10.1 Borderline personality disorder (BPD) management plan template

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 (✓/x)

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)[162]

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.