

Data supplement

Guidance for working with patients who have personality disorder (Personality Disorder Working Party, SW London and St George's Mental Health NHS Trust: reproduced with permission)

1. As part of the ongoing process of comprehensive assessment a careful history from the patient's perspective is desirable with particular attention being paid to the service user's own understanding of, and the names they give to, their own history and current problems.
2. A respectful and polite professional manner is best at all times, avoiding personal disclosure. It is unhelpful to expose patients to disagreements within and between the team.
3. If a diagnosis of personality disorder is made, an interactive discussion with the patient is desirable as soon as is practical. This will need a reasonable amount of time and an appropriate setting (private, free from interruption, etc.). The following are often important factors:

- an acknowledgement that a diagnosis can feel stigmatising
- awareness that some patients are suggestible, especially regarding thoughts of childhood sexual abuse
- a discussion of the diagnosis can:
 - be helpful as part of informed consent process
 - allow access to treatment
 - help the healthcare professional to make a clear distinction between the features of personality disorder and those of other diagnoses
 - be helpful when accompanied by written and verbal information and leaflets
- discussion of the diagnosis can be unhelpful when:
 - disagreements between professionals over diagnosis arise
 - the service user is told it is not a psychiatric problem /nothing can do/strain on resource

The discussion would best include elucidating the service user's thoughts and feelings about each aspect of the diagnosis and its implications, eliciting any concerns or questions raised and responding appropriately.

4. As soon as possible treatment and management options need to be identified. A care plan can then be drafted in collaboration with the service user. Again this is best accomplished in an interactive manner, elucidating the service user's thoughts and feelings about each aspect of the plan, eliciting any concerns or questions raised and responding appropriately.

These plans are best tailored to the needs of each individual service user and, as well as including treatment options such as occupational therapy, psychological input, etc., may contain crisis management including respite admission. Such plans should be communicated to all relevant services, for example, duty doctors, crisis services, GPs, A&E departments. Once agreed, these plans would be, as far as is possible and practical, binding to all parties.

5. Good communication with relatives and other significant people in the service user's life can be crucial. It may be desirable to involve a carer in the collecting and sharing of information, and drafting and implementing of care plans. Whether this is desirable should be decided in cooperation with the service user and their choice as to who, if at all, should be involved should be respected as far as is practical. Generally, the service user will be the person who can best judge whether and when communication with a relative is appropriate. There are times, though, when such communication may be inappropriate, e.g. if a close relative was a past abuser.
 6. At all stages as much information as possible, including written information and website addresses, should be given to the service user.
 7. Where possible continuity of contact between patient and individual professionals is desirable; where this is not practical notice of staff time off or changes of staff is helpful.
 8. At each stage of care, there should be good communication and liaison between different agencies and professionals involved in the care of the patient. This may include primary care and A&E teams.
 9. For patients who require extra input for reasons of their own safety, such as one-to-one nursing care, reference should be made to the trust's observation policy. The policy requires that a second opinion is sought if 2 weeks or more of one-to-one supervision is needed. Active consideration should be given as to whether the second opinion at this stage is from a psychotherapist or psychiatrist. This should be discussed with the service user, their concerns and questions sought, and as far as possible questions answered.
 10. As far as is possible these guidelines should still apply to patients detained under the Mental Health Act 1983.
 11. Exceptionally, there may be some instances in which professionals feel they must override the service user's views – for example, because they need to contact the nearest relative to comply with the Mental Health Act 1983 in the case of an assessment under the Act, or in order to ensure the safety of the service users or others. If professionals do override the user's wishes in this way, they will inform them of this and explain the reasons why, except if in doing so they consider that the health or safety of the user or others would be jeopardised. In this case, the professionals concerned would need to record with some care the reasons for not disclosing this information to the user. This would only happen in exceptional circumstances, and generally the wishes of the service user will be respected and professionals will be open about any action that they take.
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