

WORKING WITH BORDERLINE
PERSONALITY DISORDER –
WHAT WORKS!

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ESSENTIA HEALTH & WELLBEING CENTRE

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Today's Schedule

- Field Mentoring in the Management of BPD
- Phone calls and coaching when an individual is in crisis
- Psychological First Aid: Supporting Staff
- Specific issues for management of BPD (past experiences and team brain storming session)
- Implementing a BPD Management Policy and supported decision making
- Documentation: What do you need to record in your notes

FIELD MENTORING

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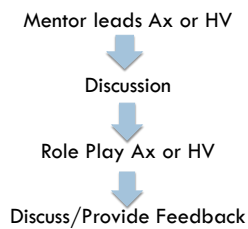
What is Field Mentoring

- Supervisory tool used to assist mental health professionals further develop and enhance clinical skills
- A process of mutual learning and professional development and not a process of micro-management
- The role of field mentoring is to support the enhancement of clinical skills
- It's a process informed by a recovery informed approach

4 Types of Field Mentoring

- Mentor Led
- Mentoree Led
- Prompting
- Shaping

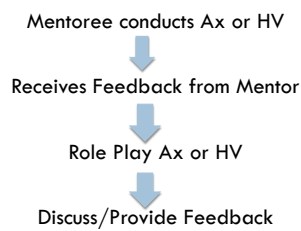
MENTOR LED



MENTOR LED

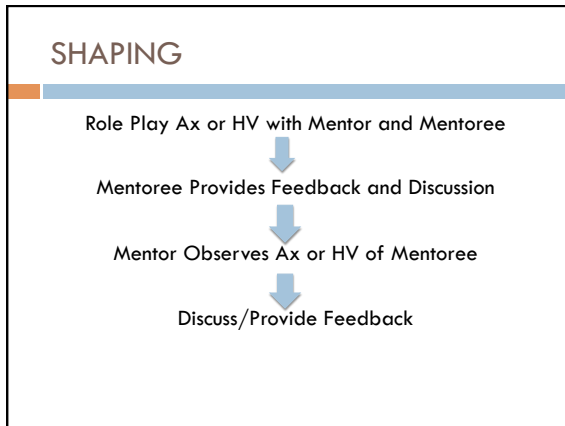
- Field mentor takes the lead role in working with the consumer for the purpose of modelling how to use a specific skill or tool.
- The field mentor and clinician discuss the session afterwards.
- On a subsequent session, the field mentor observes the clinician using the skill or tool.
- Afterwards, they discuss the session.

MENTOREE LED

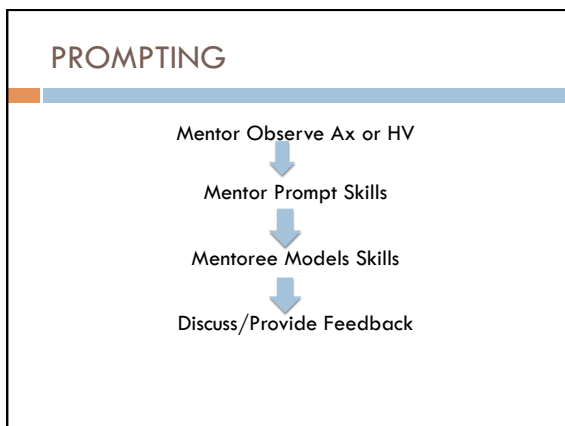


MENTOREE LED

- Clinician takes the lead role in working with the consumer with minimal involvement from the field mentor.
- After the session, the field mentor and clinician discuss what worked well and what did not.
- Using role play, the field mentor models as the clinician and presents alternative ways the session might have been conducted.
- The role play is discussed, along with possible switching of roles for further practice.



- ### SHAPING
- Field mentor and clinician role play using a new skill or tool prior to meeting with the consumer.
 - The field mentor gives the clinician feedback on using the skill or tool.
 - The field mentor then goes out with the clinician to observe him/her using the skill or tool with a consumer.
 - Afterwards, the field mentor provides feedback to the clinician.



PROMPTING

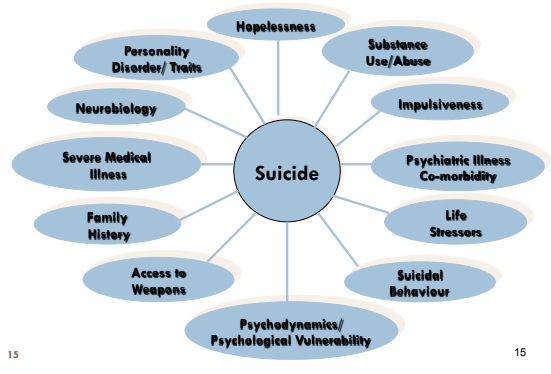
- Clinician takes the lead role in working with the consumer and will try using a new skill or tool.
- If needed the field mentor might intervene during the session and assist by modelling the skill or tool.
- Afterwards the field mentor and clinician discuss the session.

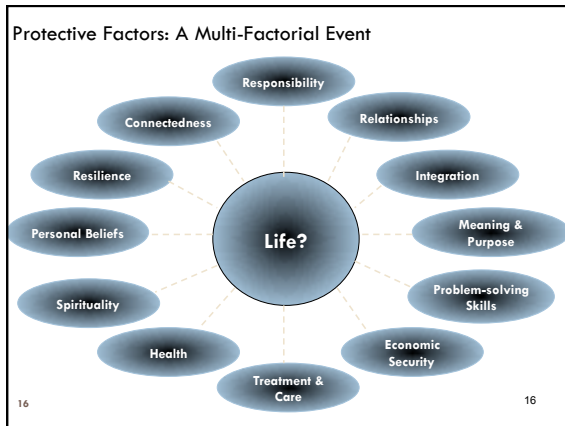
MANAGING CALLS WHEN SUICIDE IS RAISED

Adapted from: Rosenthal, H. (2003). "Twelve Must-Know Myths About Suicidal Clients." *Counselor: The Magazine for Addiction Professionals*, 4(5), 22-23.

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A Multi-Factorial Event





What's important

- Be yourself.
- The right words are unimportant.
- If you are concerned, your voice and manner will show it.

Approach to call

- Listen.
- Let the person unload despair, ventilate anger.
- If given an opportunity to do this, he or she will feel better by the end of the call.
- No matter how negative the call seems, the fact that it exists is a positive sign. The person wants help and they still have hope!

Approach to call

- Be sympathetic,
- Be non-judgmental,
- Be patient,
- Be calm,
- Be accepting.

The caller has done the right thing by getting in touch with another person.

Is the person suicidal?

- If the caller is saying I'm so depressed, I cant go on, ask **The Question:**
 - Are you having thoughts of suicide?
 - You are not putting ideas in his head,
 - You are doing a good thing by offering clarification
 - You are showing that:
 - you are concerned
 - you take their concerns seriously
 - and that it is OK to share their pain with you.

Is the person suicidal?

- If the answer is yes, you can begin asking a series of further questions:
 - Have you thought about how you would do it (PLAN);
 - Have you got what you need (MEANS);
 - Have you thought about when you would do it (TIME SET).
- 95% of all suicidal callers will answer no at some point in this series or indicate that the time is set for some date in the future.
 - This will be a relief for both of you.

Talking About Problems

- Simply talking about their problems for a length of time will give suicidal people relief from loneliness and pent up feelings, awareness that another person cares, and a feeling of being understood.
- They also get tired -- their body chemistry changes.
- These things take the edge off their agitated state and help them get through a bad night.

REFER ONTO A SERVICE TO PROVIDE THIS

Things to Avoid

- arguments,
- problem solving,
- advice giving,
- quick referrals,
- belittling and making the caller feel that has to justify his suicidal feelings.

It is not how bad the problem is, but how badly its hurting the person who has it.

In an emergency

- If the person is ingesting drugs, get the details (what, how much, alcohol, other medications, last meal, general health)
- The person needs an ambulance!
- A shift partner can call while you continue to talk to the person, or you can get the callers permission and do it yourself on another phone while the caller listens to your side of the conversation.

Get support!

- Do not go it alone.
- Get help during the call and debrief afterwards.
- Take some time to breath!
- Don't just go to the next appointment and forget...
- Call colleague... "I just need to run something past you..."

Others who are suicidal

- Your caller may be concerned about someone else who is suicidal.
- Just listen, reassure him that he is doing the right thing by taking the situation seriously, and sympathize with his stressful situation.
- With some support, many third parties will work out reasonable courses of action on their own.
- In the rare case where the third party is really a first party, just listening will enable you to move toward his problems.
- You can ask, Have *you* ever been in a situation where you had thoughts of suicide?

Client presents in crisis, consult a mental health professional and:

- maintain a calm and non-threatening attitude
- try to understand the crisis from the person's point of view
- explore the person's reasons for distress...changing of appointment
- use empathic open questioning, including validating statements, to identify the onset and the course of the current problems
- avoid minimising the person's stated reasons for the crisis
- refrain from offering solutions
- offer referral to appropriate mental health options for support
- debrief
- review organisational response over time

Crisis Support Numbers

- **Imminent risk:** call 000
- **High Risk/Concerns/Clarification:** Triage/CATT/ED
- **Suicidal ideation:** SuicideLine (Crisis Intervention & Bereavement Counselling) 1300 651 251
<http://suiceline.org.au/>
- **Counselling and support:** Suicide Call Back Service (includes online counselling) 1300 659 467
<http://www.suicidecallbackservice.org.au/>

PHONE COACHING APPROACH FOR BPD

Adapted from: Linehan, M. M. (1993a). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York: Guilford Press.

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DBT Targets for Phone Calls

- **Decreasing**
 - suicide crises behaviors
 - service destructive/ending behaviours
 - sense of conflict, alienation, distance with the clinician
- **Increasing**
 - immediate contacting of primary clinician before thing escalate
 - generalisation of behavioural skills
 - the use of skillful means when in crisis

Telephone strategies Checklist
From Linehan (1993) p. 499

Clinician **ACCEPTS** phone calls from client as appropriate in various situations

- Clinician informs client of the 24 hour rule on phone call following self-harming behaviour, and stick to it
- During problem solving (coaching) calls, clinician coaches the client on using crisis survival and other skills to tide them over until next session
- Clinician is willing to repair client alienation or their own service interfering behaviors during phone calls

Telephone strategies Checklist
From Linehan (1993) p. 499

Clinician consider **SCEDULING** client initiated phone calls during regular times

Clinician **INITIATES** phone contacts:

- To extinguish functional correction between clinicians attention and suicidal behaviour
- To interfere with client's avoidance

Clinician gives client **FEEDBACK** about phone call behaviour during individual meetings.

Telephone strategies Checklist
From Linehan (1993) p. 499

TACTICS THAT GO AGAINST PHONE COACHING

- Clinician does therapy on the phone
- Clinician is mean-spirited about accepting phone calls
- Clinician makes judgmental interpretations of Client's phone calls to Clinician
- Clinician is not available when they have indicated they would be

Skills Phone Coaching Guide

Phone coaching provides opportunities to obtain assistance with applying skills.

Skills phone coaching can be used for:

- Problem solving which skills to use in a situation
- Rehearsing a skill before a situation
- Staying on task and avoiding a full blown crisis
- Repairing a relationship.

Skills Phone Coaching Guide

Skills phone coaching is not individual therapy or a chat.

It has the specific focus of working on skills and the clinician will assist the client to identify skills to use in the specific situation.

Most phone calls will last no longer than 10 minutes.

Skills coaching phone calls will involve asking you to:

- Briefly describe the current situation
- Identify what skills they have tried to use
- Explore what skills could be used
- Identify a plan of action to follow the phone call.

Skills Phone Coaching: 24 Hour Rule

Clinicians will not engage in coaching phone calls made following and within 24 hours of an episode of self-harm.

If a client calls within 24 hours of self-harm they will be directed to medical care/AMHS or other safety measures.

Exceptions to this are:

- If the client has further thoughts of suicide or self-harm
- In this case coaching skills will be offered or and the individual directed to appropriate interventions

PSYCHOLOGICAL FIRST AID:
SUPPORTING STAFF

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What is Psychological First Aid?

Psychological first aid is a 'humane, supportive response to a fellow human being who is suffering and who may need support'

Sphere Project for Minimum Standards in Humanitarian Response
www.sphereproject.org

What is Psychological First Aid?

- Psychological First Aid is an evidence-formed modular approach to help in the immediate aftermath of disaster or terrorism
- Designed to reduce initial distress
- Foster short- and long-term adaptive functioning and coping



Elements of psychological first aid

The elements of psychological first aid are to promote:

- Safety
- Calm
- Connectedness
- Self-efficacy and group efficacy
- Hope

When do we use Psychological First Aid?

Psychological first aid is an approach developed to help people affected by an emergency, disaster or traumatic event.

These principles also apply to service providers following:

- Client suicide or death
- Workplace Assault
- Witnessing a traumatic event in the workplace
- Fires in workplace
- And other workplace incidents

The **Need** for Psychological First Aid


- Research by Breslau found over 80% of Americans will be exposed to a traumatic event
- Approximately 9% of those exposed to a traumatic event develop PTSD.
- Disasters may create significant impairment in 40-50% of those exposed (Norris, 2001, SAMHSA).



Who delivers PFA?

Designed for delivery by mental health and other disaster response workers within a wide variety of response units:

- First responder teams
- Health care providers
- School crisis response teams
- Faith-based organisations



Basic Objectives of PFA

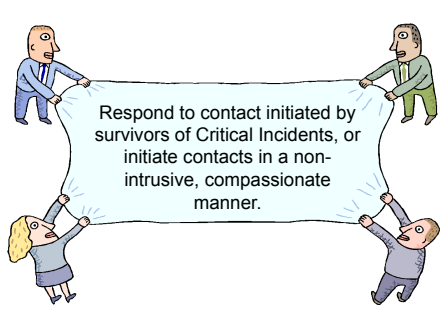
- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate & ongoing safety and provide physical & emotional comfort.
- Calm & orient emotionally overwhelmed or distraught survivors.
- Offer practical assistance & information to address immediate needs/concerns.

Overview of Core Actions

Basic objectives of providing early assistance within days or weeks following an event.

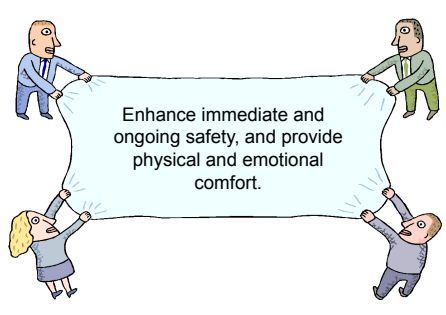
Providers should be flexible, and base the amount of time spent on each core action on the survivors' specific needs and concerns.

Core Actions: Contact & Engagement



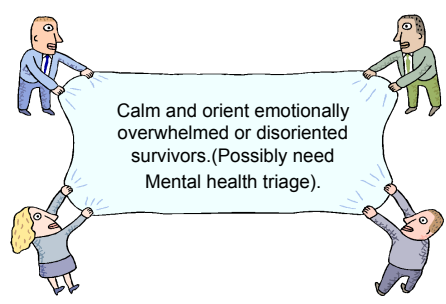
Respond to contact initiated by survivors of Critical Incidents, or initiate contacts in a non-intrusive, compassionate manner.

Core Actions: Safety and Comfort



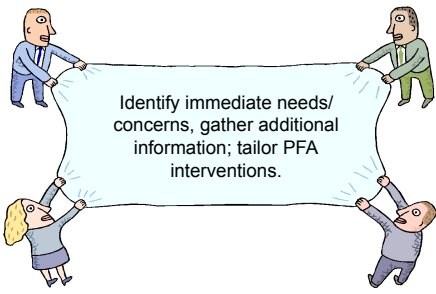
Enhance immediate and ongoing safety, and provide physical and emotional comfort.

Core Actions: Stabilisation



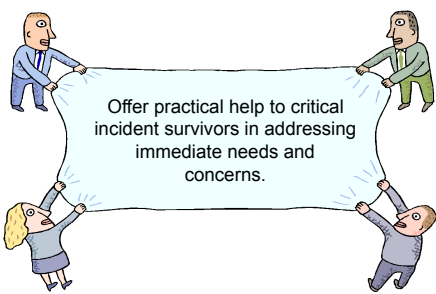
Calm and orient emotionally overwhelmed or disoriented survivors. (Possibly need Mental health triage).

Core Actions: Information Gathering



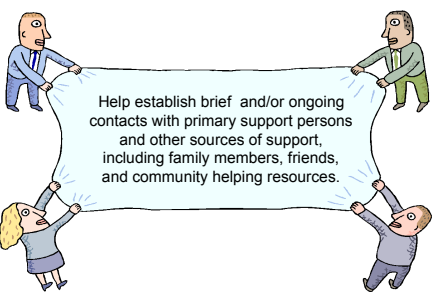
Identify immediate needs/
concerns, gather additional
information; tailor PFA
interventions.

Core Actions: Practical Assistance



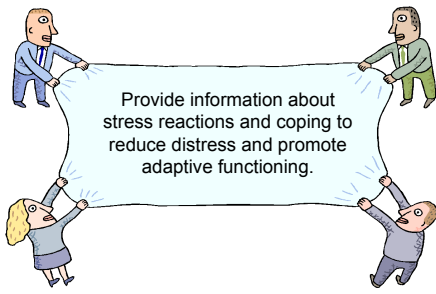
Offer practical help to critical
incident survivors in addressing
immediate needs and
concerns.

**Core Actions:
Connection with Social Support**



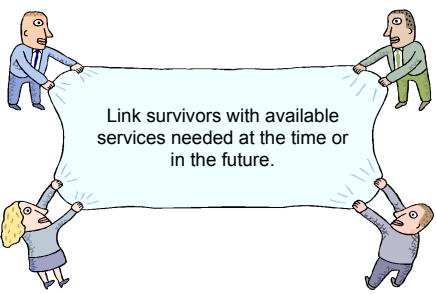
Help establish brief and/or ongoing
contacts with primary support persons
and other sources of support,
including family members, friends,
and community helping resources.

Core Actions:
Information on Coping



Provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

Core Actions:
Link with Services




Link survivors with available services needed at the time or in the future.

Service Providers are **human, too!**

Service Providers are like everyone else they get anxious, depressed, experience trauma, relationship difficulties... this goes on.

No one is invincible!



Before YOU Begin...

Providing care & support for individuals with mental health concerns can be an enriching profession and personal experience through helping others.

It can also be physically and emotionally exhausting.


Consider your current health, family, work circumstances.

Personal Considerations... Plan ahead!

Assess your comfort level with the various situations you may be experiencing while providing care for individuals with mental illness.

Working with:

- Individuals who are experiencing intense distress and extreme reactions.
- Individuals who may have had significant traumas
- Displacement and sometimes removal from culture and usual environments
- In a chaotic, unpredictable environment.



Personal Considerations, cont.

- Working in an environment with minimal or no supervision...or, conversely, micromanaged.
- Working with and providing support to individuals from diverse cultures, ethnic groups, developmental levels, and faith backgrounds.
- Environments where risk of harm or exposure is not fully known.

Things that may effect your resilience

- Recent surgeries or medical treatments
- Recent emotional or psychological challenges or problems
- Any significant life changes or losses within the past 6-12 months
- Earlier losses or other negative life events (triggered emotions)
- Dietary restrictions that may impede work
- Ability to remain active for long periods of time
- Ability to endure physically exhausting conditions

Family Considerations

- Is your family prepared for you to work in environments where risks are unknown?
- Will your support system (family/friends) assume some of your family responsibilities if you need it?
- Shift work? On-call?
- Do you have any unresolved family/relationship issues that will make it challenging for you?
- Do you have a strong, supportive environment to return to after a hard day's work? How would that look?



Personal/Family/Work/Life Plan

Take time to prepare for:

- Family & other household responsibilities
- Pet care
- Work responsibilities
- Community activities/responsibilities
- Other responsibilities & concerns
- Holidays!!!!!!!



During Working Day

When providing care & support in the mental health & community services sector it is important to:

- recognise common and extreme stress reactions
- how organisations can reduce the risk of extreme stress to providers
- how best to **take care of yourself** during your work.
- know when to say no!
- Knowing when to take time out



Common STRESS Reactions

There are a number of common responses when working in our sectors:

- Increase/decrease in activity level
- Sleeping difficulties
- Substance use
- Numbing
- Irritability, anger, and frustration
- Vicarious traumatisation in the form of shock, fearfulness, horror, helplessness
- Confusion, lack of attention, difficulty making decisions
- Physical reactions (headaches, stomachaches, being easily startled)
- Depressive or anxiety symptoms



EXTREME Stress Reactions

- Compassion stress: helplessness, confusion, isolation.
- Compassion fatigue: demoralisation, alienation, resignation.
- Preoccupation or compulsive re-experiencing of trauma experienced either directly or indirectly.



Extreme Stress Reactions, cont.

- Attempts to over-control in professional or personal situations
- Withdrawal and isolation
- Preventing feelings by relying on substances, over-preoccupation with work, drastic changes in sleep



Extreme Reactions...

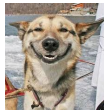
- Serious difficulties in interpersonal relationships, including domestic violence
- Unnecessary risk-taking
- Depression accompanied by hopelessness (which has the potential to place individuals at higher risk for suicide)



NO!! DON'T LEAVE!!
THERE ARE THINGS YOU CAN DO!!!!

Service Provider Self-Care (Proactivity)

- Manage personal resources
- Plan for family/home safety (child care; pet care, husband care etc.)
- Get adequate exercise, nutrition, relaxation



Use stress management tools regularly, such as:

- Accessing supervision routinely to share concerns, difficult experiences, and strategising approaches
- Practice brief relaxation techniques
- Use the buddy system to share upsetting emotional responses
- Stay aware of limitations and needs



Self Care, cont.

- Recognise when you are Hungry, Angry, Lonely or Tired & take appropriate self-care measures
- Increase activities that are positive
- Practice your faith/philosophy/spirituality
- Spend time with family/friends
- Learn how to “put stress away”
- Write/draw/paint
- Limit caffeine, tobacco, and substance use



Make every effort to...

- Pace yourself; self-monitor
- Maintain boundaries: delegate, say “no”, avoid working with too many consumers with a particular presentation in a given ‘shift’.
- Check in regularly with colleagues, family/friends
- Work with colleagues...
- Take relaxation/stress management/bodily care/refreshment breaks
- Try to be flexible, patient, and tolerant
- Accept things you cannot change.

WIN-WIN Opportunity!

Identify, utilise, and maintain self-care now:

- Physical Health
- Mental – Emotional Health
- Relationships (Marriage / family / work)
- Personal Interests (Hobbies, activities, etc.)
- Take your leave & participate in life!!!!!!

Your well-being will be enhanced...

The Outcome...

You will have increased the probability of favorable outcomes at work because you have increased:

- Optimism
- Confidence
- Resources
- Resilience

Not only for consumers... but for yourself!

**ESTABLISHING
PROTOCOLS AND
APPROACHES TO
MANAGEMENT OF BPD**

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What we do Well at the moment!

- Commitment to work together to support individuals with BPD & Emotion Regulation Difficulties
- Dedicated & Motivated Staff to improve services and impact
- Comprehensive Assessment of Need
- Engaging with individuals of highest need whilst on waiting lists and in holding programs

What we do Well at the moment!

- Accepting there is a need for an informed approach to the management of BPD
- Considering Clinician's Workloads
- Flexibility of thinking – Lateral Thinking
- Supporting clinicians through formalised training

Things we can improve

- At times we can be trying to make an individual fit the service brief rather than making the service fit the individual's needs
- Services can be time limited – quick to exit individuals
- See individuals as a group of problems – “labeling them” not seeing people as individuals

Things we can improve

- Move the focus from “having to meet targets”
- Move towards treating the cause of the behaviour/presentation rather than focusing on the symptoms of an individuals problem
- Funding and Service descriptions that don't inhibit comprehensive service delivery
- Environment at time inhibits engagement - smaller community

Things we can improve

- Availability of services available locally
- Waiting list management
- Interagency communication and engagement

Identified Needs in Service Delivery

- Further Education
- Peer Support & Supervision
- Field Mentoring
- Interagency Collaboration
- Sector Wide Approach to Management of BPD & Emotion Dysregulation

**CORE COMPETENCIES
& PERSONAL
ATTRIBUTES OF STAFF**

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CORE SKILLS & COMPETENCIES

- What are the core competencies for clinicians?
- What skills do you need to have to be effective?
- What education and development needs are required to be effective?
- What are the organizational requirements of your role?
- Think from the perspective of:
 - Your team
 - Your clients
 - Carers
 - Other Service Providers

PERSONAL ATTRIBUTES

- To be successful in the management of Emotion Regulation difficulties and individuals with Borderline Personality Disorder a range of personal attributes have been identified to enhance an individuals capacity to meet the needs of consumers through the attainment of a range of core competencies for service providers

PERSONAL ATTRIBUTES

- Self Confidence in ability to apply skills and knowledge
- Empathy
- Professionalism
- Ability to employ crisis intervention skills
- Ability to embrace conflict resolution strategies when needed
- Organisation Skills with the ability to prioritise
- Sense of humour (irreverence)

PERSONAL ATTRIBUTES

- Humility
- Ability to not take things personally
- Non-judgmental stance
- Composure
- Patience
- Ability to acknowledge personal strengths and vulnerabilities
- Knowing how to and when to access de-briefing, support and supervision
- Mastery of Work/Life Balance

**IMPLEMENTING A BPD
MANAGEMENT POLICY
AND SUPPORTED
DECISION MAKING**

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Why Specific Strategies

- One of the most common of mental health concerns presenting in workplace of service providers
- Challenges to staff professionally and personally
- Produces most conflict within the health sector
- High mortality rate
- Low motivation to manage and support by some health staff
- Consumers become frustrated with management and treatment approaches of health professionals

Conflict and Crisis

- Avoid assuming responsibility for an individual's problems. Assist an individual to assume responsibility (for change) even if they are not at fault. Not looking to prove that any one perspective is right or wrong (Dialectics - both sides of the story)
- Assist with & reinforce problem solving in an attempt to promote individual responsibility and independent coping.

Conflict and Crisis

- Help the individual identify potential solutions, weigh up the pros and cons to choose a direction, highlighting options even when limited options.
- Encourage personal implementation of a chosen strategy, rather than find someone else to do it. (Role play this to support adoption of this approach)
- Offer information on relevant support services and coping strategies, rather than becoming the support service or strategy yourself. (Stick to the role you have articulated in the first sessions)

Suicidal feelings or feeling unsafe.

- Encourage the individual to address any suicidal or safety issues with appropriate support including mental health professionals and/or emergency services if risk is immediate (inclusive of altered state due to substance use).
- Encourage the use of crisis support lines before the crisis reaches it's pinnacle! (Suicide Call Back Service, Lifeline, Kids Helpline, Men's Helpline).
- Reinforce the use of adaptive diversionary/ distraction strategies to cope (mindfulness, music, TV, leisure interest, activity requiring concentration etc).

Engaging in self-harming behaviour

(cutting, burning, overdosing or alcohol/drugs)

- Support the individual to focus on/ identify specific triggers and emotions contributing to the behaviour, rather than the behaviour itself. (What happened today? What state of mind are you presently in? Is there something that is triggering your current distress?).
- Acknowledge feelings/ issues first and then suggest alternative strategies for dealing with them and avenues for crisis support. (Validation and problem solving in a non-judgmental way)

Difficulty maintaining healthy boundaries/ stable emotional attachments both personally and professionally

- Clarify personal/ professional boundaries and relationship expectations in the initial sessions (Orientate and shape the relationship). Be clear within yourself as to what you are able to provide within the environment you hold your role in.
- Clarify your parameters regarding helpful and healthy behaviour in interpersonal interactions.
- If boundaries are overstepped address the issue in a timely & non-judgmental manner. Explain why maintaining boundaries are important and potential consequences of overstepping them.

Difficulty controlling and/or regulating emotional reactions to situations and events.

- Avoid reacting emotionally to a client's emotional reaction to a situation or event (Use your WISE Mind)
- Remain calm in tone and manner (Check your breathing and center through observing your body)
- Reinforce your view/position non-judgmentally (Use a describe versus interpretation) on the situation (Broken record approach)
- Acknowledge the individual's current emotions as valid, not right or wrong (Validation)

Difficulty controlling and/or regulating emotional reactions to situations and events.

- Set limits on the behaviour to help contain the situation and behaviours you may find challenging. Return to initial limits you raised and negotiated at the commencement of service provision.

Difficulty identifying and expressing a range of emotions.

When asked "How are you feeling?" the person may respond with "I don't know" or "all good", "bad" or "numb" or "nothing"

- Monitor cues indicating escalating emotions (overly dismissive, tension, raised voice, averting eyes, attacking) and if appropriate observe & describe changes, validate the distress in a non-judgmental manner.
- Discuss with the individual, choices of how to respond/ deal with the situation. (Help review the pros and cons of those choices)

Difficulty identifying and expressing a range of emotions.

- Assist the individual to identify emotional responses (How would you imagine someone would respond if they were happy? Sad? In love? Hurt? Felt Abandoned? Felt Shame?).
- If unable to name an emotion, assist by discussing physiological markers of different emotions experienced by the individual.

Expression of emotions via aggressive outburst or impulsive behaviour (avoid black and white thinking)

- Articulate concern authentically yet non-judgmentally! Articulate your motivation to support the individual and if feeling threatened or fearful of perceived threat you will be unable to fulfil role.
- Obtain advice/ assistance for dealing with difficult situations through colleagues/supervision/client's treating team/public mental health services. Consider natural consequences as opposed to rule driven limits.

Expression of emotions via aggressive outburst or impulsive behaviour (avoid black and white thinking)

- Seek support afterwards even if thought not to be necessary. Self-care is essential to long-term health.
- Acknowledge any immediate triggers in the environment and compare/contrast with positive experiences/successes/adaptions moving towards the best outcome and the 'bigger picture'.
- Encourage the individual to 'test their life view' Stop, take a breath and think about the whole situation not just one part of it and then respond (I wonder if there is a part of this situation not yet seen/considered?).

Behaviours impacting others

Unrealistic demands, making threats to get needs met, omitting segments of information to enhance a particular interpretation of an event.

- Set clear parameters of working collaboratively (reiterate need for collaborative approach as discussed in the first sessions. Re-orientate when needed).

Behaviours impacting others

- Calmly and non-judgmentally review limits exploring potential natural consequences of the specific unhelpful behaviour.
- Clarify and confirm information before responding to it. Validate the trigger for the behaviour, not focusing on the behaviour nor interpreting as good or bad.
- Collaborate with the individual to develop independence and problem solving strategies rather than discussing whether the behaviour is right or wrong.

Behaviours beyond limits of relationships.

Not attending or arriving late to scheduled meetings with people, externalised interpretation of issues with no focus on individual choices.

- Resist any urge to take responsibility for all issues, even if that means potential negative consequences for the individual (If your client arrives late for meeting do not extend the time of the meeting. Meeting concludes at scheduled time).

Behaviours beyond limits of relationships.

- Reiterate parameters of working collaboratively as discussed in the first sessions. Calmly and non-judgmentally review these limits, and potential natural consequences of unhelpful behaviour.
- Clarify and confirm information before responding to it. Describe the links leading to the behaviour, not focusing on the behaviour nor interpreting the behaviour as good or bad.

Behaviours beyond limits of relationships.

- Positively reinforce any approach by the person to take steps in the direction of working towards change (i.e. – offer praise, spend some quality time together, show more warmth).

DOCUMENTATION

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Documentation

- Professional and legal responsibility
- Ensures accountability and adherence to practice standards
- Legal evidence of the episode of care provided by a health worker or community service for a consumer
- Essential communication technique between health professionals
- Is there to review critical incidents if they should occur
- Provides an insight into your contact with a consumer for others to provide further support to your consumer should you no longer be able to do so
- Is the end product of health care episode

Principles of Documentation

- Basic Elements present:
 - ▣ Time
 - ▣ Date
 - ▣ Program Name
 - ▣ Who was there and professionals involved in care?
 - ▣ Where was the episode of care provided?
 - ▣ Your name and role within the program
- Logical and easy to read

Principles of Documentation

- Only use organisational approved abbreviations
- Be relevant to your role and document facts not judgments or opinions outside your role
- Be factual and document what has occurred or was observed. NO GUESSING!
- Maintain continuity in documentation with consideration of previous episodes of care
- Don't wait to the end of your shift or the next day to document

Principles of Documentation

- Privacy & Confidentiality - Who should have access to information? Be aware of organisational policy!
- First hand accounts! If you are documenting for someone else say so in your notes
- Document whether consumer followed through on last session's plan and make a new plan going forward

Principles of Documentation

- Be careful of having a negative or bias attitude
- No value judgments! Stick to the facts. Quote when needed to make a point. Don't speculate!
- Avoid vague language
 - "appears"
 - "apparently"
 - "somewhat"
 - "I think"
 - "I am not sure"
 - "doesn't appear"

Principles of documentation

- Avoid using words that imply errors have been made
 - "Mistake"
 - "Accidentally"
 - "unintentionally"
- Quality over quantity
- Consistent review of documentation (peer review, supervision, management, documentation working party)
- Make time to explore difficulties with documentation
- Develop effective systems

Questions to ask yourself

- ❑ Does my treatment plan accurately reflect the identified service I am providing?
- ❑ Have all stakeholders involved been informed?
- ❑ Are interventions targeted and specific?
- ❑ Do the goals for care include consumer/carer wishes?
- ❑ If I wasn't to return to work could someone take over this consumer's care?

Questions to ask yourself

- ❑ Have I made judgments or stuck to the facts?
- ❑ Do my notes flow? Are they consistent?
- ❑ Did the consumer complete tasks outlined in last session's plan?
- ❑ Who needs to do what before the next appointment?
- ❑ What would the court/lawyers/consumer/my supervisor think if they read my notes?

Consider the law!

- ❑ Knowing how to chart reduces risk of liability
- ❑ If it wasn't documented it didn't happen!
- ❑ If you forget to chart something and need to make a late entry do so. Include date of care and date of note.
- ❑ Never alter notes. If you make an error you need to put a line through the error and sign to acknowledge the error. Don't leave blank lines!

Consider the law!

- Always document according to care plan and service that is to be provided. In legal disputes you will be questioned on how close the care you have given is correlated within the service brief and planned care.
- Your professional experience is not relevant. Your job description is more relevant and the expectation is you provide services relevant to your employed role

Consider the law!

- Don't chart in advance! Stay in the present moment and document what is happening now.
- Having someone else document for you is illegal
- Avoid putting any information about staff conflicts or disputes about decisions for treatment in consumer's notes. There are other avenues for this
- Be familiar with program policy

SO LETS SUMMARISE!

WHAT WORKS?

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What Works!

- Understanding BPD/Emotion Dysregulation
- Clinicians with certain skills & Qualities
- Dialectics
- Setting Limits, Guiding Practice & Open Discussion
- Teaching Life Skills
- Validation
- Gaining Commitment
- Knowing what's missing & improving service delivery
- Field Mentoring
- Supporting Clinicians
- Supported Decision Making

THANK YOU FOR YOUR
PARTICIPATION 😊

ANY QUESTIONS?
