Personality Disorder
Integrated Care Pathway
(PD–ICP)

6: Psychosocial Interventions

July 2015
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The NHS Highland Personality Disorder Service will coordinate future reviews and updates of this document.

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Contents

6 Psychosocial Interventions
  6.1 Introduction .................................................................................................................................
  6.2 General psychosocial interventions .............................................................................................
  6.3 Specific psychosocial interventions ..............................................................................................
  6.4 Interventions with a primary focus on Phase 1 ...........................................................................
      6.4.1 Dialectical Behaviour Therapy (DBT) ..................................................................................
      6.4.2 Systems Training for Emotional Predictability and Problem Solving (STEPPS) ..................
      6.4.3 Cognitive Behaviour Therapy for Personality Disorder (CBTpd) ......................................
      6.4.4 STAIRWAYS (follow-on group from STEPPS) ..............................................................
  6.5 Interventions with a primary focus on Phase 2 ..........................................................................  
      6.5.1 Dialectical Behaviour Therapy—Prolonged Exposure (DBT-PE) ........................................
      6.5.2 Eye movement desensitisation and reprocessing (EMDR) ..............................................
      6.5.3 Trauma Focused Cognitive Behavioural Therapy (tfCBT) ..............................................
  6.6 Interventions with a primary focus on Phase 3 ..........................................................................  
      6.6.1 Occupational Therapy (OT) ...............................................................................................  
      6.6.2 CAS Day Service for People with Personality Disorder ...................................................
  6.6.3 Vocational Support Service .....................................................................................................

References ............................................................................................................................................
6. Psychosocial Interventions

6.1 Introduction

In the past, personality disorder has often been deemed untreatable and patients have been excluded from services on that basis. However, over the past 20 years, several treatments have demonstrated benefit in the treatment of personality disorder. The greater part of the work has focused on borderline personality disorder, probably because of the often dramatic presentations, high demand on services, and elevated suicide rates of people with the condition. However, some studies have looked at other specific personality disorders with some success. For example, there is some evidence that that Cognitive Behavioural Therapy (CBT) may be of value in the treatment of avoidant personality disorder.

All treatments which have been demonstrated to be beneficial for personality disorder are forms of psychosocial intervention. Despite a significant body of work, there has been no robust experimental demonstration that any other form of treatment (including medication) is of significant benefit in the treatment of the condition.

A psychosocial intervention can be defined as any intervention that emphasizes psychological or social factors rather than biological factors. Psychosocial interventions can be taken to include specific psychological therapies, such as Dialectical Behaviour Therapy (DBT), and more general interventions, such as crisis planning, problem-solving training and psychoeducation.

All psychosocial interventions for personality disorder should be concordant with, and informed by, the concepts described in the General Principles Section of this document, namely:

- Recovery
- General treatment strategies of:
  - Collaboration
  - Consistency
  - Motivation
  - Validation
  - Self-knowledge and self-reflection
- Stages of change model
- Phase-based treatment
  - **Phase 1: Stabilisation (Making Stable):** this phase, with a primary focus on the present, deals with safety, containment and promotion of self-regulation and control.
  - **Phase 2: Exploration and Change (Making Sense):** this phase, with a primary focus on the past, can commence once stabilisation occurs, even temporarily. The aim is to identify and make changes to the factors which underlie the unhelpful behaviours. This phase can involve dealing with the effects of trauma and dissociation; treating self and interpersonal problems; and treating maladaptive traits.
  - **Phase 3: Integration and Synthesis (Making Connections):** this phase, with a
primary focus on the future, is not so much about changing existing psychological and interpersonal structures and processes as putting new ones in place. The aim is to promote a more integrated sense of self and a healthier interpersonal environment — this may include new leisure activities, occupational/educational activities, new roles and relationships.

- Matched care

The psychotherapies for personality disorder which have evidence of effectiveness are largely derivatives of either psychodynamic approaches, or cognitive-behavioural approaches, although some have features of both. Within NHS Highland, the specific psychosocial interventions available are primarily cognitive-behavioural in orientation. For example, STEPPS and DBT, the two main Phase 1 treatments for borderline personality disorder available in NHS Highland, are cognitive-behavioural treatments.

6.2 General psychosocial interventions

This represents a very broad category of interventions which are of value across different conditions and will not be specific to the treatment of personality disorder. It is beyond the scope of this document to attempt to make a list of general psychosocial interventions, but examples include crisis planning, problem-solving training, emotion regulation training and psycho-education of various kinds. The category of general psychosocial interventions also includes recovery and relapse-prevention planning (for example, the Wellness Recovery Action Plan or (WRAP). As stated previously, it is important that any interventions used are coherent with, and informed by, the concepts described in the General Principles Section of this document and fit within an overall psychologically-informed formulation and treatment plan.

Crisis planning is of particular importance in personality disorder and should be considered early in any treatment process. When people with personality disorder experience intense emotions, their ability to think clearly is reduced, often even more than for other people. Hence a crisis plan can be invaluable, with options and contacts for dealing with a crisis situation readily available. Although a crisis plan may be produced in collaboration with a clinician, it necessarily remains the patient's document. However, clearly it is likely to be useful for the patient to share copies with relevant people. Examples of crisis self-management plan templates can be found in the Appendix.

6.3 Specific psychosocial interventions

Specific psychosocial interventions are interventions which have been specifically developed for the treatment of personality disorder. These interventions should be delivered in a phase-appropriate manner as part of an overall treatment package. It is important to recognise that no one intervention on its own represents a comprehensive treatment for personality disorder.

Review of the treatments for personality disorder with evidence of effectiveness reveals that the different approaches have some features in common. The principal factors are listed in the Borderline Personality Disorder NICE Guideline and include:

- having an explicit and integrated theoretical approach used by treatment team and therapist and shared with the patient
- provision for appropriate therapist supervision
- clear structuring of care
• being relatively longer term (NICE guidelines suggest interventions of less than 3 months should be not used to treat personality disorder unless the short intervention forms part of a longer term treatment plan. This is in part because emotional dysregulation associated with perceived abandonment is likely when a treatment ends and a shorter treatment is unlikely to provide the opportunity to learn the skills needed to self-regulate effectively).

All specific psychosocial interventions should be delivered by professionals with the appropriate training, experience and competencies. Given the challenges of working with people with personality disorder, appropriate supervision is crucial. The intensity, frequency and form of the supervision required is likely to vary from intervention to intervention. For example, the clinicians delivering an extensively manualised treatment such as STEPPS may benefit from brief post-group peer supervision between skills trainers, multidisciplinary discussion at CMHT meetings, and discussion within usual clinical supervision. However, at times, certain challenging issues may arise which may warrant additional supervision. Some more intensive interventions like Dialectical Behaviour Therapy (DBT) have scheduled weekly supervision built into the treatment model.

While psychosocial interventions should as far as possible be delivered according to the protocols upon which evidence of benefit is based, it is recognised that rurality and remoteness may sometimes make this impossible. In these situations, a flexible, pragmatic approach is advised. For example, it may be reasonable to consider delivering the STEPPS materials to a patient on an individual basis if attendance at a group is impossible. However, in such a case, it should be made clear that the intervention which is being delivered is not STEPPS per se, and consideration needs to be given to the treatment frame and related factors. The Personality Disorder Service is available for consultation as required.

While it is acknowledged that some interventions may address more than one phase of treatment, for the sake of clarity, the interventions commonly available in NHS Highland are listed below under the phase of treatment which represents the usual primary focus. The description for each intervention attempts to answer four questions:

• What is it?
• Who is it for?
• Who is it not for?
• How can it be accessed?

Each Intervention is on a separate page to simplify printing.

6.4 Interventions with a primary focus on Phase 1

Most of the evidence base for the treatment of personality disorder relates in particular to borderline personality disorder. Perhaps understandably, given the dramatic, resource intensive and risky presentations associated with marked emotional and behavioural dysregulation, almost all the published literature for borderline personality disorder describes interventions with a focus on Phase 1 (stabilisation).

While stabilisation is of paramount importance, it should usually be regarded as a means to enable the subsequent phases of treatment to take place and not as an end in itself. Clinical experience suggests that if subsequent phases of treatment are not undertaken when necessary, relapse to previous unhelpful patterns of behaviour is likely, impeding the patient's
recovery. As explained in more detail in the General Principles Section, subsequent phases of treatment may not always require formal input from mental health services and may be worked through by the person using their own personal and interpersonal resources. For example, a person with emotional and behavioural dysregulation but without a significant trauma history may attain sufficient behavioural and emotional stability from completion of the STEPPS program to allow meaningful reflection on, and changes to, longstanding patterns of behaviour. This might mean that the person recognises that lack of structure and meaningful use of time had helped to maintain their difficulties in the past. They may decide to join new social groups and enter employment (Phase 2). The improved interpersonal and social landscape which results may contribute to an improved sense of self and connection to their family, friends and wider society, reducing the likelihood of future relapse, distress and dysfunction (Phase 3).
6.4.1 Dialectical Behaviour Therapy (DBT)

**What is it:** DBT is a structured intensive CBT-based Phase 1, tier 3 treatment for people with severe borderline personality disorder.

Treatment generally lasts for 6 months to 1 year. Each week the patient attends a 2 hour skills training session in which 2 DBT therapists teach skills of mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness. It takes 26 weeks to complete a cycle of the 4 skills modules. Patients often complete 2 cycles of skills training.

In addition to the skills training, each patient attends for 1 hour of individual therapy each week with the same therapist. This involves the patient recording daily emotions, behaviours and thoughts on a diary card which is reviewed in session with a view to enhancing and generalising skills.

DBT is not used as a stand-alone treatment but represents part of an overall care plan. DBT is delivered by the Personality Disorder Service in Inverness, serving the whole of NHS Highland.

**Who is it for:** Individuals with severe borderline personality disorder. DBT is primarily a technology of behavioural and emotional stabilisation and has an evidence base in reducing parasuicidal behaviour and psychiatric hospitalisation. Individuals are required to be on the Care Program Approach for the duration of their involvement in DBT.

**Who it is not for:** Less severe forms of borderline personality disorder (consider STEPPS). Personality disorders without a severe borderline component. Patients who pose risks which are unmanageable in a community group setting.

**How can it be accessed:** In NHSH, the DBT program is a specialist service. Referrals are taken from secondary and specialist mental health services. The PDS encourages contact to discuss possible referrals.
6.4.2 Systems Training for Emotional Predictability and Problem Solving (STEPPS)

**What is it:** STEPPS is a highly manualised, tier 2, CBT-based skills training program with a systems component for people with borderline personality disorder and traits. The principle focus is on Phase 1 (stabilisation). STEPPS was originally developed as an add-on to usual treatment rather than a stand alone treatment. Treatment lasts for 20 weeks. During that time the individual attends a weekly 2 hour skills training session in which 2 STEPPS skills trainers teach skills addressing a broad range of difficulties associated with borderline personality. Individuals are given specific homework each week related to the topic of the session and they are also asked to record situations of high emotional intensity. The first half of each session comprises a review of homework and new skills are taught during the second half.

Significant others are involved as part of the reinforcement team and are given recommendations on how to respond to the person with BPD in a situation of emotional intensity. Participants should ideally also have an individual skills reinforcer with whom they should meet weekly — this can be anyone with some knowledge of mental health issues for example a GP, CPN, mental health social worker etc. The idea is that the participant brings the homework to the reinforcer, explains that week’s topic and discusses any problems, in much the same way that a child asks for help with school homework from a parent. The individual skills reinforcer and the significant others make up the reinforcement team. A session for members of the reinforcement team is usually offered early in the 20 week program.

**Who is it for:** Individuals with moderate borderline personality disorder and or borderline features. Severely behaviourally dysregulated individuals are more likely to benefit from the more intensive DBT.

**Who is it not for:** People who do not fulfil criteria for borderline personality disorder or experience borderline features. Patients who pose risks which are unmanageable in a community group setting.

**How can it be accessed:** Each CMHT runs its own STEPPS group and referral of possible candidates should the made to the CMHT.
6.4.3 Cognitive Behaviour Therapy for Personality Disorder (CBTpd)

**What is it:** CBTpd is a modified individual cognitive behaviour therapy for individuals with personality disorder. It primarily focuses on Phase 1 (stabilisation) and 2 (making sense) but there may be some work on Phase 3 (making connections) for some patients. Treatment typically lasts for 30 sessions over a period of one year, which is a longer course of treatment than in standard CBT. There is more of an emphasis on a developmental perspective than in standard CBT and a written narrative formulation is developed with the individual early in the therapy process. Early treatment targets include behavioural stabilisation, especially of harmful behaviours. Later phases of treatment attempt to reduce other overdeveloped behaviours and increase underdeveloped behaviours. Cognitive work focuses on the level of core beliefs rather than at the level of automatic thoughts as in standard CBT.

**Who is it for:** Individuals with personality disorder, although best evidence is for borderline personality disorder. Individuals who are unable to benefit from a group based treatment, for example people with hearing impairment, may also find CBTpd more suitable.

**Who is it not for:** People who do not fulfil criteria for personality disorder.

**How can it be accessed:** CBTpd availability within the PDS is currently limited but referrers can contact the PDS or locality Clinical Psychologist/CBT therapist to discuss the possibility of this intervention for particular patients.
6.6.3 STAIRWAYS (follow-on group from STEPPS)

**What it is:** STAIRWAYS is a one-year long, twice monthly advanced group program developed for clients with borderline personality traits and disorder who have completed the 20-week STEPPS program. The reduction in frequency from the weekly STEPPS program is designed to encourage group members to seek out non-therapy activities between meetings. Each session lasts for 2 hours. New participants are able to join the group at frequent intervals as opposed to STEPPS which runs as a 20 week closed group.

The program, which is cognitive-behavioural in orientation, reinforces and expands on the skills learned in STEPPS with the aim of improved management of emotional intensity. There is also an emphasis on the application of the new skills to specific goals and challenges in the occupational, educational, recreational and interpersonal domains. The primary focus of STAIRWAYS is on enhancing Phase 1 emotion regulation skills, although there is increased focus on Phases 2 and 3 compared with STEPPS.

**Who is it for:** Individuals with moderate borderline personality disorder and traits (perhaps in early remission) who have completed STEPPS and are relatively behaviourally stable.

**Who is it not for:** People who have not completed STEPPS. People who are significantly behaviourally dysregulated.

**How can it be accessed:** STAIRWAYS is currently offered within the Inverness CMHT on a limited basis only.
6.5 Interventions with a primary focus on Phase 2

People with personality disorder will often have a history of abuse. Around three quarters of people with borderline personality disorder will have recallable abuse and about half of people with BPD will meet criteria for post-traumatic stress disorder (PTSD). Some have suggested that those people exposed to repeated, expected trauma which is perceived as inescapable, can develop a condition known as complex PTSD. Although this disorder is not specifically described in ICD-10 or DSM-5, it is frequently written about in mainstream journals. Its diagnostic criteria are similar to borderline personality disorder and treatment approaches are similar, although the evidence base is much smaller. The clinical utility of separating these conditions is unclear.

Eye Movement Desensitisation and Reprocessing (EMDR) and Trauma-focused Cognitive Behaviour Therapy (tfCBT) have been included in this section because of the high rates of PTSD in the personality disorder patient group. However, strictly speaking, they are not personality disorder-specific interventions, but were developed for people with PTSD (with or without personality disorder).

Although Phase 2 treatment will often concern post-traumatic problems, sometimes the work will deal with other difficulties in long-standing patterns of behaviour and thinking.

Integration or “joining-up” of the different phases of treatment in a timely manner is crucial. The commencement of phase 2 treatment should occur when the patient is “stable enough”. Although each decision should be made on a case by case basis, the criteria used to determine readiness for trauma work within the DBT-PE protocol provides a reasonable guide:

- Not at imminent risk of suicide (by next month or by next session)
- No life-threatening behaviour for a period of 2 months or so
- Ability to control life-threatening behaviours in the presence of cues for those behaviours
- No serious therapy interfering behaviour
- Trauma work is the patients highest priority treatment target
- The patient wishes to engage in the work at this point
- Ability and willingness to experience intense emotions without escaping

Very often, progression through phases is not unidirectional and many people will require short periods of restabilisation during later phases of treatment.
What is it: DBT is a structured intensive CBT based Phase 1, tier 3 treatment for people with severe borderline personality disorder.

Treatment generally lasts for 6 months to 1 year. Each week the patient attends a 2 hour skills training session in which 2 DBT therapists teach skills of mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness. It takes 26 weeks to complete a cycle of the 4 skills modules. Patients often complete 2 cycles of skills training. In addition to the skills training, each patient attends for 1 hour of individual therapy each week with the same therapist. This involves the patient recording daily emotions, behaviours and thoughts on a diary card which is reviewed in session with a view to enhancing and generalising skills.

DBT is not used as a stand-alone treatment but represents part of an overall care plan. DBT is delivered by the Personality Disorder Service in Inverness, serving the whole of NHS Highland.

Around half of patients with borderline personality disorder will also meet diagnostic criteria for post-traumatic stress disorder. Once stabilisation has occurred with standard DBT, it may be appropriate to consider using the DBT-Prolonged Exposure (DBT-PE) protocol for Phase 2 of treatment (trauma work).

DBT-PE is an integration of DBT and standard Prolonged Exposure (a CBT approach with an evidence base for treating PTSD). DBT-PE is delivered within the individual component of DBT. The sessions will typically last 90 minutes to 2 hours, compared with the 1 hour sessions of the standard DBT individual component.

The two main components of DBT-PE are imaginal exposure and in vivo exposure. Imaginal exposure involves the patient voicing the narrative of relevant past traumatic events and listening to recordings of the narrative between sessions until habituation to the associated emotion occurs. In vivo exposure involves the construction of a hierarchy of distressing situations which are avoided because of past trauma events and exposure to the distressing situations. The aim is habituation to the associated emotions and reduction in behavioural and cognitive avoidance.

DBT-PE is conceptualised as a treatment strategy within DBT and patients engage with all usual components of DBT in DBT for the duration. If behavioural destabilisation occurs during DBT-PE, the treatment focus will return to Phase 1 or standard DBT.

Who is it for: Individuals with severe borderline personality disorder and post-traumatic symptoms. Individuals need to be on the Care Programme Approach for the duration of their involvement in DBT.

Who it is not for: Patients not in DBT.

How can it be accessed: In NHSH, the DBT program is a specialist service. Referrals are taken from secondary and specialist mental health services. The PDS encourages contact to discuss possible referrals. Patients cannot be referred for DBT-PE itself (as opposed to referring for DBT) as it represents a treatment strategy within DBT rather than a standalone treatment in its own right. All patients who are referred for DBT will receive a trauma assessment and DBT-PE will be offered if appropriate.
6.5.2 Eye Movement Desensitisation and Reprocessing (EMDR)

**What is it:** EMDR is a psychological treatment which has been demonstrated by several meta-analyses to be effective in the treatment of post-traumatic stress disorder (PTSD). It is recommended as a first line treatment for PTSD by NICE.

The treatment involves visualisation of traumatic events while experiencing auditory, visual or tactile bilateral stimulation. It is not a treatment specifically for people with personality disorder but was developed for people who experience PTSD. EMDR is listed here given the substantial proportion of people with personality disorder who also meet criteria for PTSD. EMDR represents a Phase 2 treatment.

**Who is it for:** Individuals with PTSD who are sufficiently stable.

**Who it is not for:** Individuals who are not sufficiently stable, especially those who use harmful behaviours to regulate emotional distress.

**How can it be accessed:** Refer via Community Mental Health Team single point of referral. Direct discussion with the person who provides EMDR in the sector might be helpful to facilitate integration of Phase 1 with Phase 2 work.
6.5.3 Trauma Focused Cognitive Behavioural Therapy (tfCBT)

**What is it:** tfCBT is a form of CBT which has been demonstrated by several meta-analyses to be effective in the treatment of post-traumatic stress disorder (PTSD). It is recommended as a first line treatment for PTSD by NICE. tfCBT represents a Phase 2 treatment.

The treatment usually involves imaginal exposure to traumatic memories and real life exposure to avoided situations, together with cognitive restructuring. These procedures can involve narrating the story of the traumatic events within session and listening to recordings of the story between sessions; actively exposing oneself to avoided and feared situations; and challenging unhelpful thoughts which are helping maintain patterns of avoidance. It is not a treatment specifically for people with personality disorder but is listed here given the substantial proportion of people with personality disorder who also meet criteria for PTSD.

**Who is it for:** Individuals with PTSD who are sufficiently stable.

**Who it is not for:** Individuals who are not sufficiently stable, especially those who use harmful behaviours to regulate emotional distress.

**How can it be accessed:** Refer via Community Mental Health Team single point of referral. Direct discussion with the person who provides tfCBT in the sector might be helpful to facilitate integration of Phase 1 with Phase 2 work.
6.6 Interventions with a primary focus on Phase 3

For some people, Phase 1 work (perhaps with some Phase 2 work) will be sufficient to allow Phase 3 to occur without the involvement of services. However, some patients will benefit from a specific intervention to enable meaningful personal, interpersonal and social progress to occur.
6.6.1 Occupational Therapy (OT)

**What is it:** Occupational Therapy is concerned with enabling individuals to live more productive and enjoyable lives in vocation, employment, social interactions and leisure, through the use of purposeful activities.

The occupational therapist usually works as part of a multi-disciplinary team and can contribute to the overall care plan of individuals referred to the team. Each person is assessed individually, goals are identified together and a programme of activities is planned collaboratively. The individual is asked to identify outcomes which are measurable to enable interventions to be evaluated, for example: “I want to be able to join an evening class”, “I will be able to discuss my feelings with my partner”, “I want to be able to do my own shopping and cooking” or, “I want to get an interesting job”. Activity programmes are reviewed regularly and adapted as necessary.

Activity is at the core of occupational therapy practice. If the therapist cannot engage the client in activity that has meaning and value for him, then there can be no meaningful assessment and no treatment implementation. Engagement is achieved by involving the client at all stages of the treatment process, by understanding what will motivate the individual, and by establishing an expectation that clients attending occupational therapy will be active in their own treatment processes. The activity must be purposeful and achievable for the person and take place in settings relevant for that person. Activities can take place on a 1:1 basis, in a group, or in both settings.

**Summary of activity functions:**
- Activity is essential for the normal development of the individual. Without activity no personal development can take place, and inability to perform activities competently leads to a maladaptive development.
- People use activity to explore the environment and to test their own position in it.
- We become embedded in our social and cultural context through activity.
- Activity helps to build a healthy personal and social identity.
- Activity is intrinsically satisfying.
- Activity is used to learn and practice skills that can be used for occupational performance.
- People are able to adapt to changing circumstances through activity.
- The individual can construct purpose and meaning in his life and gratify his needs through activity.
- Relationships with others can be made through shared activity.

**Who is it for:** OT is for anyone who wants to overcome physical, psychological or social problems arising from illness or disability. The person needs to be motivated to identify goals and to engage in activities.

**Who is it not for:** As OT requires active participation for it to be effective, it will not work if the person is not ready to become involved in trying activities.

**How can it be accessed:** OTs work in hospitals and in the community. Within mental health services, they are based in CMHTs (Community Mental Health Teams). A referral from a GP, psychiatrist or other worker is required. Self-referrals can be made in some teams and the person’s GP would be made aware.
6.6.2 CAS Day Service for People with Personality Disorder

**What is it:** The CAS (Coping and Succeeding) Day Service for people with personality disorder is a community-based service which takes place each Friday from 09:30 to 15:30 at Rowans, New Craigs Hospital. CAS Day Service represents a tier 3, Phase 3 (integration or making connections) intervention. The usual length of treatment is 36 weeks. CAS, a co-produced service, has been developed and is delivered by a partnership of the Personality Disorder Service with service users and other stakeholders along Recovery principles. The service is primarily directed at helping an individual make connections with others and society and by doing so, enhance their self-identity, interpersonal and social connections.

CAS has a primary focus on Phase 3 and, to a lesser extent, Phase 2 but it is not an intervention with an emphasis on stabilisation. Other interventions (eg DBT or STEPPS) are more appropriate for stabilisation of harmful behaviours. Furthermore, some individuals, although behaviourally stable, may benefit from Phase 2-focused interventions, for example specific trauma work, before making best use of CAS.

The CAS Day Service includes elements of structured group work, self-directed time and social time. Broad themes covered in the core groups include promotion of physical health and well-being; living skills; self-management; and vocational rehabilitation. These themes are addressed by providing direct information and education; enabling direct introduction to new activities/behaviours; and making and highlighting links between people and services.

In the spirit of co-production, participants have a major role in planning and organising the content of the core groups and the day to day running of the service. Participants develop and work towards their own goals in the interpersonal, occupational, recreational and educational domains.

**Who is it for:** Individuals with personality disorder or personality disorder in early remission (not solely people with borderline personality disorder) who are motivated to make changes and who do not carry current risk issues which would preclude safe placement in a community setting.

**Who is it not for:** People who do not meet the general diagnostic criteria for personality disorder.

People with current risk issues which preclude safe placement in a community setting — for example, people who present a significant risk of violence to others or a significant risk of harm to themselves.

People who are unwilling or unable to usefully work cognitively, affectively and behaviourally, for example people with active substance dependence, brain injury or low weight anorexia nervosa.

**How can it be accessed:** CAS is part of the Personality Disorder Service, a specialist service which accepts referrals from secondary and specialist mental health services. A self-referral option is currently being piloted. New participants can join the group at frequent intervals.
6.6.3 Vocational Support Service

What is it? The Vocational Support Service aims to work in partnership with individuals who have experienced mental health challenges; supporting them on their vocational pathway. The service will help individuals to identify vocational goals and support the steps towards achieving them.

The Vocational Support Team will work individually with people to help explore opportunities such as volunteering, further education, gaining or sustaining paid employment. Support may also include identifying community activities, building self-confidence or improving skills with computers and other technology in terms of preparing people for vocational activities.

Who is it for? The Service is for those individuals, aged 18 or upwards, who have had difficulty gaining or sustaining vocational activities due to mental ill health.

Who is it not for? This service is not for people who do not wish to move forward with vocational goals.

How can it be accessed? The Vocational Support Team has two bases — one in Inverness and the other in Thurso. For more information or to receive a referral form please contact:

Vocational Support Team (Inverness)
Rowans 1
New Craigs
Leachkin Road
Inverness IV3 8NP
Tel: 01463 253 635  Email: nhshighland.vocationalsupport@nhs.net

Vocational Support Team (Thurso)
The Bungalow
Dunbar Hospital
Thurso KW14 7XE
Tel: 01847 896 831  Email: heather.jappy@nhs.net
References


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