Australian Government
National Health and Medical Research Council

Caring for People with Borderline Personality Disorder:
A REFERENCE GUIDE FOR HEALTH PROFESSIONALS

WORKING TO BUILD A HEALTHY AUSTRALIA

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Disclaimer

This document is a general guide to appropriate practice, to be followed subject to the clinician's judgement and patient's preference in each individual case. The guideline is designed to provide information to assist decision-making and is based on the best available evidence at the time of development of this publication.

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About this reference guide

This reference guide contains information about how to care for people with borderline personality disorder (BPD).

It is a summary of the 2012 National Health and Medical Research Council (NHMRC) *Clinical practice guideline for the management of borderline personality disorder*[1] ('full BPD guideline'). The full guideline and reference guide are intended for health professionals, including Aboriginal health workers, clinical psychologists, general practitioners, mental health nurses, mental health occupational therapists, mental health social workers, midwives, nurses, psychiatrists, psychologists and staff of emergency services.

Health professionals should refer to the full guideline for more detailed guidance, summaries of the clinical evidence on which the guidance is based, and references.

1 National Health and Medical Research Council. Clinical practice guideline for the management of borderline personality disorder. Melbourne: National Health and Medical Research Council; 2012 (available at http://www.nhmrc.gov.au).

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Key recommendations

Health professionals at all levels of the healthcare system and within each type of service setting should:

- acknowledge that BPD treatment is a legitimate use of healthcare services
- be able to recognise BPD presentations
- be aware of general principles of care for people with BPD and specific effective BPD treatments
- refer the person to a specialised BPD service or other services as indicated
- provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness) according to their level of training and skill
- undertake continuing professional development to maintain and enhance their skills.

Health professionals should consider assessment for BPD (or referral for psychiatric assessment) for people (including those aged 12–18 years) with any of the following:

- frequent suicidal or self-harming behaviour
- marked emotional instability
- multiple co-occurring psychiatric conditions
- non-response to established treatments for current psychiatric symptoms
- a high level of functional impairment.

People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals.

Adolescents with BPD should be referred to structured psychological therapies that are specifically designed for this age group. Where unavailable, they should be referred to youth mental health services.

Medicines should not be used as primary therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder.

Health professionals should inform people with BPD about the range of BPD-specific structured psychological therapies that are available and, if more than one suitable option is available, offer the person a choice.

The majority of a person's treatment for BPD should be provided by community-based mental health services (public and private).

Health professionals should refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available.

Borderline personality disorder

Borderline personality disorder (BPD) is a mental illness that can make it difficult for people to feel safe in their relationships with other people, to have healthy thoughts and beliefs about themselves, and to control their emotions and impulses. People with BPD may experience distress in their work, family and social life, and may harm themselves. Having BPD is not the person's own fault – it is a condition of the brain and mind.

Research has not yet discovered exactly how a person develops BPD, but it probably involves a combination of biological factors (such as genetics) and experiences that happen to a person while growing up (such as trauma early in life). For most people with BPD, symptoms begin during adolescence or as a young adult, but tend to improve during adult life. Research has not yet shown how health systems can best help prevent people developing BPD.

For more information about risk factors and prevention, refer to **Section 3. Managing risk factors and preventing BPD** in the full guideline.

Diagnostic assessment for BPD

When to suspect a person may have BPD

Signs that someone has BPD include making frantic efforts to avoid being abandoned by other people (even if they are only imagining that other people are abandoning them), repeatedly having intense and unstable relationships with other people (such as intensely disliking someone that they previously idealised), being very unsure of who they are and what to think about themselves, acting impulsively in ways that could be very risky (such as spending money, risky sexual behaviour, substance abuse, reckless driving or binge eating), repeatedly harming themselves or threatening to commit suicide, experiencing intense emotional 'lows', irritability or anxiety for a few hours or days at a time, constantly feeling 'empty', experiencing unusually intense anger and being unable to control it, and sometimes feeling paranoid or experiencing strange feelings of being detached from their own emotional or physical situation.

Health professionals should consider assessment for BPD (or referral for psychiatric assessment) for people (including those aged 12–18 years) with any of the following: frequent suicidal or self-harming behaviour, marked emotional instability, multiple co-occurring psychiatric conditions, non-response to established treatments for current psychiatric symptoms, or a high level of functional impairment.

Initial assessment for BPD

Before making the diagnosis of BPD, trained mental health professionals should carefully ask questions about the person's life, experiences and symptoms.

The initial assessment should generally focus on safety to self and others, and on how well the person is currently functioning psychologically and socially. This assessment should aim to identify co-occurring mental illness (e.g. substance misuse, eating disorders), coping strategies, strengths and vulnerabilities, and the needs of any dependent children.

The assessment process can sometimes be distressing for people with BPD. The clinician should avoid re-traumatising the person with unnecessary history taking if this can be obtained elsewhere or at follow-up. Questions about past adverse experiences should be handled sensitively.

A comprehensive and careful diagnostic assessment is essential, because treatment for people with BPD is significantly different to treatment for people

with substance use, depression, post-traumatic stress disorder, bipolar disorder or psychotic symptoms who do not have BPD.

Making the diagnosis

BPD is usually diagnosed using the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* (DSM).[2] Generally, health professionals should not make the diagnosis of BPD in prepubescent children.

It can be challenging for less experienced health professionals to make the diagnosis accurately, because the symptoms of BPD overlap with those of other conditions such as major psychiatric disorders (e.g. depression, substance use disorders, eating disorders, post-traumatic stress disorder, bipolar disorder, psychosis) and other personality disorders. To confirm the diagnosis, it may be necessary to get a second opinion from a mental health professional who has experience in diagnosing and managing personality disorders.

After making the diagnosis, health professionals should tell people with BPD that they have this illness, explain the symptoms, talk about how the person's own experience would fit this diagnosis, emphasise that it is not their fault, and carefully explain that effective treatments are available. Some health professionals believe it is better not to tell a person they have BPD (particularly if the person is younger than 18 years old), mainly because some parts of the health system and society have discriminated against people with BPD and increased their suffering. However, there are advantages in telling the person the diagnosis:

- Knowing the diagnosis can help the person understand what they have been experiencing.
- Making the diagnosis known might help ensure a person receives effective treatment.
- Telling the person the diagnosis respects their control over their own life.
- Accurate diagnosis can guide treatment. Having the diagnosis explained carefully by a health professional may prevent self-diagnosis using unreliable or incorrect information accessed via the internet.
- People with BPD may be relieved to learn that their distress is due to a known illness. Knowing the diagnosis can help people feel more optimistic when they learn that it is an illness shared by other people, that effective treatments for BPD are available, and that people with BPD can recover from their symptoms.

For more information about diagnosing BPD, refer to **Section 4. Identifying and assessing BPD** in the full guideline.

2 The 4th edition–Text Revision was current during the development of the full guideline [American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th edition, Text Revision (DSM–IV-TR). Washington DC: American Psychiatric Association; 2000].

Principles and processes for managing BPD

Health professionals' behaviour towards clients with BPD

Health professionals at all levels of the healthcare system and within each type of health service, including general practices and emergency departments, should recognise that BPD treatment is a legitimate use of healthcare services. Having BPD should never be used as a reason to refuse health care to a person.

Health professionals working with people who have BPD should be respectful, caring, compassionate, consistent and reliable. They should listen and pay attention when the person is talking about their experiences, take the person's feelings seriously, and communicate clearly. If a person with BPD is upset or letting their feelings take over, health professionals should stay calm, and keep showing a non-judgemental attitude.

Health professionals should understand that people with BPD may be very sensitive to feeling rejected or abandoned, and so may be upset when their treatment comes to an end or if they can no longer see the same staff. Health professionals should plan these changes in advance and explain them to the person.

Acknowledging trauma

Many people with BPD have experienced significant trauma, either in the past or in their daily lives, so they need health care that makes them feel safe while they recover. Assessment of trauma should be done sensitively and in an appropriate context. For example, a history of past trauma should not be elicited in the emergency department during a crisis.

When people with BPD have disclosed past trauma, health professionals should validate the person's experience and respond with empathy. Health professionals should only discuss past trauma with the family of a person with BPD if the person has given their consent.

Individual management plans

For many people with BPD, their goals for treatment involve managing their emotions, finding purpose in life, and building better relationships.

Every individual with BPD should have a tailored management plan (Template 1) developed for them with their collaboration. The person's family, partner or carer should be involved in developing the management plan, if this is in the person's interests and they have given consent for others to be involved.

A clear, brief crisis management plan (Template 2) should also be developed for each person.

> For more information about individual management plans, including crisis plans, refer to Section **8.4. Developing a BPD management plan** in the full guideline.

Managing crises, self-harm and suicidal behaviour

If people with BPD repeatedly self-harm or attempt suicide, their usual health professional should assess their risk regularly. Health professionals need to gain an understanding of the person over time to be able to tell when the person is at high risk of suicide, and to know whether the person needs to keep working on their long-term BPD treatment or whether they need immediate special care to keep them safe. People who live with thoughts of suicide over time tend to recover when their quality of life improves.

Table 1 lists some general principles for health professionals to follow when a person with BPD shows high immediate risk of suicide, even if they are not the person's usual health professional.

When a person with BPD is experiencing a crisis, health professionals should focus on the 'here and now' (Table 2). Issues that need more in-depth discussion (e.g. past experiences or relationship problems) can be dealt with more effectively in longer-term treatment by the health professional who treats them for BPD (e.g. the person's usual psychiatrist).

Health professionals should try to make sure the person stays involved in finding solutions to their own problems, even during a crisis.

> For more information about assessing and managing crises, self-harm and suicidal behaviour, refer to **Section 8.5. Assessing and managing risk of self-harm or suicide** in the full guideline.

Table 1 What to do if a person with BPD is at high acute risk of suicide

Do not leave the person alone. If necessary, use the powers of local mental health legislation.
Prevent or reduce access to the means of suicide.
Do not use threats or try to make the person feel guilty.
Consult senior staff.
Contact all other people involved in the person's care (e.g. health professional, crisis team, mental health service, hospital, family, partner, carers, other supports).
Find out what, or who, has helped in the past.
Clearly explain your actions.
Do not agree to keep the suicide plan a secret.
Make a management plan.
Consider whether brief admission to a psychiatric inpatient service is needed.

Adapted from Project Air Team. *Treatment guidelines for personality disorders* Version 1.2 April 2011. NSW Health and Illawarra Health and Medical Research Institute; 2010. Available at www.projectairstrategy.org

Table 2 Principles of response to a BPD crisis

During a crisis
Respond to the crisis promptly, whether reported by the person or by a family member or carer.
Listen to the person – use an interviewing style that validates the person's experience and shows that you believe the person's distress is real. Let the person 'ventilate' – this can relieve tension.
Be supportive, non-judgemental, and show empathy and concern. Express concern if the person mentions suicidal thoughts or other risks to their safety.
Assess the person's risk. Check if there is any change in the pattern of self-harm and suicidality that could indicate high immediate risk. Check for repeated traumatic experiences or new adverse life events.
Assess psychiatric status and rule out co-occurring mental illness.
Stay calm and avoid expressing shock or anger.
Focus on the here and now.
Take a problem-solving approach.
Plan for the person's safety in collaboration with them. Do not assume that you know best about how to help them during a crisis. Ask the person to say if they want help and to explain what kind of help they would like. Provide practical help.
Clearly explain your role and the roles of other staff members.
Communicate with and involve the person's family, partner or carers, if appropriate.
Offer support to the person's family, partner or carers.
Refer the person to other services, as appropriate, and make a follow-up appointment.
Consider offering brief admission to an acute psychiatric inpatient facility if the person has presented to an emergency department and is at significant immediate risk of harm, or if the person has a co-occurring mental illness (e.g. depression or substance use disorder).
Where possible, liaise with other clinicians/teams/hospitals involved in the person's care. These should be identified in the person's management plan and crisis plan (if available).

Table 2 (cont.)

After a crisis
Follow up by discussing all safety issues, including their effect on you, within the context of scheduled appointments.
Actively interpret the factors that might have helped provide relief (e.g. the perception of being cared for).
Explain that it is not feasible to depend on the mental health service or GP to be available at all times. Help the person use a problem-solving approach to identify practical alternatives in a crisis.
Help the person deal with their anger whenever it becomes apparent.

Adapted from Project Air Team. *Treatment guidelines for personality disorders* Version 1.2 April 2011. NSW Health and Illawarra Health and Medical Research Institute; 2010. (available at www.projectairstrategy.org) and Gunderson JG, Links PS. Borderline personality disorder: a clinical guide. 2nd ed. Washington, DC: American Psychiatric Press; 2008.

Roles of community-based and acute care services

The majority of a person's treatment for BPD should be provided by community-based mental health services (public and private). Examples of roles are shown in Table 3.

Where available, health professionals should consider referring people with severe and/or enduring BPD to a specialised BPD service (e.g. Spectrum Personality Disorder Service for Victoria) for assessment and ongoing care.

Admissions to hospitals or other inpatient facilities should not be used as a standard treatment for BPD and should generally only be used as short-term stays to deal with a crisis when someone with BPD is at risk of suicide or serious self-harm. Hospital stays should be short, and aim to achieve specific goals that the person and their doctors have agreed on. Health professionals should generally not arrange long-term hospital stays for people with BPD.

If a person with BPD needs to visit an emergency department because they have harmed themselves or cannot cope with their feelings, staff should arrange mental health treatment to begin while the person's medical needs are being dealt with. Emergency department staff should attend to self-inflicted injuries professionally and compassionately.

Coordinating BPD care for an individual

If more than one health service provides care for an individual with BPD, all the health professionals involved should choose one health professional to be the person's main contact person, who will be responsible for coordinating the person's care across all health services that they use.

The management plan (including a clear, short crisis plan) should be shared with all health professionals involved in the person's care, and should be updated from time to time. If a person with BPD repeatedly visits the emergency department or their GP for immediate help during a crisis, the crisis plan should be made available to these health professionals too.

Fostering knowledge, skills and attitudes for effective care

Health professionals at all levels of the healthcare system and within each type of service setting should:

- acknowledge that BPD treatment is a legitimate use of healthcare services
- be able to recognise BPD presentations
- be aware of general principles of care for people with BPD and of specific effective BPD treatments
- provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness) according to their level of training and skill
- refer the person to a specialised BPD service or other services as indicated
- undertake continuing professional development to maintain and enhance their skills.

People who are responsible for planning or managing health services that provide care for people with BPD should make sure the health professionals who work there are given proper training in how to care for people with BPD, and are given adequate supervision according to their level of experience and the type of work they are doing. Health system planners and managers should also make sure health professionals are given enough support and have access to help from experts who are experienced in caring for people with BPD.

For more information about providing and coordinating effective BPD care in the Australian health system, refer to **Section 6. Organising healthcare services to meet the needs of people with BPD** in the full guideline.

Table 3 Roles of health professional disciplines and services in BPD care

Discipline or service	Potential roles
All health professionals	• Recognising BPD presentations • Applying general principles of care for people with BPD • Being aware of effective treatments • Providing structured psychological therapies (if appropriately trained and skilled) • Providing non-specific mental health management and treatment for co-occurring mental illness according to level of training and skill • Referring to a specialised BPD service or other services as indicated • Keeping knowledge and skills up to date
Community-based services	
Primary care health service (Primary care mental health professionals including general practitioners, practice nurses, nurse practitioners, Aboriginal health workers, clinical psychologists)	• Conducting/arranging mental health assessment for a patient who has repeatedly self-harmed, shown persistent risk-taking behaviour or shown marked emotional instability • Referring to mental health services for diagnostic assessment if the diagnosis is uncertain • Working with the person to develop a BPD management plan or obtaining and reviewing the management plan (if developed by the person's main clinician within another service) • Referring to an appropriate mental health service for specific treatment when indicated, then collaborating as part of the mental healthcare team, to ensure that treatment is consistent and cohesive • Treating the person for co-occurring mental illness (e.g. depression)
Community-based crisis response teams	• Applying general principles of care for people with BPD • Applying principles of crisis management
Public and community-based mental health services	• Conducting comprehensive diagnostic assessment • Providing structured psychological treatments

Table 3 (cont.)

Acute services	
Emergency departments and services	• Applying the principles of managing self-harm and suicide risk for people with BPD • Attending to self-inflicted injuries professionally and compassionately • Initiating mental health treatment while medical needs are being dealt with • Arranging mental health assessment for people who have repeatedly self-harmed • Conducting risk assessment to determine whether the person requires admission to a psychiatric unit • Determining whether the person is receiving long-term psychological treatment and arrange referrals as necessary • Contacting the person's GP and mental healthcare provider/s before discharge • Establishing protocols to ensure that people with known BPD are recognised, receive care promptly and are treated in a non-judgemental way that will not worsen their symptoms or escalate a crisis
Hospital inpatient psychiatric service	• Where appropriate, providing brief acute inpatient admission for structured crisis intervention directed towards specific, pre-identified goals (could be considered if suicidal or significant co-occurring mental health conditions) *Note: Long-term inpatient care for people with BPD should generally be avoided, except in the context of specialised BPD services.*
Referral services	
Specialised BPD service	• Providing treatment for people with BPD who have complex care needs or those at high risk for suicide or significant self-harm • Providing consultation to primary care services and mental health services • Providing education, training, supervision and support for health professionals, including support for rural and remote services, education for local general mental health services, and consultation and advice for GPs managing BPD • Health promotion and advocacy (e.g. raising awareness of BPD and reducing stigma) • Providing education for families and carers and supporting them • Undertaking research to develop better treatment models for BPD

Treatments for BPD

Several structured psychological therapies (Table 4) are more effective in the treatment of BPD, compared with the care that would otherwise be available ('treatment as usual').

People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more health professionals who are adequately trained and supervised. Health professionals should advise people with BPD which structured psychological therapies are available, explain what these treatments involve, and offer them a choice if more than one suitable option is available.

Adolescents (14–18 years) with BPD, or who have symptoms of BPD that are significantly affecting their lives, should be offered structured psychological therapies that are specifically designed for BPD and provided for a planned period of time. Where available and appropriate, adolescents and people under 25 years should be provided with treatment in youth-oriented services.

Doctors should not choose medicines as a person's main treatment for BPD, because medicines can only make small improvements in some of the symptoms of BPD, but do not improve BPD itself.

For more information about treatments for BPD, refer to **Section 5. Managing BPD** in the full guideline.

Table 4 Structured psychological treatments effective for BPD

More effective than treatment as usual:*
Cognitive–behavioural therapy (CBT)
Dialectical behaviour therapy (DBT)
DBT skills training
Emotion regulation training (ERT)
Interpersonal psychotherapy
Manual-assisted cognitive therapy (MACT)
Mentalisation-based therapy (MBT)
Motive-oriented therapeutic relationship (MOTR)
Schema-focussed psychotherapy (SFP)
Systems training for emotional predictability and problem solving (STEPPS)
Transference-focussed psychotherapy (TFP)
Effective when compared with each other:
Cognitive analytic therapy# (CAT)
General psychiatric management (a form of structured psychological therapy)**
Good clinical care#
Other structured psychological therapies§
Supportive psychotherapy
The Conversational model of psychotherapy
Therapeutic community (a type of residential treatment)

*Shown to be more effective than treatment as usual in randomised clinical trials in people with BPD. In some randomised controlled trials 'treatment as usual' was skilled care provided by clinicians experienced in BPD management.

**As effective as DBT in a randomised controlled clinical trial.

'Good clinical care' is an Australian form of standardised, structured, team-based clinical care developed at Orygen Youth Health, Melbourne. Cognitive analytic therapy and 'Good clinical care' were equally effective in people aged 14–18 with BPD or features of BPD in a randomised controlled clinical trial.

§ Structured psychological therapies that have been developed for people with BPD and are commonly advocated and practised. These therapies may have benefits, but have not been evaluated in randomised clinical trials.

References in section 5.1.2.1 of full guideline.

Supporting families, partners and carers of people with BPD

Families, partners and carers can play an important role in supporting the person's recovery. Health professionals should acknowledge and respect their contribution. Health professionals should, with the person's consent, involve families, partners and carers of people with BPD when developing a crisis plan. However, some people with BPD prefer not to involve others. Health professionals should respect their choice, and offer them a chance to change their mind later.

Health professionals should help families, partners and carers of people with BPD by:

- giving them clear, reliable information about BPD (Section 9)
- arranging contact with any support services that are available, such as carer-led programs that educate families/carers on BPD and respite services
- giving them information about how to deal with suicide attempts or self-harm behaviour
- advising them about the most helpful ways to interact with the person with BPD
- offering referral to family counselling.

Having BPD does not mean a person cannot be a good parent. Health professionals may consider referring parents with BPD to programs designed to help them improve parenting skills. If a mother has BPD, health professionals who provide care for her should do everything possible to help her children too. If a mother with BPD needs to go to hospital, her baby should stay with her if possible.

Where children or young people are carers of an adult with BPD, health professionals should provide education about BPD, help them deal with their parent's emotional and psychological states, and put them in touch with services that can help them with their own life.

For more information about supporting families, partners and carers of people with BPD, refer to **Section 7. Supporting families, partners and carers** in the full guideline.

- Templates and resources

TEMPLATE 1

Borderline personality disorder (BPD) management plan

Personal details

Name:	Date of birth:
Address:	
Phone:	
Family member's/partner's/carer's contact details:	
Date:	Next review date:

Health professionals involved in treatment

Name	Contact details	Role	Alternative contact person	Contact for alternative	Copy of this plan received (✓/✗)

Case summary

Brief history:
Diagnosis:
Current living arrangements and social circumstances:

Risk assessment

Risk to self
Acute suicide risk:
Long-term patterns of self-injurious acts High-lethality behaviours: Low-lethality behaviours:
Other risks
Risks to other people
Risks to property

Treatment goals

Short-term treatment goals:
Long-term treatment goals:

Current psychosocial treatment

Approach	Commencement date	Planned review date	Provider/s

Medicines

Current medicines (if any)

Name of medicine	Dosing information	Purpose

Medicines previously unsuccessful in a therapeutic trial:
Cautions (e.g. medicines associated with overdose):
Health professional primarily responsible for prescribing and reviewing medicines:

Management of self-harm during office hours

Management of self-harm outside office hours

If person calls before self-harm has occurred (chronic pattern):
If person calls after self-harm has occurred (chronic pattern):

Agreed responses to specific presentations

Presentation	Response	Notes

Indicators for reviewing treatment plan

Indicators of increased risk related to self-harm/suicidality behaviour patterns:
Other possible indicators of increased risk:

Emergency department treatment plan (if applicable)

Usual clinical presentations:
Indications for hospital admission:
Predicted appropriate length of admission:
Discharge planning notes:

Inpatient treatment plan (if applicable)

Indications for admission:
Predicted appropriate length of admission:
What to do if person self-harms during admission:
What to do if person found to be under the influence of substances while admitted:
What to do if person expresses suicidal thoughts at the time of a planned discharge:

Rationale for interventions and strategies

Clinical interventions/responses that have been helpful in the past:

Situation	Intervention or response	Outcome	Notes

Clinical interventions/responses that have been unhelpful in the past:

Situation	Intervention or response	Outcome	Notes

Coping/management strategies used by the person

Situation/problem	Strategy/action	Successful (yes/no)	Notes

Signatures

Clinician:
Client (if appropriate and willing):
Family/Partner/Carer (if client is willing):

Adapted from Spectrum (BPD service for the state of Victoria) http://www.spectrumbpd.com.au

Explanatory notes

Health professionals involved in treatment: Clearly describe the role of each health professional in the person's treatment, including the frequency of contact with the person. For each health professional listed, the name and contact details of one or more alternative health professional should be provided. List health professionals from all services involved in the person's care, including the person's usual GP.

Risk assessment: Outline the patterns of chronic self-injurious behaviours and acute suicide risk situations and any other risks (sexual, financial, driving, substance intoxications, etc.). The description of chronic acts of self-injury should differentiate high- and low-lethality behaviours (relatively low-lethality self-injurious acts such as superficial cutting and burning, minor overdoses should be differentiated from high-lethality behaviours such as taking massive overdoses, self-asphyxiation by hanging, carbon monoxide poisoning, etc.).

For each self-harm pattern, provide information about the period typically leading to self-harm, including the usual sequences of thoughts, feelings and actions and any observable signs.

Record any risk of accidental death by misadventure.

List factors/situations that are likely to contribute to acute risk of suicide (e.g. loss of relationships, disappointments, contact with particular people who the person associates with abuse).

Where possible, specify the relationship of self-harm acts to the meaning they have for the person (e.g. overdosing on prescribed medicines or hanging after calling for help may be associated with relief from emotional pain; superficial cutting may be associated with abandonment anxiety; driving recklessly, starving, binging and purging might be associated with relief from cognitive pain; deep lacerations done in secret after an overdose on paracetamol and under influence of alcohol may be associated with intent to die).

Treatment goals: Examples of short-term goals include keeping the person alive, reducing self-harm acts, reducing need for hospitalisations, improving therapeutic engagement, reducing substance use, etc. Examples of long-term treatment goals include transferring the person to another health service for long-term psychotherapy, achieving clinical remission, functional recovery, etc.

Interventions/strategies that have helped in the past: List helpful and unhelpful interventions/strategies with examples for each crisis or self-harm pattern, including presentations to all services involved (e.g. emergency department, general practice, acute psychiatric inpatient facility, usual mental health service provider). The person's inputs are very important in completing this section. Specifically mention the responses that the person considered to be invalidating.

Possible indicators of risk outside the self-harm/suicidality risk behaviour patterns: Include individual risk indicators e.g. psychosis, major depression, etc.

Agreed responses to specific presentations: Record agreed actions to be followed in specific circumstances (e.g. presentation with substance intoxications, presentation following self-harm) as negotiated with the person.

TEMPLATE 2

BPD crisis management plan

Personal details

Name:	Date of birth:
Address:	Phone:
Family/partner's/carer's contact details:	
Health professionals involved in the person's care:	

Date of plan

Clinical notes

Diagnostic statement:
Brief clinical summary:
Developmental history:
Triggers for self-harm or suicidal behaviours:

Description of crisis pattern from past history

Duration:
Frequency:
Triggers:
Behaviour during crisis:

Safety concerns during a crisis

Self-harm behaviour during crisis:
Suicidal behaviour during crisis:
Safety concerns for others and property:

Management strategies during a crisis

Who the person should contact in a crisis within office hours:
Who the person should contact in a crisis outside office hours:
Planned response:

Strategy	Notes

Notes for specific health services

Service	Notes
Emergency department	
GP	

Admission to acute psychiatric facility

Indications for admission:
Brief voluntary admissions have been negotiated with the person (Yes/No):

Rationale for management strategy

Person's suggestions for what may help:

Clinical interventions/responses that have helped in the past:

Situation	Intervention or response	Outcome	Notes

Clinical interventions/responses that have been unhelpful in the past:

Situation	Intervention or response	Outcome	Notes

Person's own copy of crisis plan

Copy received (✓/✘):	Copy of separate version attached (✓/✘)
Treating Clinician:	
Patient (if willing and able to negotiate the plan):	
Family/Partner/Carer: (if client is willing)	

Signatures

Clinician:
Client (if appropriate and willing)
Family/Partner/Carer (if client is willing):

Adapted from Spectrum (BPD service for the state of Victoria) http://spectrumbpd.com.au

Explanatory notes

Clinical notes: The developmental history should be aimed at eliciting empathy in care providers. Triggers for self-harm or suicidal behaviours should include an empathic account of the person's usual reasons for self-injurious behaviours.

Contact information for public mental health services

Australia-wide	**Healthdirect Australia** (health information service) Website: www.healthdirect.org.au Telephone: 1800 022 222 (24 hours)
Australian Capital Territory	**ACT Government Health Directorate (ACT Health)** Website: www.health.act.gov.au Telephone (general enquiries): 13 2281
	Mental Health Crisis Team Telephone (24 hours):1800 629 354 or 02 6205 1065
	Transcultural Mental Health Centre Telephone (8.30 am–5.30 pm Monday to Friday): 1800 648 911
New South Wales	**New South Wales Government Ministry of Health** Website: www.health.nsw.gov.au Telephone (general enquiries): 02 9391 9000
	Mental Health Line Telephone (24hrs): 1800 011 511
Northern Territory	**Northern Territory Government Department of Health** Website: www.health.nt.gov.au Telephone (general enquiries): 08 8999 2400
	Northern Territory Crisis Assessment Telephone Triage and Liaison Service Telephone (24 hours): 1800 682 288 (1800 NT CATT)
Queensland	**Queensland Health** Website: www.health.qld.gov.au Telephone: 13 43 25 84 (13 HEALTH)

South Australia	**SA Health** Website: www.sahealth.sa.gov.au Telephone (general enquiries): 08 8226 6000
	Mental health triage service/Assessment and Crisis Intervention Service Telephone (24 hours): 13 14 65
Tasmania	**Tasmanian Government Department of Health and Human Services** Website: www.dhhs.tas.gov.au Telephone (general enquiries): 1300 135 513
	Mental Health Services Helpline Telephone: 1800 332 388
Victoria	**Victorian Government Department of Health** Website: www.health.vic.gov.au Telephone (general enquiries): 1300 253 942
	Mental Health Services Telephone (9.00 am–5.00 pm): 1300 767 299 or 03 9096 8287
Western Australia	**Western Australian Government Department of Health** Website: www.health.wa.gov.au Telephone (general enquiries): 08 9222 4222
	Mental Health Emergency Response Line Telephone (state-wide): 08 9224 8888 Telephone (Perth metropolitan): 1300 555 788 Telephone (Peel region): 1800 676 822

For more information on available BPD services

Well Ways
Information and program designed by the Mental Illness Fellowship of South Australia (available at http://www.mifa.org.au/well-ways) to help families, partners and carers:

- understand the illness
- learn how to cope and interact with the person in a way that helps in their recovery and allows them to maintain their lives and lifestyles where possible
- develop ways of communicating so that they can support the person
- communicate effectively with health professionals caring for the person
- overcome harmful effects of guilt and stigma

Mental Health First Aid
Written materials and support (available at http://www.mhfa.com.au/cms/)

Royal Australian and New Zealand College of Psychiatrists
Self-harm. Australian treatment guide for consumers and carers booklet (available at http://www.ranzcp.org)

Private Mental Health Consumer Carer Network
Information for consumers and carers who use private-sector mental health services http://www.pmhccn.com.au)

Project Air Strategy for Personality Disorders
Website: https://ihmri.uow.edu.au/projectairstrategy/index.html

Spectrum, The Personality Disorder Service for Victoria
Website: http://www.spectrumbpd.com.au/
Telephone (8.30 am–5.30 pm Monday to Friday): (03) 8833 3050

Lifeline
Website: http://www.lifeline.org.au/
Provides access to crisis support, suicide prevention and mental health support services
Telephone (24 hours): 13 11 14

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www.nhmrc.gov.au
GPO Box 1421, Canberra ACT 2601
16 Marcus Clarke Street, Canberra City ACT
T. 13 000 NHMRC (13 000 64672) or +61 2 6217 9000 F. 61 2 6217 9100 E. nhmrc@nhmrc.gov.au