnostic criteria for schizophrenia.

The histrionic and narcissistic diagnoses are rarely used now in New Zealand probably because of pejorative, derogatory and in the case of histrionic...
A person meeting diagnostic criteria for narcissistic personality disorder is generally more functional, less fragmented and more likely to be accessing private mental health services.

**Aetiology**

People meeting diagnostic criteria for borderline personality disorder have a high incidence of reported physical and sexual abuse.\(^{11}\) However, looked at from the other perspective, only a small percentage of people who have been sexually abused meet diagnostic criteria for borderline personality disorder. Neurophysiology of people meeting diagnostic criteria for borderline personality disorder is characterised by hyper-responsivity of the noradrenergic system to stress and reduced serotonin activity.\(^{23}\) (Reduced serotonin activity has been linked with impulsiveness.) While some studies have not been supportive, others have found an increased incidence of brain trauma, childhood attention deficit hyperactivity disorder and learning disability. It has not been shown, at this stage, whether the neurochemical features are related to inborn physiology or whether they are a consequence of emotional trauma. Increasingly researchers and theorists are proposing a complex multi-factorial aetiological model embracing predisposing and resilience factors with individuals having different pathways.\(^{24,25,26,27}\)

All theoretical schools are agreed about the aetiological importance of childhood abuse, neglect and invalidation. All schools are mindful of the neurophysiological factors but are in disagreement about the relative aetiological importance of these. A threshold model proposes different aetiological pathways for each individual. For example if there is a history of brain trauma/dysfunction, a lower level of environmental trauma may be sufficient compared to someone with no history of brain dysfunction.

**Prognosis**

There are no absolutely naturalistic studies where people meeting diagnostic criteria for borderline personality disorder have not been treated and were followed up, nor are there ever likely to be. The studies by Stone, McGlashan, Plakun and Paris are considered to be as “naturalistic” as is possible.\(^{17,28,29,30}\) These four studies are methodological flawed in being retrospective, but have the credibility of obtaining similar results. Clients were followed up for 15 years or more. Level of function, five years after discharge, was poor and similar to people diagnosed with schizophrenia. Seventy percent of those who committed suicide had done so in the first five years after discharge.\(^{17}\) After 15 years however, provided the clients had not committed suicide, people were doing reasonably well with two-thirds functioning “well” (GAS above 60), with most working and having a social life, whereas people with schizophrenia continued to function poorly.\(^{17}\) Forty percent were considered cured (GAS above 70). Hospitalisation had mostly ceased after the first five years. This research is consistent with anecdotal information that people generally get better with time, if they don't commit suicide. This information can be affirmative to the importance and success of inpatient and crisis staff endeavours in keeping a client alive, countering
the demoralisation, which often exists because the client is not “cured”. This changes a cognitive frame of a string of short-term therapeutic failures to one of a successful long-term endeavour (see page 31 ‘Duration of Treatment’).

Linehan speaking to a client says, “I’m telling you something, listen to me. If you don’t kill yourself you are going to make it, you’re going to get out of hell. You’re going to get out of here; it’s not always going to be so bad. Life is not always going to be so painful, and you’re not going to hurt so bad. You’re going to get to be a more normal person who has a life that’s worth living. That’s going to happen to you if you don’t kill yourself. You worked too hard, and you’re too capable not to get there. You’re going to get out, you just have to keep yourself alive”.[31]

Poorer prognostic factors are alcohol and substance use, severity, antisocial traits or personality disorder, aggression and an absence of protective factors of talent, attractiveness, high intelligence and self-discipline.[17] The presence of personality disorder also has an adverse impact on treatment outcomes for people with Axis 1 disorders.[32]

Morbidity and Mortality

- The morbidity and suicide rate of people meeting diagnostic criteria for this disorder is high.[2,17,29,30,33-40]
- The suicide rate of those presenting for treatment is 10 percent.[17,29,30,39]
- This rises to 36 percent with severer forms of the disorder (eight out of eight DSM 3 criteria).[17]
- The suicide rate with the severest forms, which are invariably associated with co-morbidity, is higher still.
- Stone found a suicide rate of 45 percent when alcohol abuse, borderline personality disorder and major affective disorder coexisted.[17]
- This high mortality rate is similar to people meeting diagnostic criteria for schizophrenia or bipolar affective disorder.[17,39]

As the majority of people meeting diagnostic criteria for this disorder who suicide will do so in the first five years after presentation, it is likely that the rate of suicide in this period is higher for those with a borderline personality disorder diagnosis than any other mental health diagnosis. Runeson et al.[41,42] study of 58 consecutive suicides among 15-29 year olds in Sweden showed one-third would have met diagnostic criteria for this disorder which was the most common psychiatric diagnosis, higher than that of depression. Considerable recent attention has been placed on the early treatment of people meeting diagnostic criteria for schizophrenia. There is sufficient information indicating the appropriateness of similar attention being placed on early intervention in those presenting with borderline personality disorder.
Health Resource Usage

Swartz et al demonstrated that people meeting diagnostic criteria for borderline personality disorder use mental health services at higher rates than people from other mental health diagnostic groups, except for people meeting diagnostic criteria for schizophrenia, whose utilisation rates were similar. Sansone et al demonstrated people meeting diagnostic criteria for this disorder having higher health care utilisation in primary care settings. Morton and Buckingham documented inpatient and community health resource usage of 91 people meeting diagnostic criteria for this disorder in Victoria, Australia, who made the most use of services. The average cost of treatment of these 91 people over a two year period was $A59,340 (1994/5 cost estimates) with approximately 90 percent of costs for inpatient care. Krawitz identified, by the key informant method, the five people meeting diagnostic criteria for this disorder with the highest use of mental hospital services in a New Zealand service with a catchment population of 320,000. He retrospectively documented the mean number of acute inpatient days used over a six-month period as 69.6 days/client. Perry, using the key informant method, retrospectively looked at the acute inpatient usage of five people meeting diagnostic criteria for this disorder with the highest service usage over a five-year period in a catchment population of 300,000 in New Zealand. The mean acute inpatient days used was 56.6 days/client per year. Clients in the Stevenson and Meares’ study (see page 26 ‘Psychosocial Treatments’) used a mean of 86.1 days in hospital in the year prior to treatment.

The next two studies are interesting but because of their retrospective case note methodology need to be viewed cautiously. Drysdale found nine of the ten most frequent users of a New Zealand public mental health crisis service were people meeting diagnostic criteria for borderline personality disorder [personal communication 1998]. Long found forty-six of the 100 highest utilisers of a public mental health service had a case note diagnosis of borderline personality disorder (Personal communication 1999). People meeting diagnostic criteria for this disorder are generally receiving treatment in a reactive manner without a specific proactive treatment package and are already high users of service. The problem with current health resource usage is that much of it goes into crisis treatment, which fails to address the evidence that long-term treatment is required for effective outcomes.
Treatment Issues And Clinical Pathways

Assessment

An adequate assessment of a client's problems and needs is required for clinician and client to engage in a mutually agreed plan of action. The assessment will be modified according to the setting and context (whether in inpatient or outpatient settings; whether for crisis management or ongoing therapy and whether the client is well known to the clinician). Treatment issues exist right from the very beginning of an assessment. As such, the need for gathering factual information must be balanced with other factors, such as the need to build a therapeutic alliance, to engage the client collaboratively, to instill realistic hope and to maximise client self determination. There is a danger, especially among inexperienced staff, of gathering information invasively which can complicate effective future treatment. This should not however, be a reason to neglect doing a thorough risk assessment.

Areas of assessment need firstly to include the general information appropriate to any psychiatric assessment: demographic data, contact persons and social supports, presenting problem/s, stressors, risk assessment, level of function, past treatments, past psychiatric history, past medical history, current medications, drug and alcohol use, biographical history, temperament and personality style, mental status. This information should assist with confirming the diagnosis.

Further areas of assessment which may then be needed include:

- further risk assessment including determination of acute versus chronic suicide (see 'Acute versus Chronic Suicide Risk' page 50)
- further mental status assessment including especially affect, presence of psychosis, and cognitive functioning
- skills deficits and strengths, short and long-term levels of function, client role dysfunction and skills required
- client goals and motivations for different types of treatment including effective and ineffective past treatments
- family and or current living environment – is this facilitating change and if not, what else is required, including seeing caregivers, if this will improve assessment and facilitate change
- institutional/mental health system of care available to the client – is this facilitating change and if not, what else is required
- personality style, including impulsiveness, identity, anger, relationships, self-determination and how distressed to current maladaptive behaviours
- formulation/conceptualisation: the brief synthesising of pertinent information making linkages between present and past behaviours, feelings and events. This provides clarity and understanding as to how this person got to be who and where they are on the day of assessment, and will underpin the clinical plan including the targeting of acquiring skills and environmental change.
Risk Assessment

Many concepts of risk assessment can be drawn from general psychiatry with the recent risk assessment guidelines produced by the Ministry of Health being a good reference point.[46] Whilst statistical risk factors such as age, substance use, depression are useful, clinical decisions need to be very individual. “Extreme caution is required when applying probabilities derived from actuarial methods to individuals.”[46]

Individual risk assessment will be influenced by:

- intensity of the emotional pain, especially feelings of hope/hopelessness and despair
- whether the client can see alternatives
- whether the client feels alienated (experiencing the availability of caring others, protective values of connection)
- client view of the “afterlife”
- degree of suicide planning
- prior suicide attempts (correlated with later suicide)[47]
- aborted suicide attempts (where the person planned an attempt and at the last minute changed their mind) are correlated with later suicide[48]
- distinguishing acute from chronic suicide patterns (see ‘Acute versus Chronic Suicide Risk’, page 50).

Team Structure

People meeting diagnostic criteria for borderline personality disorder have tended to receive treatment that is fragmented and reactive. Poor outcomes are then used as evidence of the inefficacy of treatment. A cohesive team structure essential for all areas of mental health is even more critical in this area. The requirement for integration of services, the absence of clearly defined guidelines and the life and death decisions that need to be made, mean that staff differences will be very evident. A cohesive team structure will assist these differences being constructive rather than destructive.

At the core of the team structure is the client and key clinician working wherever possible in collaboration. The key clinician, who may or may not be the therapist, and is usually the clinician who has the most client contact, coordinates treatment with the client. As outlined in the section on ‘Investing Value and Status in the Key Clinician Role’, (page 53) the key clinician needs to be trained, supported and empowered to lead and determine the clinical plan. The key clinician will ensure that all relevant parties are involved in developing the clinical plan, in agreement wherever possible with the clinical plan, know their role in the clinical plan and are consulted and informed of any changes made. Relevant parties may include internally: outpatient, inpatient, crisis, respite, day programme, prescribing clinician, substance use services, emergency, child and forensic services and externally: caregivers, family, private therapist, Children and Young Persons Services, police and lawyers. Roles and treatment goals need to be clear. A clear,
transparent and coherent team structure will minimise fragmentation of treatment and assist the calm, considered following through of the clinical plan.

Team/ System Culture

The culture ideally will:

• matter to the people who are part of it. People will define themselves in terms of it, care about it and be willing to sacrifice to improve it. Members will seek to help weaker members. [Adapted from Shenagh Gleisner - personal communication]

• be co-operative and mutually supportive

• accommodate constructive conflict and not be divided by it

• proactively address staff differences

• validate the clients, the work and the clinicians doing the work, which will include adequate resourcing to do the job

• encourage and support professionally indicated risk-taking. (See 'Professionally Indicated Risk-Taking' page 48)

Clinical Plan

The clinical plan lies at the heart of the treatment. Having a regularly reviewed clinical plan implies that individual conceptualisation/formulation of client issues take place and that relevant parties are participating in ongoing dialogue and are aware of and reasonably in agreement with the clinical plan. This will encourage integration of services. Surprises are kept to a minimum. The plan will include crisis guidelines, pathways to respite and hospitalisation and the clients' individual crisis strategies. The latter will include what has and has not worked in the past, such as a list of safe people to contact, safe places to go to, activities which make the client feel safe, self soothing skills, emotion acceptance skills and alternatives to self-harm. See Appendices for an outline of a clinical plan.

Contracts

Contracts are frequently used and have an important role to play especially in acute inpatient units, ongoing therapy and around high-risk behaviours. The advantages of contracts are that:

• the parties have been talking to one another

• mutual collaboration and power sharing are implied with inappropriate power differences being decreased

• clients may feel empowered and therefore more in control

• expectations and responsibilities are clarified (decreases idealisation/devaluation and likelihood of complaints)

• structure, predictability and a reality base are provided

• self control is increased because of clarity and structure
• a place of agreement is established that can be returned to when conflict arises.

Miller[49] describes common errors in formulating a contract as being:
• “unduly restrictive or one sided
• inhibition of emotional growth
• staff assume an overly parental role
• covert punishment or rejection
• substitution for therapy
• at times staff may be tempted to rely on contractual agreements to manage behaviour instead of investigating the reasons for the behaviour
• relaxation of therapeutic vigilance.” [49]

Contracting with the client against suicide carries no legal protection. Some clinicians use contracting against suicide as a therapeutic endeavour but McMahon writes, “By insisting that the person with borderline behaviour maintain their safety or else go into hospital, a disjunction is created between what the client is communicating (that they are out of control) and staffs’ expectations (that they are able to and will control themselves). The consequence is greater distress in the client who feels invalidated and a corresponding increase in self-harm and suicidal behaviour.”[50]

It should be noted that “creating a contract with a client is a reflection of the therapeutic relationship and is therefore only as good as the alliance on which it is founded.” Whether a contract serves as a helpful adjunct to treatment or as a counter therapeutic distancing device, depends on how it is conceptualised, designed and negotiated.[51]

Psychosocial Treatments – Outcome Studies

The Cochrane Collaboration has not done a systematic review on borderline personality disorder nor is one planned. Crits-Christoph, in reviewing the treatment of borderline personality disorder in “A Guide to Treatments That Work” (a 1998 text focused on evidence based research) names four studies only: those of Linehan, Barley, Stevenson/Meara trial, and Munroe-Blum/M arziali.[52]

Linehan et al randomised controlled trial of Dialectical Behaviour Therapy (DBT) versus treatment as usual demonstrated a 60 percent reduction of self-harm and a reduction of hospital days of 39 days (control - eight days) in the one-year of treatment.[33,34] DBT uses cognitive and behavioural strategies to support and educate the client towards more adaptive behaviours. Treatment consists of weekly individual therapy (motivational interviewing, problem and solution analysis) and a weekly skills training group and telephone contact (skills coaching and generalisation of skills).

Barley et al in a part-prospective, part-retrospective controlled study of an inpatient unit (median length of stay - 106 days) using a DBT model demonstrated a three-fold decrease in self-harm episodes.[53]
Stevenson and Meares, in a prospective study, treated clients twice weekly for one year using a self psychology model. This model is more gentle and less challenging than traditional psychoanalytic approaches. The therapist aims to provide the client with a soothing empathetic experience. This, alongside the restoration of inevitable empathic failures leads to the client developing a more integrated identity. Results demonstrated a decrease in violent behaviour by 70 percent, medical visits by 87 percent, self-harm episodes by 78 percent, hospital admissions by 59 percent, hospital days by 49 percent (86.1 days-44.1 days) and there was a significant reduction in symptoms measured on a self-administered rating scale.[35] The Linehan study appears to have had a population with a considerably higher baseline rate of self-harm than the Stevenson/Meares study. The Linehan and Stevenson/Meares studies demonstrated an important capacity to maintain clients in treatment with retention rates of 83 percent, well above the 50 percent figure previously considered acceptable.

Munroe-Blum and Marziali, in a randomised control trial, treated clients for thirty ninety-minute sessions using a modified form of psycho-dynamic group psychotherapy (interpersonal group psychotherapy) versus twice-weekly individual psychodynamic psychotherapy. Both experiment and control groups made equally significant improvements measured on self-administered rating scales, but the experiment group treatment was cheaper.[54] It appears the study population had less severe difficulties than the clients in the Linehan and Stevenson/Meares studies with only one-third having a history of suicide attempt (not defined) and one-third (presumably much overlap) with a history of hospitalisation. The Linehan and Munroe-Blum/Marziali studies are the only two randomised, controlled trials published on psychosocial treatments to date.

Other studies are methodologically weaker or the client group studied included people meeting diagnostic criteria for personality disorder other than borderline personality disorder. There are four positive prospective outcome studies, where clients were used as their own controls, which took place in residential, semi-residential or day programmes. Tucker et al, Vaglum et al and Hafner/Holmes’ treatment were psychodynamic, all using therapeutic community principles.[36,37,38] Krawitz’s study had only six clients with a borderline personality disorder diagnosis and used a treatment package, which included psychodynamic, cognitive-behavioural, and sociopolitical approaches.[55]

Nehls reported on a trial of five clients who essentially were in charge of their brief acute hospital admission rights. Results showed a 47 percent decrease in the number of days in hospital (25.8-13.8 per client for the year).[56] Nehls’ other study used a pragmatic group case management approach.[57]

The Cochrane Collaboration in 1998, completed a systematic review of treatments for deliberate self-harm.[58] This review reports significantly reduced self-harm for two treatments: depot flupenthixol and DBT and non-significant trends towards reduced self-harm for two treatments: problem-solving therapy.
and the provision of an emergency contact card. The review goes on to state:

“The results of this systematic review indicate that currently there is insufficient evidence on which to make firm recommendations about the most effective forms of treatment for patients who have recently engaged in deliberate self-harm. This is a serious situation given the size of the problem of deliberate self-harm throughout the world and its importance for suicide prevention.”\[58\]

Several current treatment trials will provide much needed information over the next few years. In Sydney, a replication of the Stevenson/Mearses is underway using a waiting list control. In Melbourne, a randomised controlled trial comparing cognitive analytic therapy with intensive case management will begin shortly. There are numerous DBT studies taking place in different centres including a trial of DBT versus Kernberg’s psychoanalytic psychotherapy. A DBT replication randomised controlled trial is in press and a replication randomised controlled trial by Linehan is currently being reviewed by a journal. The American Psychiatric Association gave a 1998 “Gold Award” to a small community programme which successfully integrated DBT with positive pre-post outcomes.\[59\] Preliminary data for the one year of treatment showed decreases of hospital days by 77 percent, face to face contact with emergency services by 80 percent and treatment costs by 58 percent.\[59\]

In summary, there is currently a paucity of research, however DBT is the best researched treatment model for people meeting diagnostic criteria for severe forms of borderline personality disorder followed by self psychology as practiced by Stevenson/Mearses. For less severe forms, interpersonal group psychotherapy has been researched with a randomised controlled trial. The very limited treatment outcome studies and absence to date of published replications is short of the desired standard. Nevertheless, there are strong suggestions of effective treatments which will almost certainly be consolidated over the next few years. These treatments can guide current practices, which can evolve as new data becomes available. Not providing services till the data meets the standard we would like, is overly cautious and will continue the perpetuating self reinforcing cycle of poor outcomes and negativity.

Commonalities Between Different Models

Different models all have firm explicit contracts, a high degree of clinician engagement and a proactive disciplined approach to impulsive behaviour.\[60,61\] All models highlight the importance of the client-clinician relationship, of the therapeutic alliance and of patterns of client behaviours manifesting in the client-clinician relationship.\[60,61\] All models require the clinician to remain relatively calm in crisis, be mindful of their feelings and to set limits to assist the clinician in maintaining warmth for the client, so essential for a positive outcome.\[60,61\] Allen in exploring similarities in four different models notes the acceptance that therapists will make errors, which
need to be acknowledged (perhaps with a brief apology) and used if possible to therapeutic advantage. He notes all four models attempting to have clinicians interacting in a manner that minimises the client feeling criticised. At the same time however, he also states “all four paradigms caution against treating the patient as if he or she were fragile or incapable of being reasonable...”. It is important for clinicians to be well grounded in the theory and practice of the model they are using. There is a place for using an integrative model provided this too is well grounded and not an ad hoc reactive approach.

Pharmacological Treatments

Like psychosocial treatments, the pharmacological treatment of people meeting diagnostic criteria for this disorder has made advances in the last 15 years but still remains in its infancy. Research is difficult because of the high comorbidity and the natural history of rapid fluctuations in symptoms. Trials are few, have shown only modest gains or can't be replicated. This tends to confirm anecdotal clinical experience that currently, pharmacological treatment, if used, should be as an adjunct only. Of course, comorbid conditions such as major depressive episode should be treated in their own right. Woo-Ming and Siever have reviewed the pharmacological treatment of personality disorder in “A Guide to Treatments That Work” (a 1998 text focused on evidenced-based research) as has Hirschfield in a 1997 article.

Serotonergic Agents

There has been one randomised double blind placebo controlled trial of fluoxetine (20-60mg) showing global improvement, including mood, but especially impulsiveness. Paroxetine in a single randomised double blind placebo controlled trial resulted in a modest reduction of suicidal behavior in a group of patients with “repeated suicide attempts but not major depression”. Therapists perceived a decrease in client impulsiveness in a double blind placebo controlled trial of people with personality disorder taking Lithium, but Lithium has considerable dangers when not taken as prescribed. These results are consistent with the knowledge of people meeting diagnostic criteria for this disorder having diminished serotonergic function.

Neuroleptic Agents

One double blind trial of thiothixene and haloperidol (4-12mg) and another double blind placebo controlled of haloperidol showed modest global improvement in symptoms. Woo-Ming and Siever in reviewing a number of studies using neuroleptic agents state, “... it may be reasonable to choose an antipsychotic medication for a borderline patient who has a predominance of psychotic-like features...”
Anti-convulsants

Carbamazepine has been researched with mixed results with one study demonstrating improvement in impulsiveness and stability of mood but this was not replicated in a later study.[23]

Older agents (tricyclic anti-depressants, older MAOI’s)

Some of the older noradrenergic agents, whilst tending to improve mood symptoms, sometimes made impulsiveness, irritability and mood control worse. This is in keeping with the knowledge of people meeting diagnostic criteria for this disorder having a hyperresponsive noradrenergic system. “Noradrenergic agents such as the tricyclic antidepressants or MAOI’s are less desirable; although they may have an effect on depressive or atypical depressive features, results have been inconsistent in the trials so far. If they are used, patients should be carefully monitored for the appearance of increased impulsiveness.”[23]

Other Agents

Many other psychopharmacological agents have been reported to be successful in anecdotal case reports. There are also a number of open uncontrolled trials. Whilst the information from these sources may provide pointers for future research, they are short of the standard required to recommend treatment, especially in a client group whose symptoms naturally fluctuate. Of most interest are naltrexone, clonidine, sodium valproate, paroxetine and risperidone.

The prescribing clinician must resist the considerable pressure that often occurs for a quick cure. Prescribing should be done as one would for any other disorder with adequate doses taken consistently and for a satisfactory duration. Until this has taken place, the prescribing clinician should advise that the medication has not been adequately trialed and resist the pressure to change medication or add further medication. Also prescribing clinicians need to integrate pharmacological and psychological effects such as the medication being experienced as a symbolic yet tangible currency of caring or authority.

In summary, if medication is to be used, fluoxetine would in general be a reasonable first choice. In time, it is likely that other SSRIs will be shown to be effective. A neuroleptic agent could be a first choice if prescribing for someone with psychotic symptoms or a history of psychotic symptoms. In time, it is also likely that the newer neuroleptic agents will be shown to be effective. Mood stabilising medications such as carbamazepine and sodium valproate are other possibilities.
Prescribing in Crisis

If a client can manage a crisis without external pharmacological assistance, this will greatly enhance their self capacity and confidence for future crises. If this is not possible, the pragmatic use of minimal doses can de-escalate a crisis and stabilise the situation. There is no evidence base to recommend what medications to use. However, some people believe benzodiazepines to be contra-indicated in this client group because of their capacity to reinforce further crises, possible disinhibiting effect and potential for addiction. To use medication because of inadequate resources to provide psychosocial interventions is short of best practice.

Duration of Treatment

The best studies of outpatient treatment with people meeting diagnostic criteria for severe forms of borderline personality disorder had people in treatment for one year.\(^{33,34,35}\) While positive results were obtained during this duration, both groups see best practice treatment lasting longer than this (personal communication Stevenson 1996, personal communication - Linehan 1997), perhaps on average two to four years. This is in keeping with knowledge obtained from naturalistic prognosis studies (see ‘Prognosis’ page 20). Some clients can’t be engaged successfully in consistent regular long-term treatment, but can be engaged in “long-term intermittent treatment”. Here, an individual clinician or system will be available to the client if/when they seek crisis or short-term treatment. The principle is to maintain what advantages of continuity are possible and for the client to feel connected and not abandoned. It is easier to maintain an optimistic position, so necessary for positive outcome, if a long-term perspective (years) is held.

Prioritising Interventions

People meeting diagnostic criteria for this disorder present unremittingly with a wide range of important pressing problems, which are potentially overwhelming for client and clinician. This presents the clinician with a dilemma of what to focus on. Many authors, in particular Herman, have broken down therapy into a three-stage model with the first stage being about stabilisation, safety and trust, the second stage about emotionally expressive work (“metabolism of the trauma”) and the third stage about generalisation of changes into the wider community of the client.\(^{67}\) The client generally moves through the three stages as they progress but most of the difficulties experienced in this work are in the first stage. Treatment priorities in stage 1 should be guided by the principle of doing what is going to best achieve stabilisation and safety. Clearly, acute suicide interventions take priority, as would life-threatening weight loss in someone with anorexia nervosa. A client who is using heroin daily is likely to be assisted towards stabilisation by getting onto a regular consistent dose of methadone. A clear, coherent clinical plan or tending to the client’s accommodation needs are other examples which might best assist stabilisation. Priorities need to be individualised to the particular situation each client is in. These concepts will assist treatment planning in relation to the severity of problems the client has.
DBT uses a similar prioritising process as follows:

**Pre-treatment Stage**
- Assessment, commitment to and orientation to therapy

**Stage 1**
- Suicide and self-harm behaviours
- Therapy interfering behaviours (of client and clinician)
- Quality of life issues

**Stage 2**
- Post traumatic stress therapy

Sexual abuse needs to be recognised and its importance acknowledged. There is expert consensus that specific psychological exploration of abuse material should only be done when there is sufficient stabilisation. Inexperienced therapists, understandably, recognising the importance aetiologically of the abuse, may enter into psychological exploration too early, causing destabilisation. Briere writes of the need to balance consolidation versus exploration. The anomalous situation of Accident Compensation Commission (ACC) funding for sexual abuse treatment encourages exploration of sexual abuse material before the client is ready. Counsellors are paid to do “sexual abuse work” not the often more important work on the sequelae of sexual abuse such as destabilisation, and mistrust. Also, ACC accreditation of sexual abuse counsellors ensures that clinicians have adequate skills to do stage 2 work but not necessarily stage 1 work.

There is very little information to guide clinicians about different treatment models for people with different levels of severity of the disorder. Clarkin and Linehan felt that DBT might be best suited to people meeting diagnostic criteria for the severest forms of borderline personality disorder [personal communication – 1997]. Marziali and Clarkin felt that the interpersonal group psychotherapy model used by Munroe-Blum and Marziali to be less well suited for people meeting diagnostic criteria for the severest forms of the disorder [personal communication – 1997].

**Crisis Work**

Crisis work is an important adjunct to core outpatient treatment and should be guided by the clinical plan set out by the key clinician and client in consultation with the crisis team (See ‘clinical plan’ in Appendices.) This written plan will be available to crisis workers who will be especially interested in the clients prioritised crisis intervention options and how to best support these. Crisis workers will contribute to the improving and modifying of the clinical plan in an evolving fashion. Frequently crisis (and inpatient) services are seeing people due to the absence of a comprehensive outpatient service. This is short of best practice. Crisis work with people meeting diagnostic criteria for this disorder is very different from the long-term engagement of the key clinician and therapist. The goal is to assist the person to get back to their pre-crisis level of function and to “live to fight another day”. Crises with people meeting diagnostic criteria for this disorder are inevitable and an essential learning opportunity for the client to develop a more adaptive
The crisis session usually needs to be structured, with goals of the session collaboratively defined, directing/redirecting discussion to the original problem and defined goals of the session and with clear roles and responsibilities. If an impasse is reached, the clinician can point out the impasse and consequence of certain behaviours, take time out and get a second opinion.

Wherever possible, the clinician should avoid taking responsibility for the client, and involve the client in determining options. Crisis workers need to be supported and encouraged to take professionally appropriate risks (see page 48 ‘Professionally Indicated Risk-Taking’), to tolerate high levels of anxiety associated with at-risk behaviours and to be aware whether the system has a client controlled admission policy (see page 36 ‘Client Controlled Brief Acute Admissions’). Clinicians need to be trained in, and aware of, the clinical and medico-legal issues around acute versus chronic suicidality and balancing short-term versus long-term risk (see page 50 ‘Acute versus Chronic Suicide Risk’ and ‘Short-Term versus Long-Term Risk’).

Information which can be helpful in crisis work on risk assessment, clinical plan, contracts, pharmacological treatment, duration of treatment, prioritising interventions, some anti-suicide interventions, crisis hierarchy, self-harm, limit setting and inpatient setting are available in sections under those titles.

Some Anti-Suicide Interventions

The risk assessment will guide anti-suicide interventions, which may include:

- instillation of realistic hope
- looking for alternatives
- making connection and tending to client’s feelings of alienation
- looking for internal contradictions and ambivalence regarding desire to die: is there even a tiny part that doubts, that is fearful of dying, that objects to dying? Heightening ambivalence: getting internal commitment (with oneself) to engage in internal and external dialogue over this ambivalence
- decreasing impulsiveness by internal agreement (with oneself) to wait till next appointment to discuss ambivalence
- create distance, if possible, from clients access to lethal weapons and drugs
- all above linked in with Young’s Crisis Hierarchy.[69]

Crisis Hierarchy - Young[69]

- increased contact
- use strategy appropriate to dominant dimension of client (abandoned, angry, self-punitive)
- contact significant others
- consultation
- medication
• community support
• hospitalisation
• committal

Self-Harm

Persistent self-harm is frequently associated with the diagnosis of borderline personality disorder. It is critical to be clear whether actions of harming the body were intended to suicide or for other reasons. Self-harm most commonly is used to alleviate emotional distress especially related to anxiety and anger. In these situations the self-harm is a private act. Successful treatment will lead to more adaptive alternatives. Of more difficulty for clinicians are self-harm actions, which are covert communications. Here, the clinician will attempt to encourage overt communication alternatives and not reinforce the communication behaviour. Treatment may involve a behavioural chain analysis of the sequence of events leading to self-harm, with the intention of the client becoming more aware of possible points to intervene differently in the future.

The earlier in the pathway the intervention, the better. This is a core feature of DBT or for that matter any cognitive behavioural approach. Frequently, however, especially with clients new to treatment, interventions may only be able to be carried out immediately before self-harm or not at all. Immediate alternatives to self-harm include activities which are somewhat less harmful, distracting activities and self-soothing activities.

Cognitive Behavioural Strategies

Work using behavioural analysis, cognitive inferences and core beliefs/schemas can be found in standard cognitive behavioural texts as can training in impulse control, tension/distress reduction and self-soothing. However, it is probably best to use texts which are focused on people meeting diagnostic criteria for this disorder, because of the modifications required for this group.\[11,19,70,71\] There are many books available for the client or lay person using these principles.

Limit Setting

Limit setting is appropriately used to increase the client’s adaptive behaviour and has been written about extensively. More recent literature has been legitimising the use of limit setting to prevent clinician burnout and for the clinician to maintain positive feelings for the client.\[11,69,72,73\] “Limit setting needs to limited”, as it is a unilateral non-collaborative action. Limit setting should, wherever possible, be in the context of a responsive, supportive and validating relationship. Dawson asks the client what they want and the clinician/system states what can or can’t be delivered.\[74\] Client and clinician then negotiate and discuss matters including the consequences for the client if the clinician/system boundaries are breached.
When preparing to set a limit, clinicians must be prepared for an escalation of behaviour as the person checks out whether what is stated will be carried through. If the clinician is uncertain about their or the systems capacity to maintain the limit in the face of an escalation of behaviour, then it is best to not set the limit. Intermittent reinforcement of the behaviour will otherwise occur which is very difficult to alter. Inappropriate limit setting can sometimes be a result of the clinician being unable to constructively process their feelings for the client. For this reason, wherever possible, the clinician should delay limit setting when angry with the client. It is important for the clinician to monitor their own limits, communicate these clearly to each client and to be aware of warning signs that their own limits are being reached towards. The greater care the clinician takes of themselves such as tending to physical, emotional and spiritual well-being, the broader and more flexible their limits are likely to be. Attention to caseload, supervision and consultation needs, will have a similar effect.

Acute Inpatient Services

Acute inpatient services are an important part of coherent, coordinated clinical plans of service delivery but should be seen as an adjunct only to the comprehensive outpatient service provided. Acute inpatient services are not designed to provide ongoing treatment for people meeting diagnostic criteria for this disorder, yet frequently end up doing so by default, due to the absence of comprehensive outpatient services.

There is consensus expert opinion that acute inpatient units can cause iatrogenic (caused by the health care system) deterioration by encouraging the client to less responsibility for their behaviours. Alternatively the client may demand discharge, whilst behaving in a manner which makes discharge a clinical dilemma. Common reasons for acute inpatient admissions are treatment of comorbid diagnoses, acute suicidality and respite to achieve stabilisation. If admission is being considered for respite, it is best to aim towards creative alternatives, which maximise client self-determination, autonomy and responsibility. These include intensive outpatient support, domestic help, day stays, motels and supported accommodation.

Admissions, when they do occur, need to be wherever possible, brief and goal-focused on reducing symptoms related to the current crisis. The unit will have clear structures and clinicians will have clearly defined roles. A goal-focused contract will exist with, wherever possible, a clear discharge date and outpatient contract. Outpatient planning, which is at least as important as the inpatient “work”, will be coordinated with and influenced by the key outpatient clinician and needs to have begun prior to admission. A contract with clearly defined readmission criteria and pathways to be readmitted will be in place before admission preferably, or as soon as possible after admission. These vigorous structures provide the client and staff with a “greater sense of control and empowerment”.

Cognitive-behavioural programmes using and modifying DBT methods have been developed for use on acute inpatient units. To keep the admission
brief requires clear understandings of the issues of acute versus chronic suicidality, short versus long-term risk (see ‘Acute versus Chronic Suicide Risk’ and ‘Short-Term versus Long-Term Risk’ page 50), and organisational support for professional indicated risk-taking. In units where brief admissions are proactively contracted for, and able to be sustained, staff morale is higher with more positive attitudes to the clients involved. This is likely, in turn, to improve outcome. Pre-discharge deterioration should be expected.

Involuntary admissions should be avoided wherever possible (see ‘Clinical Appropriateness of the Use of Mental Health Legislation’ page 47) and lengthy admissions subject to routine local peer review. O’Brien in a 1998 review of inpatient nursing care explores some disadvantages of close monitoring of the client and advantages of brief hospitalisation and client controlled admissions.\textsuperscript{75}

**Client Controlled Brief Acute Admissions**

Clients controlling their brief acute admissions could lead to large gains being made in current systems. Unfortunately very little research has been done nor much written about this dimension of treatment. However, the principle is endorsed by a number of international experts (Gunderson, Herman, Linehan and Nehls: personal communication – 1997). Nehls reported on a trial of five clients who essentially were in charge of their brief (48-72 hours) acute hospital admission rights. Results showed a 47 percent decrease in the number of days in hospital (25.8–13.8/client for the year).\textsuperscript{56} In Madison, USA, Krawitz visited two of the three acute inpatient wards and found this system being routinely used with known clients in both places.

Anecdotal literature reports on the efficacy of such systems exist. Krawitz having run 36 workshops in ten different New Zealand centres in 1997 and 1998 had a unique opportunity to listen to others experiences of this system. He heard of about fifty clients where this had been used with positive effect for client and clinician. He has not yet heard of a situation where this has proved to be a negative therapeutic endeavour. Watson over the last two years and Krawitz, dating back 13 years have had positive experiences using this system.

Principles of the system are empowerment of clients to be in charge of their treatment, avoiding unnecessary power struggles (which invariably the clinician can’t win) and brief hospitalisation as a form of intensive respite and time out, but not a place of “treatment”. The communication to the client is firstly, that acute inpatient wards are usually a destructive place to be unless the stay is brief, and secondly, that “treatment” takes place in the community, not the acute ward.

Such a system can take a huge pressure off inpatient staff to “fix” the unfixable, leaving them with the more manageable task of being friendly and courteous, rather than trying to “treat” the client. Inpatient clinicians should be neutral and kind but refer most matters to the outpatient key
clinician. Policies which could be considered on an individualised basis include: a clear direction to staff to not build up intense individual relationships, having different staff each day attending to the client and not having the outpatient key clinician and therapist see the client on the ward. These potential policies are controversial and have risks associated with them, especially of dislocation and fragmentation of important healing relationships. Client controlled brief acute admissions are dependent for maximum efficacy and efficiency on a well-resourced outpatient treatment programme.

Many of the principles used with client controlled admissions can be used in clinician controlled admissions, if it is decided that the acute unit is a place of respite and not “treatment”. Researching this system of service delivery could have far-reaching impact if found to confirm the positive outcomes anecdotally reported. As each centre in New Zealand has only a few clients on such a system, nationally coordinated research would be required to generate sufficient numbers to be methodologically sound. This could be a task for a group of people in academic positions and national leaders.

**Specialist and Rural Mental Health Services**

There is a paucity of useful literature or written expert consensus related to specialist services such as forensic, child and adolescents, eating disorders and substance use. Generalising from knowledge in adult mental health areas is needed. Clinicians can be guided by focusing on treatment goals, which will best achieve stabilisation for the client. Child services present unique problems around responsibility and confidentiality where the person is a minor. Normal adolescents have many traits of borderline personality disorder. Clinicians are eager not to burden an adolescent with a pathological label and identity as patients, whilst also not wanting to miss those people for whom early proactive treatment will prevent considerable future morbidity.

Forensic psychiatry and the justice system are presented with a number of difficulties. Inpatient forensic services generally were not designed for people meeting diagnostic criteria for borderline personality disorder and in many ways are counter-therapeutic. Disempowerment and necessary institutional (as opposed to individualised) rules run counter to what is known about effective treatments. There is no evidence that long-term involuntary treatment is beneficial. Expert opinion indicates the opposite. People meeting diagnostic criteria for antisocial personality disorder are more of a concern to the community than people meeting diagnostic criteria for borderline personality disorder because violence is directed at others rather than oneself. Unfortunately, evidence of treatment efficacy is absent.

Clinicians and clients in rural areas will need to make creative modifications such as greater use of the telephone, primary care and community groups.
Stigma, Language And Clinician Feelings

Consumer Perspective on Policy

This section on Consumer Perspective on Policy was written by Merinda Epstein, Consumer Consultant on numerous Australian national committees, leader of award winning research and author of several publications.

One of the most healing things I have been able to do for myself has been to access my psych files through freedom of information legislation. I use a line when speaking to various groups, it goes like this: “You know all the awful things you thought they were writing about you – they were.” People usually laugh, especially other consumers who can relate immediately to what I am saying about power. When I accessed my records, I discovered that the language used to describe me by mental health workers underwent a palpable change (for the worse) subsequent to my being diagnosed with borderline and other personality disorders. While undergoing treatment, I had experienced a discrepancy between denigrating attitudes and caring rhetoric as being a consequence (or symptom) of my own evil. It seemed that a personality disorder diagnosis was telling me that my whole being was wrong: that there was a fundamental inadequacy about me as a human person.

Unfortunately, insensitive ‘reading’ of traditional intervention strategies in this field would have us believe that people labelled in this way take insufficient responsibility for their own behaviours; in my case the opposite was the case. I took all the responsibility for my failure to gain respectful treatment. The records showed me that the discrepancy was ‘real’ and that responsibility for it lay outside me.

As I have become more and more aware of the political debates that have been going on in New Zealand and Australia I have started to better understand the links between public mental health policy and politics. It became very clear to me that the nature of so-called personality disorders, for example, renders them risky in a political sense. There was a feeling that if people with so-called personality disorders were defined less brutally and perhaps even treated respectfully, kindly, genuinely and supportively by public services there would be a risk that others would seek this ‘good treatment’ and so the system would become flooded and there would be no resources left for people with ‘real’ illnesses. This argument is very rarely expressed so explicitly. Rather, it is assumed and the fear of inundation lies unstated but taken for granted.

The policy response to this unacknowledged fear has been to institute a language relating to differential assessment of severity. Often, the definition of severity revolves around demonstrable self-harm on the part of the individual being assessed. Unfortunately this limited understanding of severity and the practices that grow out of it result in promoting crises (N C A G, 1995). Thus, certain self-replicating perceptions about the nature of ‘personality disorders’ are promoted, such as:
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- the notion that ‘PDs’ are beyond redemption
- the belief that ‘PDs’ are a management problem
- the idea that self-injuring acts are deliberate attention-seeking strategies.

A consumer writes, “While notions of seriousness and blamelessness remain attached to a medical/biological definition of ‘real’ and judgmental notions like manipulation, attention seeking, acting out, dysfunctional relationships and blame remain attached to so-called ‘personality disorders’ we are going to force consumers to want and need definitions of self which they believe have some chance of allowing them some semblance of dignity.” (Morton)

In any considerations relating to national policy change the following need to be taken into account:

- While certain aspects of the ‘medical model’ of care have been notably inadequate (or even detrimental) for these consumers, replacing this type of care with psychology-based programmes would achieve little unless, at the same time, negative and damaging attitudes within the system towards people who have been labelled with ‘personality disorders’ are challenged. Not only psychiatrists and nurses but also psychologists and social workers are in need of further training. This requires consumer-led staff education programmes supported by adequate infrastructure and money.

- Public anti-discrimination campaigns need to become inclusive: that is, they need to take into account people whose experiences of mental distress are not episodic, are not responsive to medication, and do not attract public attention.

References:


Stigma and Discrimination

Unlike the stigma the community puts on mental illness, the stigma associated with borderline personality disorder has been shown to come from within our profession. Often there is individual and institutional avoidance of treating people meeting diagnostic criteria for borderline personality disorder. When they are seen, it may be with ambivalence or annoyance. Linehan describes how, clients who come to services with a diagnosis of borderline personality disorder may already be disliked before they have even been seen.
Clients in treatment are often embroiled in clinician attitudes which are derogatory or denying the legitimacy of their right to access resources. Studies have demonstrated clinicians having less empathy for people meeting diagnostic criteria for borderline personality disorder than other diagnostic groups and making more belittling comments.\cite{79,80} Consumers have identified this stigma.\cite{1,81,82} “Current politics are espousing the ‘biology of mental illness’ and therefore appealing for public compassion for the ‘victims of disease’. Empathy is sought for victims of illness rather than survivors of horrors.”\cite{82} Consumers have drawn parallels with the stigma associated with AIDS in the early 1980s.\cite{82}

Some of the stigma may be linked with the impact on mental health professionals of having clients who do not tend to get better in the short term and also infringe the code of behaviour of the sick role: co-operation, appreciation, gratefulness. Lewis and Appleby argue that psychiatrists view people with “mental illness” as deserving of compassion because they have not caused their problems. People with personality disorder on the other hand are viewed as not having a “mental illness”, seen as being in control of their behaviour and consequently not deserving of compassion.\cite{78}

**Negative Terminology**

Words are important carriers of information and significantly shape the future. Some commonly used terminology such as “PD, worried well and just behavioural” invalidates clients, is offensive and almost certainly, leads to poorer outcome. We need to explore terminology, which is more helpful. “Attention seeking” might be better replaced with “in need of attention”, “manipulation” with “manoeuvre” and “greedy” with “in need.”\cite{69,73}

The term “splitting” whilst conveying an important concept has frequently been corrupted to blame the client for all staff differences. In this process staff disempower themselves of the capacity to do anything about the situation. Gunderson is quoted, “The danger in seeing splitting as too much of an intrapsychic problem and not enough of an interactive one is that it underestimates the capacity of clinicians and other people to correct it.”\cite{83} “Splitting” occurs around many difficult clinical scenarios unrelated to people meeting diagnostic criteria for borderline personality and is often an indication of capacity to resolve staff differences. A descriptive alternative of “staff differences” goes some way towards dealing with the problem.
Clinician Values and Feelings

This section on clinician values and feelings written by Dr. Nick Argyle Clinical Director, Auckland Healthcare, Director, Balance programme (borderline personality disorder treatment programme), Auckland Healthcare and Honorary Senior Lecturer, Department of Psychiatry and Behavioral Sciences, Auckland University.

Clinician values significantly impact on service provided. Success of treatment is partly dependent on clinicians coping with their own feelings in reaction to the client. People meeting diagnostic criteria for borderline personality disorder do not fit into psychiatric services very well. These services generally deal with either: (a) psychotic patients whose distress is not easy to empathise with, and for whom clinicians are happy to take responsibility, or (b) clients with other Axis 1 diagnoses who are insightful cooperative, and respectful. People meeting diagnostic criteria for borderline personality disorder are difficult to understand, often disagree with clinicians’ advice, and lead to great staff suffering. The residual meaning of the term ‘borderline’ may be that these clients are between services.

Descriptive systems like DSM-IV give an illusion of understanding, as they do not really illuminate aetiology or process. There is also an implied precedence of Axis I over Axis 2, with some services being restricted to “proper” patients with Axis I diagnoses. The comorbidity of borderline personality disorder with substance disorder, eating disorder, psychoses and most of all with affective disorder is great, and accurate formulation often difficult. Certainly descriptive and diagnostic skills are important in assessment. But prolonged searching for a diagnosis other than borderline personality disorder can be destructive. It must be possible to make a positive diagnosis of borderline personality disorder, not only by ruling out other diagnoses. And it must be possible to acknowledge the primary, long-term importance of this disorder even when criteria for major depressive episode or other Axis I disorders are met.

Clinicians may be praised by other staff for protecting them, by discharging or refusing access to people meeting diagnostic criteria for this disorder. This may be an easier goal than making the patient better. The negative feelings to a client can be felt by all members of a team or unit, so inappropriate action by individual staff is not so evident to the others. Faced by a client who is causing staff to suffer, who is challenging to the clinician because he/she does not understand them, and who they do not know how to best help, it is easy to either designate them as non-patients and exclude them from care, or be punitive and detain in hospital in a restrictive manner. This rejection or punishment counter-therapeutically reinforces for the client that the world is in fact punishing and/or rejecting. It is also reflected in the way mental health services are contracted for and individual units’ entry criteria set. Often borderline personality disorder does not fit anywhere.

Frequently staff are divided with one group identifying with the “victim” dimension of the client and wishing to nurture and the other group identifying with the “perpetrator” dimension of the client and wanting to set limits. The
task is for individuals and treatment teams to synthesise these two positions which are both valid but only a part perspective.

Medication does have a role in therapy, especially with comorbid problems, but drugs may be over-used. Medication can be a powerful distracter. Changing medication to deal with frequent crises and mood changes can dissuade the client and other staff from recognising the importance of psychosocial interventions, or undermine on-going psychological therapy. Of course, medication can be helpfully prescribed in conjunction with other therapy but this needs to be done sensitively. The application of the Mental Health Act is an all or nothing decision and this can mesh nicely with sudden swings in clinician feelings, for example from caring and understanding to anger and rejection. For a doctor, being legally responsible for someone you cannot understand is difficult.

With modern developments in therapy, clinicians have an obligation to learn more about borderline personality disorder and to be more optimistic in care. This implies a greater awareness of values and feelings and the complexity of an individual's problems. There is already more awareness of 'dual diagnosis' (substance abuse and an Axis I diagnosis). Perhaps we are now moving towards acknowledging the third dimension so commonly seen in psychiatric practice, personality disorder. As people meeting diagnostic criteria for borderline personality disorder take their toll on us and are hard to help with our traditional methods, we often distance ourselves from these clients and consider their problems as illegitimate or self-inflicted. Our desire to keep ourselves unscathed is one of the roots of the attitude in mental health culture which invalidates the problems of these clients. Financial resourcing of treatment is almost certain to be strongly influenced by such attitudes.
Resourcing

Often public mental health services respond to people meeting diagnostic criteria for borderline personality disorder only when they are suicidal. This encourages the very behaviours clinicians are trying to decrease. The need to develop services that will indicate to clients that their morbidity will be responded to without them having to be suicidal is clinically self-evident. The notion that clients are choosing to lead lives of misery when they could do otherwise, or that they are not trying hard enough, is fanciful in the extreme and indicative of the stigma that exists. This stigma needs to be named, discussed and challenged.

The history of the “untreatability” of people meeting diagnostic criteria for borderline personality disorder came out of the experiences of psychoanalysts who found this client group did not respond well to usual psychoanalytic treatments of the day and in fact frequently got worse. Consistent with knowledge at the time, this group was considered unsuitable for treatment. Cognitive behaviour therapists, with their focus on specific treatment targets and goals, were developing their treatments elsewhere and did not explore the treatment of this group. A few decades later both psychodynamic and cognitive behavioural clinicians began modifying their approaches and engagement with people meeting diagnostic criteria for this disorder. Out of this fresh engagement, positive research studies and publications have arisen. The belief that treatment was ineffective was understandable in the absence of outcome studies demonstrating efficacy. This history still contributes to the current reactive ad hoc and “haphazard” delivery of treatment.[4]

Morton and Buckingham’s findings on expenditure patterns suggest that “the substantial amount being spent on containment rather than treatment could be used to achieve more positive clinical outcomes”. [5] Perry[45] likewise persuasively argues that a well-resourced, planned and proactive outpatient service will make more efficient use of financial resources currently being spent. The majority of the 91 clients reported by Morton and Buckingham,[5] the five clients reported by Krawitz[44] and the five clients reported by Perry[45] (see ‘Health Resource Usage’ page 22) would represent the 0.1 percent of people meeting diagnostic criteria for this disorder who make the most use of resources. Evidence is strongly suggestive that for this 0.1 percent (65 people in New Zealand), a proactive evidence-based treatment would be cost effective, primarily due to the decreased use of hospitalisation.

For the other people meeting diagnostic criteria for this disorder whose initial hospitalisation rates in New Zealand are generally lower, proactive evidenced based treatment will probably cost more than is being currently spent despite expected savings on hospitalisation. However, if initial hospitalisation rates are high, as they are in the Stevenson/Mears study (86.1 days in year prior to treatment) and appears to be in the Linehan study, financial savings may continue to occur. In Linehan’s study there was a reduction of 31 hospital days in the year of treatment[33,34] and in Stevenson and Mears’ study a reduction of 42 hospital days in the year following treatment.[35] With the cost of an acute inpatient bed in New Zealand in 1998 being $NZ368/day,
this would translate into financial savings on hospitalisation of $NZ 11,400 and $NZ 15,450 per client.

A retrospective cost analysis of the Stevenson and Meares study showed health resource reduction of $A21,000 per client in the year following treatment. The first year of treatment, with costs of the therapy factored in, resulted in a net health resource reduction of $A8,500 per client.[84] Gabbard et al, in reviewing economic impact of borderline personality disorder, conclude that treatment has a beneficial effect on costs, particularly through the decreased use of hospitalisation.[85] Gabbard et al comment that Heard calculated that DBT for people with borderline personality disorder saved approximately $US10,000/patient/year.[85] Preliminary data on the DBT program in New Hampshire shows a reduction of treatment costs of $US26,000/client in the first year of treatment with the costs of DBT provision factored in.[59]

Intensive community treatment could involve a ratio of ten clients:one FTE key clinician. This is the ratio on which the DBT research was done and how DBT is being currently practised in the public system in Seattle (personal communication - DBT research team, University of Washington). The ratio used in Stevenson and Meares’ study is not stated but is likely to be similar. Mobile Intensive Teams (MIT) with a ratio of ten clients:one FTE clinician have been set up in a number of parts of the country to treat people with severe Axis 1 disorders who are high users of the service. This provides a comparable precedent for the type of client/clinician ratios being proposed for people with severe treatable Axis 2 disorders who are high users of the service. To not set up a service with similar staff ratios, would require a persuasive argument as to why it was not discriminatory.

It is appropriate we target those with the severest forms of the disorder. An arbitrary definition of “severest” could be the 1 percent of people most affected with borderline personality disorder which would represent 650 people in New Zealand. At a ratio of 10 clients:1 FTE key clinician this would be 65 FTE key workers. This figure is mostly for service provision in community mental health centres but also includes specialty areas such as substance use, dual diagnosis, child and adolescent, forensic and eating disorders. The Blueprint for Mental Health Services in New Zealand makes appropriate recommendations for a regional service, which will provide advice, training and consultation.[86] The regional service is to be used “where the demand for a service in local areas is very small, and very specific, and relatively rarely required skills are needed”. This paper has outlined that the demand is large, needed across virtually all areas of mental health especially community mental health centres and that the skills required are needed routinely every day. The regional service proposed by the Blueprint “would not have long-term users”. [86]

The Blueprint has not addressed ongoing local outpatient treatment that is required if there is to be effective service. Resources required in local outpatient settings for effective treatment do not currently exist. The Blueprint has, however, allowed for significant total service growth. For
example, another 300 FT Es for community teams for services for adults, nationwide. Some of the additional resource needs to be directed to meeting the needs of people meeting diagnostic criteria for this disorder.

As community teams and other mental health staff grow in number over coming years, part of the service growth must include more focus on providing effective therapies and interventions for people meeting diagnostic criteria for borderline personality disorder. Other funding possibilities are a negotiated relationship with ACC and a redistribution of existing resources from other areas, especially acute inpatient and crisis services.

In targeting those with the greatest severity, there is a danger of encouraging clients who fall below the threshold required for intensive treatment to exhibit greater pathology in order to access treatment. Currently, services target those with the greatest severity, which does encourage increased pathology in order to access treatment. Increased funding will not solve the problem entirely, but will shift the threshold and move the problem to less crucial client behaviours. This iatrogenic system problem, which already exists with current funding, requires further exploration.

The high suicide rate (10-45 percent) and high morbidity combined with knowledge of effective evidence-based treatments and workforce availability lead to the conclusion that considerable ring-fenced funding should go to the treatment of this group. For the most disabled group, the financial cost of well-considered, skilled, proactive treatment may not be much different from financial costs of a reactive service, due to the cost savings of decreased hospitalisation. Money not ring-fenced is likely to end up in other areas. Not funding intense proactive treatment of people meeting diagnostic criteria for severe forms of borderline personality disorder is likely to be discriminatory and may well be unethical.
The Legal Environment

New Zealand Mental Health Act 1992 - Legal Aspects

Over the last decade, there has been considerable national and international debate whether people with borderline personality disorder can be compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992. The situation has clarified somewhat in New Zealand over the last few years following exploration of the matter by Brookbanks, Simpson and the 1996 ruling of Judge Inglis QC.

In order for the Mental Health (Compulsory Assessment and Treatment) Act 1992 to be used, the person has to have, what the act legally defines as, a “mental disorder”. The act defines “mental disorder” as “an abnormal state of mind… characterized by delusions, or by disorders of mood or perception or volition or cognition of such a degree that it:

(a) poses a serious danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself.

It is important to recognise that the term “mental disorder” as used in the Act “... is a legal and not a medical or psychiatric definition”.

Whether a person meets diagnostic criteria for borderline personality disorder or any other personality disorder is essentially irrelevant in terms of the 1992 New Zealand Mental Health Act. Instead the act defines behaviours and subjective experiences and measures functional severity with a named threshold above which the person can be considered “mentally disordered”.

People meeting diagnostic criteria for borderline personality disorder frequently have comorbid diagnoses; the behaviours and subjective experiences of which could meet the legal definition of “mental disorder” as defined by the Act. A clear example is of a person who develops a brief psychotic episode.

Without a co-morbid psychiatric disorder, people meeting diagnostic criteria for borderline personality disorder could sometimes be defined by the Mental Health Act as having “disorders of mood”, “disorders of cognition” and “disorders of volition” of sufficient severity to meet one of the severity clauses. There is no requirement written into the act that compulsory treatment must improve outcome or that people must be treatable. However, Judge Inglis QC, in a critical 1996 ruling, held that the legal definition of “mental disorder” as per the Act should include the possibility that “such a finding may work to the benefit of the patient”. Whilst people meeting diagnostic criteria for this disorder are treatable, the use of mental health legislation may render them iatrogenically untreatable. Except in extraordinary circumstances, Judge Inglis’ ruling of the possibility that “such a finding may work to the benefit of the patient” would preclude the long-term
committal of people meeting diagnostic criteria for this disorder, as long-term committal is almost always a negative therapeutic endeavour. In the short-term, there is only a little more scope for the person benefiting from compulsory treatment. Such circumstances could include the person being briefly psychotic or occasionally acutely suicidal. This is explored further in the section on clinical appropriateness of the use of mental health legislation.

Clinical Appropriateness of the Use of Mental Health Legislation

Expert opinion is in agreement that the use of mental health legislation should be considered an unusual part of treatment. This is not currently the case. Mental health legislation is generally invoked when a client states acute intention to suicide. When the client indicates imminent suicide intention and then declines treatment measures to enhance safety, the clinician has to either take a risk of the client suiciding or force treatment by means of mental health legislation. The majority of such situations are covert communications to the clinician. The overwhelming majority of people who have imminent intentions to kill themselves will either proceed without telling anybody (in order to not have anyone stop them) or will tell somebody and be willing to engage in treatment. Training, experience and knowledge of the literature assist the discrimination of life-threatening and non life-threatening suicidal statement.[39] Like any other unusual treatment, use of mental health legislation needs to be monitored and locally peer reviewed.

The disadvantage of mental health legislation is that it runs completely counter to core principles upon which successful treatment is based. A core principle is that clients be responsible for their behaviour. The implication with committal is that clinicians will assume responsibility for clients’ behaviour. Invoking committal increases the inevitable power struggle, is disempowering, decreases autonomy and self-sufficiency and increases passivity – the very opposite of treatment goals. Young provides a treatment plan which “reaches towards” his clients. Nevertheless in his initial contract with his clients, he states that he will not see them again if he has to commit them.[69] Whilst at first glance this may seem harsh, it sets up expectations that in exchange for clinician responsivity, overt communication from the client is expected. Systems could institute such a plan without abandoning the client, by having another clinician take over treatment. Such expectations rapidly get passed through the client community and help shape the culture of treatment.

When the client is new to the system, the service occasionally needs to err on the conservative side until the picture becomes clearer over time. However, unless clinicians are vigilant, this can lead to a situation of repeated or ongoing committal because a precedent has been set and in the short term provokes the least anxiety. If committal is used, it should be used, wherever possible, for as brief a period as possible – up to 72 hours. Clinicians should feel comfortable and supported to remove a person from committal within as little as an hour if the imminent suicide risk has lessened. Again, training needs to clarify the indicators for suicide assessment.
When people have more control of their treatment (especially the capacity to admit themselves for brief periods) and they are being “reached to” with resourcing (rather than being kept at arms length), then the whole issue of committal mostly melts away. Increasing resourcing will significantly decrease the use of mental health legislation because treatment offered will be more effective.

**Medicolegal Risk**

People meeting diagnostic criteria for this borderline personality disorder represent a significant risk liability for clinicians and organisations providing service, particularly because of the possibility of suicide and complaints. Involvement of the media and other influential community people such as members of Parliament increases this risk liability. Gutheil in the article “The medicolegal pitfalls in the treatment of borderline patients” explains how a lack of understanding about optimal treatment choices and risks involved may lead to clinicians being blamed for ineffective treatment even when that treatment is of a satisfactory or better standard. In the event of an undesirable outcome, clinicians need to demonstrate that they practised according to a “reasonable practitioner standard”, not that they practised perfectly. An understanding of the medicolegal interface, including terminology, contributes to proactively preparing the clinician for a complaint. Having knowledge is empowering and contributes to clinicians taking necessary professionally indicated risks to enhance client outcome, despite the inevitable anxiety involved. Other measures that are helpful are: ensuring a risk/benefit analysis is done, getting a second opinion, widening and sharing the risk with the client, family and friends, clinical director, organisational lawyer and peer review group. Documentation is critical. Some of these actions are obviously harder to ensure in crisis situations but even here a second opinion can almost always be attained with a five minute telephone call. Briere states, “We are asked to take someone who has been hurt in the context of an interpersonal relationship and to treat them in, of all things, an interpersonal relationship. The client has been injured in the very channel in which psychotherapy subsequently occurs. It is not going to be smooth going.” National leaders could have an important role in setting realistic expectations for consumers, family and friends, clinicians, influential community people and the media.

**Professionally Indicated Risk Taking**

“Staff anxiety in any mental health organisation is directly proportional to how recently the .... hit the fan.” (A poor client outcome led to an inquiry or was reported in the media.)

[Anonymous workshop participant commenting on professional anxiety in treating people meeting diagnostic criteria for borderline personality disorder.]

“I know what the right clinical decision is, but I am going to look after myself.”

[Anonymous workshop participant commenting about defensive practice at the expense of client outcome.]
“I think sometimes when doctors and nurses try and protect themselves they’re not really making decisions in the best interest of the patient.” [91]

Historically in mental health there was a paucity of evidence-based effective treatment, mental health professionals practised in an environment which had few quality assurance systems in place and individual practitioners had little visibility. These factors led to varied methods and standards of practice, and on occasions, abuse of clients. This has appropriately changed with increasing visibility, accountability, peer review and other quality assurance programmes. There has been an increase in consumer complaints and heightened media visibility. Clinicians have responded by increased concern about the quality of their work. This constructive concern is now being replaced, in the treatment of people meeting diagnostic criteria for this disorder, by a “culture of fear” which is leading to defensive practices which are destructive in many ways, particularly to client outcome. The recent 1998 Ministry of Health, risk assessment guidelines has recognised the issue: “In order to achieve therapeutic gain, it is sometimes necessary to take risks. A strategy of total risk avoidance, could lead to excessively restricted management, which may in itself be damaging to the individual.” [46] The mechanisms to translate this principle into actual clinical practice need to be explored and developed by national leaders.

It is well recognised that provision of effective treatment for people meeting diagnostic criteria for borderline personality disorder requires decision making which entails risk, including that of suicide. One of the core features of successful outcomes is that clients increasingly take on responsibility for themselves, including their treatment. Clients deteriorate when clinicians take on excessive responsibility. The amount of responsibility clinicians should take requires considerable skill, is individualised for each client and varies over time, often rapidly. There is an absence of clearly defined guidelines as to how active a clinician should be and how much responsibility a clinician should take, in response to a client’s suicidal statements. Organisations, and individuals, that function as though there are clear guidelines, set up unattainable expectations for clinicians to achieve.

People meeting diagnostic criteria for this disorder have a high rate of suicide and make suicidal statements when they are seriously considering killing themselves. Alongside this, suicidal statements are also used as a form of communication – “transactions”. [74,92] Mary Graham, an ex-consumer who has set up a successful consumer-driven treatment programme, says she used to tell her therapist she was about to kill herself so that she could have more time with her therapist [personal communication - 1998]. Once a pattern has emerged that suicidal statements are being used as “transaction”, then it is likely that part of a successful treatment package will require the clinician to not respond to such suicidal statements but instead to encourage the client towards more constructive ways of communicating. Distinguishing between life-threatening and non life-threatening suicidal statements is a difficult and inexact task which Stone states is enhanced by clinical experience, supervision and knowledge of the literature on suicide risk. [39]
Acute versus Chronic Suicide Risk

Most people meeting diagnostic criteria for severe forms of borderline personality disorder are chronically suicidal, superimposed on which, from time to time is acute suicidal risk. The distinction, where possible, between acute and chronic suicide risk is critical as treatment interventions are very different and often quite opposite.

When the risk is acute, it is appropriate for the clinician to be more active and interventionistic, albeit for as short a period as possible. If the client is, and has been, chronically suicidal (without an acute exacerbation), there is no more the clinician can do to prevent such a suicide apart from setting up a satisfactory, comprehensive treatment plan.

Gutheil, an international medico-legal expert, writes, “The central issue in acute suicidal state is a matter of despair, guilt and a consequence, usually short lived emergency state that requires immediate intervention. In contrast, the chronic suicidal state represents a seriously disturbed yet consistent mode of relating to objects in the environment. In this condition the central issue is the assumption of responsibility by the patient for his or her own life and its fate. The requisite interventions are not, as in an acute state, directed towards shepherding patients through a short term crisis until the self destructive press has passed, by somatic- or psycho-therapeutic approaches.”[89] In this situation it is counter-therapeutic for the clinician to take too much responsibility. The clinician needs to adopt the “no-therapy” approach advocated by Dawson.[74] “The clinician should sidestep the imperative to take responsibility for the client’s welfare.”[93] The clinician takes a warm, engaged stance but does not offer any interventions, instead asking the client what they think would be the best option. The clinician does not get drawn in to the role of helper, and the client is expected to use their own resources to identify solutions. Documentation of the chronic suicidality provides important medicolegal protection.

Short-Term versus Long-Term Risk

To statistically increase the likelihood of the client being alive in the long term, one might need to make decisions whereby there is an increased possibility of suicide in the short term. This concept is one the community, the health profession, or even some of the mental health and legal profession are not familiar with. The concept runs contrary to most life-threatening disorders. Undergoing risky surgery however, provides a comparable model except the risks and benefits are more concrete.

Gutheil writes “To put this in crude as possible terms, the evaluators choice, largely by hindsight, appears to lie between two outcomes – a concrete dead body and the rather abstract notion of personal growth. No wonder the decision is so charged with anxiety.”[89] The Crisis Recovery Service, The Maudsley in London provides a service for individuals who self-harm. In their philosophy and protocols booklet they write, “It follows from an approach which insists on individuals taking responsibility for their own
behaviour that risks to the short-term safety of residents may need to be taken in the interests of their long-term safety and health". [94]

Mary Graham, Executive Director and co-founder of the consumer-driven treatment organisation SAFE (Self-Abuse Finally Ends), writes, “As an ex-consumer who now works with consumers, I believe that each person should be held responsible for their own behaviours. If someone wants to die there is nothing a professional would be able to do to stop him or her. The professional should work with utmost honesty and do whatever they can to help, but they should not be responsible for the client’s behaviours. When a professional takes responsibility for their client’s behaviour, they then develop a power struggle which they will not win” [personal communication - 1998].

There are ways of building structures into local systems encouraging clinicians to take professionally indicated risks. These structures can concurrently improve client outcome, protect clinicians from medicolegal risk and widen and share risks involved. Such structures include discussion with the client, client’s significant support people, colleagues including peer review groups, clinical directors and organisational lawyers. Clinicians may argue that there is insufficient time for such an intensive process. Whilst this requires intensive proactive input, it will probably be less time consuming in the long run and also improve outcome. A New Zealand acute inpatient ward, where a standard cautious approach prevailed, initiated an alternative clinical approach which entailed some risk. This risk was managed by every initial clinical plan going to, and being supported by the clinical director, organisation lawyer and a psychiatrist peer review group before the management was begun [Robinson – personal communication – 1998]. Clinical directors and national mental health leaders could encourage clinically indicated risk-taking by overtly and visibly supporting the appropriateness of such a position.

Organisations which support clinicians, who have practised according to reasonable professional standards, taking professionally indicated risks, improve overall client outcome. When clinicians believe they can/ought or their organisation expects them, to prevent somebody who is chronically suicidal from killing himself or herself, then they will practise in an iatrogenic manner. This is a well-recognised phenomenon, but the environment clinicians work in encourages the continuation of this practice. Relevant organisations include mental health providers, consumer organisations, mental health professional bodies and colleges, legal professionals, district inspectors, coroners, the Ministry of Health (including the Minister of Health) and the media.

Expectations of people and organisations need to be consistent with medical conditions, which have a similar mortality rate. For those people meeting diagnostic criteria for the severest forms of borderline personality disorder, this is likely to be about 50 percent five-year survival. This is comparable to people with Stage 3A breast cancer (fixed metastases to lymph nodes) [95] and malignant melanoma metastatic to regional nodes. [96] Fifty percent of people with acute renal failure die [97] and 10 percent of people with congestive heart failure with “mild left ventricular dysfunction and symptoms” will die per
When a person meeting diagnostic criteria for this disorder dies, clinicians could then expect the same degree of inquiry into the death, as one would have with a person who died as a result of these medical and surgical conditions. To do otherwise would suggest that mental health professionals are being discriminated against.

A willingness to take risk and to not take on too much responsibility for the client is not an invitation to avoid treatment or engage in practices that are laissez faire and without monitoring and quality assurance. The flip side of the current situation is one where clinicians do not see themselves as accountable, nor are they held to be so - a danger if the views expressed in this section are taken on superficially and poorly integrated. This is a very real danger given the discrimination and treatment avoidance linked with this client group which has existed.
Workforce Development

Introduction

The Expert Committee of the Royal Australian and New Zealand College of Psychiatrists Quality Assurance Project on the treatment of people meeting diagnostic criteria for borderline personality disorder recommended in 1991 that treatment be carried out by clinicians with “considerable special training” of a psychoanalytic nature.\(^{[99]}\) This view has been commented on as being “... somewhat ‘precious’ and not particularly helpful as a guide to the average Australian psychiatrist, or for that matter, the average psychotherapist.”\(^{[100]}\) Since The Quality Assurance Report, Linehan et al\(^{[33,34]}\) and Stevenson and Meares\(^{[35]}\) research provides us with the opportunity to rethink The Expert Committee for The Quality Assurance Project’s views. Stevenson and Meares’ study had therapists described as “relatively untrained in psychotherapy” albeit well supported by focused skilled supervision.\(^{[35]}\) There are plenty of well-trained and skilled cognitive behavior therapists and DBT requires only modest additional training for mental health professionals. This makes it possible for clients with severe form of borderline personality disorder to have accessible treatment available to them if suitable finances, supervision and administrative structures are present.

Investing Value and Status in the Key Clinician Role

“The reward system should more adequately support those therapists who care for the patients often avoided by others” \(^{[101]}\)

The key clinician, who may or may not be the therapist, and is usually the clinician who has the most client contact, coordinates treatment with the client. This role requires many multifaceted skills. The key clinician needs to face personal, medico-legal and career risks and challenges (suicide of a client, complaints, media and public expectation) without undue anxiety. Life and death-type professional decisions need to be made for which guidelines are very limited. Frequently the clinical situation requires these decisions to be made on the spot by the clinician alone, without involvement of others. Leadership qualities required are considerable. With multiple agencies involved, the key clinician needs to lead a “team” which is different for each client, where “team” changes occur frequently and where the only commonality the team have, is involvement with the client. As well as the capacity for autonomous functioning and holding of considerable responsibility, the key clinician needs to function well as a team person. The key clinician role is probably the most important role in the treatment of this group and needs to be invested with accordingly high value and status. DBT has scope for the client making brief out of hours contact with the key clinician which will decrease crisis team and inpatient costs. Remuneration schedules need exploring and specific training and supervision requirements need to be in place.
Responsiveness of the Organisation to Clinician Needs

People meeting diagnostic criteria for this disorder pose particular difficulties for the clinicians closest to them. Clinicians often feel overwhelmed and can react in counter-therapeutic ways in order to protect themselves. Clinicians require an interpersonal environment that can contain their anxiety. “A programme, group or clinician cannot contain more anxiety than the system can.”[102] The clinician requires a “sufficiently resilient holding environment that apprehends the psychic pain of clients and can bear the pain of being unable to relieve the pain.”[102] In order for clinicians to constructively process and weather the client’s fluctuating, intense behavioural and feeling states (including anger and devaluation), and keep a positive warm relationship with the client alive, the organisation requires a number of structures to be in place. A clear, practical set of policies, procedures and guidelines need to be written and fully supported at all levels of the organisation.

Supervision provides an essential “safe space for clinicians to think and reflect on, rather than deny and flee from, problems and feelings.”[102] Supervision in the effective evidence-based research of Linehan and Stevenson/M eares was, and must be in future treatments, an essential part of the treatment package and not a luxury to be added when possible. Clinicians who have a significant part of their work with people meeting diagnostic criteria for this disorder, should have individual supervision of one hour/week. This is commensurate with that provided in Stevenson/ M eares work. Additional group supervision may be needed and is part of the DBT package.

Senior staff need to be available for assisting with difficult decision-making, recognising that decisions are often made in the midst of intense, highly charged crisis situations. Clinicians require active support around the results of decisions they make, within a context of reasonable standards and the staff member having a history of competent clinical practice. Satisfactory, reasonable decisions can result in negative outcomes, and senior staff need to support clinicians in both internal and external forums, such as the coroners court. This means that any one person (especially junior staff) involved with a client does not bear the brunt of the organisation having accepted a risk-filled, but actively planned and sound treatment plan. Organisations and people assessing critical incidents need to recognise that decision-making in highly charged situations is much more difficult than at other times.

As the therapist’s task is to be ‘good-enough’ for the client so the organisation’s task is to be ‘good-enough’ for the clinician.[102] Dealing with conflict and difference is an essential task for the client, clinician and the organisation. “The amount of conflict and difference a clinician can constructively process is directly related to the amount that the organisation can process.”[102] At all levels of the organisation, linkages can be fostered which protect both the clinician and the client, by providing a confident, calm, clear environment for staff to treat people meeting diagnostic criteria for this disorder.
In summary, key system features are:
- clear, policies, procedures and guidelines
- focused coherent and skilled supervision
- senior clinical staff and management support
- a confident, calm, clear environment
- a capacity to resolve conflict and difference

Preventing Clinician Burnout

Distributing Workload
- Key clinician/therapist workload – 1 FTE:10 clients
- Some clinicians prefer to limit the number of people meeting diagnostic criteria for borderline personality disorder that they see
- Some clinicians prefer to have an exclusive workload and focus on people meeting diagnostic criteria for this disorder provided workload is not excessive

Realistic Expectations
- Clinicians/organisations acknowledge the possibility of suicide despite best practice
- Clinicians and organisations practically and emotionally prepared for a complaint

Regular ongoing Supervision
- Supervision which is focused, skilled and meets the clinician’s needs

Professional Development
- Training commensurate with the difficulty of the work
- Networking
- Stimulation from keeping abreast of recent developments in the literature

Developing a Culture of Support
- Limit setting to prevent burnout and to maintain positivity for the client, is legitimate
- Availability of skilled senior staff second opinion at short notice
- Culture which validates the work
- Institutional/system support for professionally indicated risk-taking
- Satisfactory indemnity insurance to be used should a complaint arise
- Supportive peer review systems in place.
Responsible Clinician in the Outpatient Setting

“The most suitable person should do the job”

The key clinician role is one where considerable responsibility should be matched with considerable power to determine treatment (alongside the client). This is frequently not the case, as in situations where some other person holds the dominant power determining treatment. There are conflicting views across the country whether psychiatrists should hold clinical responsibility for all clients who attend an outpatient public service. A 1998 review of clinical accountability in the New Zealand mental health sector notes, “uncertainty regarding the roles and responsibilities within the multidisciplinary team” particularly “relating to the accountability of the keyworker/case manager in relation to the psychiatrist” and recommends national clarification.[103]

The criteria that could be used to determine who should be clinically responsible to determine treatment of people meeting diagnostic criteria for this disorder are skills in psychosocial treatments and amount of time working with the client. To use other criteria is devaluing of the key clinician role and psychosocial treatments.

The current situation may sometimes support the keyworker/case manager who feels less exposed to risk but more often discourages the kind of team structure likely to maximise the cohesion required for work in this area. Repeated legal opinion is indecisive. It seems unnecessary and possibly destructive to wait for the legal system to make a precedent. National leaders could determine precedence and improve the situation by visibly supporting a position of clinical responsibility being determined by the criteria defined above.
Accident Compensation Commission

Accident Compensation Commission (ACC) funding for private but not public sexual abuse counselling encourages public mental health services to refer as many people as possible who have a sexual abuse history to private agencies or therapists. This encourages public individuals and institutions to avoid treating people meeting diagnostic criteria for this disorder. It also encourages a fragmentation of services between private therapists and the public system that often provide the crisis and acute inpatient care that is required. Private therapists are not paid for time spent integrating service delivery, which is not face to face contact with the client. Such integration either doesn’t occur or occasionally occurs only because of the beneficence of private therapists who provide the service for free. ACC are aware of these issues and are planning to fund intensive, integrated and long-term services for clients with severe problems who are not responding to the usual services funded by ACC. Other issues related to ACC and mentioned in the section ‘Prioritising Intervention’ page 31, are accreditation of ACC counsellors and system encouragement of inappropriately early exploration of sexual abuse material. There is a need for local and national exploration of solutions to these issues.
Maori And Pacific Island Peoples

Maori mental health statistics generally indicate higher than expected use of inpatient services. There is no national information available on health resource use or prevalence as pertains to ethnicity and borderline personality disorder. Anecdotal experience of clinicians in the vast majority of centres is of fewer Maori and Pacific Island people being given a diagnosis of borderline personality disorder. However Maori females have a higher hospitalisation rate for intentional self-injury than non-Maori. This limited information raises many questions. Do the different family structures of Maori and Pacific Island people give rise to different personality structures? How is the diagnosis being made? Are there ethnic biases to diagnosis? Are Maori and Pacific Island people accessing treatment at an early level? Are services culturally friendly, enabling good access or are they monocultural? Are minority groups predisposed to a higher rate of disorder? Would Maori and Pacific Island people be protected by stronger affiliative connections with family or would the effects of a society negatively impacted by colonisation lead to a higher prevalence? If this is a disorder of western civilisation, can we learn something positive from Maori and Pacific Island cultures to address this epidemic. People with knowledge on these issues need to be identified and encouraged.
Future Directions

Outpatient Models of Treatment

Which treatment models should be encouraged in the New Zealand public mental health system? DBT stands out as the most credible option. DBT has been researched using a randomised controlled trial demonstrating efficacy with people with severe forms of the disorder. It is likely that there will be several replication type studies completed over the next few years. New Zealand public system clinicians generally have warmed to, and accepted the model on being introduced to it. The modest amount of training to become a DBT therapist and the ready availability of a workforce that already has considerable cognitive behaviour therapy skills mean the method could be fairly quickly implemented.

The other model with a randomised controlled trial, interpersonal group psychotherapy\(^5\) (Munroe-Blum and Marziali), is less relevant to the New Zealand public system because the trial group treated a less severe population. Also Marziali believes the model better suited to those with less severe forms of the disorder [personal communication - 1997].

Self psychology as practised by Meares' group in the Stevenson and Meares', study is an alternative option. The research results are impressive except for the methodological weakness of not having a control group. Disadvantages of the self psychology model are that New Zealand has a weak psychoanalytic tradition, most of the workforce that does exist is in the private sector and the public system is generally critical and unsupportive of psychoanalytic treatments. Trying to encourage such a model in the New Zealand public system would be deliberately “swimming upstream”.

Other models showing promise but as yet without published data demonstrating efficacy are schema-focused therapy developed by Young and case management/rehabilitation/supportive psychotherapy. Schema-focused therapy is an integrative model with cognitive therapy at its core with extensive influence from object relations and gestalt therapies. Research is in progress [Young – personal communication – 1997]. The model is well accepted by clinicians exposed to it and fits well with the considerable cognitive therapy skills developing in the New Zealand public health sector. Case management/rehabilitation/supportive psychotherapy draws strongly from and modifies case management and rehabilitation models used for people meeting diagnostic criteria for schizophrenia and bipolar affective disorder and makes use of supportive psychotherapy practices.[105,106] Randomised controlled trials are underway in at least two centres. Its obvious strength is workforce availability and likely acceptability.

Gunderson states that 95 percent of work done with people meeting diagnostic criteria for this disorder falls under the umbrella concept of supportive psychotherapy [personal communication – 1997]. Milton and Banfi write that where clinicians are not trained in a specific model such as DBT or self psychology, “... a supportive psychotherapy is probably the
easiest to maintain, allowing for a workable combination of different interventions within a coherent model of care. In this way of working, the clinician acts as a secure base, strengthening the client's adaptive functioning through suggestion, education, limit setting and facilitating therapeutic alliance. Creation of the alliance over the long term, coupled with consistency and availability, may be of greater importance to success with the client than any of the specific therapeutic interventions themselves.\(^9\)\(^3\)

In summary, there are a number of acceptable models of treatment and individual clinicians should be supported to practice in the model that best matches their training and experience. If there is to be a local or nationally coordinated initiative, the model that currently suits the New Zealand public mental health context best is DBT. All the models mentioned are able to be practised in community mental health centres provided resourcing, training, supervision and system structures are adequately in place.

**Residential Treatment**

There is a group of clinicians that advocate for a residential service for treating people meeting diagnostic criteria for the most severe forms of the disorder, using a model similar to the Cassel in England. The argument is based on the idea that severity should be matched with intensity. Methodology on residential treatment research is not as well regarded as that on outpatient models of DBT and self psychology. Most current clinical interest, academic interest and ongoing research is in outpatient treatment models. Undoubtedly some clients would respond better to residential treatment than to outpatient treatment. In an ideal situation, there would be a wide range of options to select from, enabling people to get treatment that would best suit them. Because of fiscal restraint, service delivery options in the public sector need to be made on the basis of what is in the public good. How are most people going to benefit from monies spent? Current evidence points strongly towards outpatient treatment being developed first.

Financing a residential treatment facility before satisfactory outpatient services have been developed, has six major disadvantages.

Firstly, it deprives outpatient services of the resources required for effective treatment. Secondly, it encourages client and clinician to not give it their “best shot” with outpatient treatment because there is the “expert” residential service “out there” to whom a referral will be made. Thirdly, the ambience of “experts out there” encourages an “out of sight out of mind, not our responsibility culture”. The workforce already avoids treating this group and need no further system encouragement.

Fourthly, the workforce outside of the “expert” residential facility is where the vast majority of treatment will take place. A residential service may deskill the very staff who are doing most of the work.

Fifthly, it would dislocate treatment when residential treatment was completed and the person moved on to outpatient treatment. People meeting diagnostic criteria for this disorder respond poorly to dislocations of important
relationships. Lastly, because the New Zealand population is small and scattered, centralising a residential service in one of the major cities would disadvantage people in the other areas.

Residential services should be developed after the establishment of comprehensive outpatient services and with considerable thought and planning. To avoid some of the problems mentioned before, entry to the residential service could require each referring system to be satisfactorily resourced with finances, time and clinical skills and the referred client to have already had well-supported, proactively planned outpatient treatment over a significant time period. Spectrum, the Personality Disorder Service for Victoria, Australia, is developing policies along these lines [personal communication – 1999].

Workforce Training

Training is essential not only to directly increase clinician skills but also for the very important indirect effect of increasing clinician confidence so essential in this work. Increased skills and confidence almost certainly will result in improved client outcomes.

All clinicians who have contact with people meeting diagnostic criteria for this disorder could benefit from a foundation training providing an overview, like the two-day workshop Krawitz has developed, to provide common understandings and cohesive treatments. At Waitemata Health West, management considered this of sufficient importance for it to be approved as an orientation requirement for all new clinical staff. The Personality Disorder Project Group, in Victoria, Australia, have produced a written overview in a comprehensive manual, “Guidelines for working with serious personality disorder”. This manual could be foundation reading for all staff involved in the treatment of people meeting diagnostic criteria for this disorder and for all new staff as part of their orientation. There is some information suggesting that training can result in attitude change probably via increased empathy and the empowering effect of increased knowledge and clinical skills.

Groups requiring additional specific training to suit their needs include therapists, case managers, key clinicians, crisis workers, acute inpatient clinicians and those in specific settings such as child and adolescent, forensic, substance use and eating disorders.

More extensive training in specific treatment models is required for key clinicians and therapists. DBT requires a modest amount of training (two intensive weeks and six months of homework) to become a DBT therapist. Training is available in the USA and DBT trainers will travel to provide training in New Zealand. DBT training can accommodate large groups of up to 70 clinicians. The cost is in the vicinity of $3500 per person. There are negotiations under way for such training to take place in New Zealand, although costs are proving to be a problem. A three-year part-time training is available in Australia using the self psychology model of Meares.
modification of this training has been provided in the past in New Zealand and this might be able to be reorganised. Young is available to provide schema-focused therapy training in New Zealand [personal communication – 1997]. There are no known training programmes in case management/rehabilitation/supportive psychotherapy for treating people meeting diagnostic criteria for this disorder. If such an approach was adopted, a training package could reasonably easily be developed because of the solid traditions on which this model is based. Graham provides training in a consumer-driven treatment based on a straightforward cognitive-behavioural model and has provided over thirty workshops on this treatment approach throughout New Zealand in early 1999. The strength of this approach is the use of ex-consumers as experts, who have immense credibility and are a powerful beacon of hope for clients. This information indicates that training for key clinicians and therapists can be made available in New Zealand.

Recommended Numbers of Trained Staff:

- Foundation Training – 40 percent of all mental health staff
- Additional training for specific work areas (e.g. crisis) – 20 percent of staff in that area
- Therapists and Key Clinicians – eleven per population of 300,000 (132 in New Zealand)

The Royal Australian and New Zealand College of Psychiatrists funded under the Australian National Health Strategy and the New Zealand Health Funding Authority recently called for tenders for Clinical Practice Guidelines for “deliberate self-harm”. The Guidelines are to focus on repeated deliberate self-harm. This document has the potential for considerable importance and influence.

National Leadership

Leadership roles in New Zealand mental health lie nationally with the Ministry of Health (including the Minister), the Health Funding Agency, the Mental Health Commission, the professional colleges and national consumer organisations. Leadership locally is with clinical directors and managers of mental health services and local consumer organisations. Other influential parties to developing cultures of treatment for people with borderline personality disorder are the legal profession (most notably through district inspectors, coroners and mental health provider lawyers) and the media.

National leadership tasks are to:

- advocate for and ensure fair and equitable resourcing which is evenly distributed across the country (current resourcing is uneven)
- raise the value and status of people meeting diagnostic criteria for this disorder
- raise the value and status of the work and those involved in the work
- explore solutions to the dilemmas raised by ACC sexual abuse funding
• encourage and support mental health professionals to take clinically indicated risks
• disseminate written/verbal information supporting professionally indicated risk-taking
• address the issue of professionally indicated risk-taking at times of critical incidents
• make clear visible statements of support for staff who have practised according to a reasonable standard and been involved in a poor outcome
• make clear visible statements of support for staff who in highly charged clinical situations make decisions (that many professionals could make in similar situations) that lead to an undesired outcome
• develop a relationship with the media who then wish to report in a balanced fashion
• encourage and support minimal use of mental health legislation
• encourage setting up of local peer review systems for use when mental health legislation is invoked or when clients have been in an acute ward for a lengthy period
• encourage publications
• encourage academic appointments on a par with people with expertise in the areas of schizophrenia and affective disorders. (Currently no appointments exist.)

It is probable that the manner of media reporting is contributing to destructive, defensive practices, which statistically is likely to be increasing the chance of people dying. This needs to be researched, and if accurate, commented on by those in the highest positions of power and leadership. The Ministry of Health’s recent “Guidelines for the Media on the Reporting of Suicide” provides the general mental health perspective.[109] This could serve as a foundation to address the specifics for people meeting diagnostic criteria for this disorder. Whilst the media obviously have an appropriate ethic of free expression, the Broadcasting Act 1989 suggests (at least for television and radio) that they also have a competing ethic of not contributing to people dying.

It is recommended that a number of part-time professional/consumer be appointed to leadership positions across the country totalling two FTEs (Different configurations of the two FTE’s could be reasonably considered to maximise output). These people would have key linkages with the Ministry of Health, the HFA, the Mental Health Commission, professional colleges, consumer organisations and the media and would continue and enhance the outcome of the tasks mentioned. They would maximise national networking, coordinate relevant national research, and hold and distribute local and international information. This structure would decrease the inefficient duplication of effort that currently exists.
Conclusions

The history of mental health services involvement with people meeting diagnostic criteria for borderline personality disorder has been one of lower funding, workforce training and clinical and ethical standards than occur with other medical and psychiatric diagnostic groups. This paper names the history of stigma, which has contributed to the current situation. Attitudes have significantly changed in New Zealand in the last five years but resourcing lags behind. We now have the opportunity to correct the situation and demonstrate our valuing of this group of people. In the process we would be at the international forefront of development of high-standard, equitable, nationwide services.
References


6. Miles W. Services for the severely personality disordered. Memoranda to General Manager, Mental Health Services, Waitemata Health 1995.


Appendix One

Diagnostic criteria for borderline personality disorder - DSM 4

A pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsiveness beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

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

## Appendix Two

### CLINICAL PLAN

#### Administration

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<thead>
<tr>
<th>Clinical Plan updated on</th>
<th>Next update on (at least monthly)</th>
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<th>Client contact details</th>
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<table>
<thead>
<tr>
<th>Key Clinician</th>
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<tr>
<td>(outpatient clinician responsible for Clinical Plan development and review and integration of services)</td>
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<th>Meetings scheduled</th>
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<th>Backup for Key Clinician</th>
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<th>Therapist (if different from key clinician)</th>
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<th>Meetings scheduled</th>
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<th>Prescribing clinician (outpatient)</th>
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<tr>
<th>Other meetings scheduled (caregivers, GP, inpatient/ crisis link person/s, CYPS ...)</th>
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<tr>
<th>Inpatient Link Person</th>
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<td>(responsible for coordinating inpatient care and with key clinician for inpatient entry and exit criteria and pathways)</td>
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<th>Crisis Team Link Person</th>
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<td>(responsible for coordinating crisis care and with key clinician for crisis care entry and exit criteria and pathways)</td>
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<th>Link people for other services</th>
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**Clinical Overview**

**Summary of Psychiatric History**

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<th>Major Goal/s (agreed upon by client and key clinician for next year – no more than 2)</th>
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<tr>
<th>Lesser Goal/s with key clinician for inpatient entry and exit criteria</th>
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<tr>
<th>Stage of Treatment</th>
<th>Suicide Risk History</th>
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<tbody>
<tr>
<td>1 Stabilisation and safety</td>
<td>1 Intermittently acute</td>
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<tr>
<td>2 Exploration/ metabolism of trauma</td>
<td>2 Intermittently acute</td>
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<tr>
<td>3 Generalising changes and finishing</td>
<td>superimposed on chronic</td>
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<td>Chronic</td>
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<td>Not current</td>
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**Self-Harm**

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<tr>
<th>Purpose of self-harm (client and clinician views)</th>
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**Summary of Current and Recent History (stressors, issues, goals)**

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<tr>
<th>Current Medication/s</th>
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**Key Issues**

- Client attached to key clinician or therapist: yes/ no
- Key Clinician empowered to determine treatment: yes/ no
- Relevant services in agreement with Clinical Plan: yes/ no
- Supervision in place and meeting the need: yes/ no
- Caregiver needs being met: yes/ no

*(Roy Krawitz '98)*
Appendix 3

CRISIS PLANS

CRISIS PLAN - CLINICIAN FOCUSED
(Clinician and client will have a copy of this and Crisis Plan – Client Focused)

Pathway of agreed contact at time of crisis

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<th>9-5 Monday – Friday</th>
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<tr>
<td>Out of Hours</td>
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Contingencies of not following agreed contact procedures

Key Clinician’s Guidelines for crisis worker (eg. strategies which help/ don’t help)

Respite Plan (incl. alternatives to hospitalisation and contingency if pathway or contract not followed)

Hospital Admission Plan (incl. contingency if pathway or contract not followed)
CRISIS PLAN - CLIENT FOCUSED

(Client and clinician will have a copy of this and Crisis Plan - Clinician Focused)

People who stay alive generally do well!!

The place of crisis in my healing
(eg. How a crisis can be helpful to me in the long-term. How I can use a crisis to practise and consolidate new skills)

My Crisis Strategies:

Safety
- Safe places
- Safe people
- Activities/Items which make me feel safe

Self Soothing Skills

Distress Reduction Skills

Emotion Acceptance Skills

Alternatives to Self-harm

Other Strategies

My pathway of agreed contact at time of crisis

9-5 Monday – Friday

Out of Hours
CRISIS PLAN - CLIENT FOCUSED

This inpatient plan is either:

A) Client Controlled Admission (see ‘Client Controlled Acute Admission Contract’)

B) Limited transfer of treatment and treatment planning to the inpatient team (No changes made to medication, therapy etc. which remains responsibility of outpatient service.)

C) Larger transfer of treatment and treatment planning to the inpatient team

Aftercare Plan (incl. contract and pathway for future acute admission - to be worked on before admission)

Key Clinician guidelines for inpatient plan (strategies which help/ don’t help)

Key Clinician/ therapist can/ can’t see client during hospitalisation

Goal/ s of Admission (rarely more than 2, as contracted with client)

Meetings Scheduled

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<th>Inpatient Link Person</th>
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<th>Key Clinician/ Therapist (if in contract)</th>
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<th>Treatment monitoring and planning</th>
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<th>Other</th>
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Length of Admission

Time and Date of return ‘home’

Contracts (incl. contingencies, if any, for self-harm/ suicide/ homicide statements or behaviour )

(Roy Krawitz ’98)
Appendix Four

CLIENT CONTROLLED ACUTE ADMISSION TREATMENT CONTRACT

Adapted from University of Wisconsin Hospitals and Clinics

Frequency/duration of hospitalisation

Max. stay ................................... days/ month
Max. admissions ................................../ month

Hospitalisation may occur provided:

No self-harm in previous 24/48/72 hrs or N/ A
No illicit drug use in previous 24/48/72 hrs or N/ A

I/ P Mx
Continue O/ P Clinical Plan
(No changes to medication, therapy, families, etc. Responsibility of O/ P team)

Overall Key Clinician/ therapist can/ can't see client during hospitalisation

Contract
No self-harm N/ A
Usual participation in activities
If contract breached - return to clinician controlled acute admissions

Summary of current history (current stressors, issues)

Goal/ s of admission (rarely more than 2)

Scheduled meetings (frequency)
I/ P Key Clinician
Prescribing Clinician
Other
Treatment monitoring and planning

Current medication/ s (continue O/ P prescribing)

Other contracts
(including contingencies, if any, for suicidal/ homicidal statements or self-harm)

(Roy Krawitz '98)
Appendix Five

Principles of Effective Treatment

• Clients are responsible for their behaviour.
• Intensive proactive structured treatment is available on an outpatient basis.
• Acute hospitalisation is avoided where possible by use of resourced alternatives.
• Acute hospitalisation when unavoidable is brief.
• Acute hospitalisation can only be avoided/brief when intensive outpatient treatment exist.
• Mental health legislation is minimally used and when used is subject to local peer review.
• Medication, if used, is an adjunct only, to psychosocial treatments.
• Supervision of significant involved clinicians is an essential part of treatment packages.
• The clinician/system makes a long-term commitment to the client.
• Client attachment to the therapist/system is invariably required for effective treatment.
• The culture of the system is as important as the culture between clinician and client.
• Clinicians feel supported by the institution/system.
• A proactive clinical plan developed collaboratively between client and key clinician embodies integrated services (eg, inpatient, outpatient, crisis, drug & alcohol).
• The effectiveness of the system is as important as the effectiveness of the clinician.
Appendix Six

Specialist Services and National Network in New Zealand

In 1998, three New Zealand public services dedicated to this area were established. The Balance Program, Auckland Healthcare provides DBT to a small number of people with severe problems. RREAL (Resource for Regulating Emotions and Living), Waitemata Health provides training and consultation services to clinicians. The Personality Psychotherapy Service based in Wellington provide treatment for a small number of clients and consultation and training to other service providers in the Central HFA region. Ashburn Hall has provided a residential service for many years for people, some of whom have met diagnostic criteria for borderline personality disorder. The 1st and 2nd national gathering of public system professionals interested in this area of work took place in 1998 and 1999 and will be continued on an annual basis.