Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
HUMBER DBT SERVICE

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1.0	*5 April 2023*	*New SOP. Approved at Mental Health Division Practice Network (5 April 2023).*

Contents

1. INTRODUCTION

The Humber Dialectical Behaviour Therapy (HDBT) service provides comprehensive DBT, an approach the National Institute for Health and Care Excellence (NICE) recommends considering for women with a diagnosis of Emotionally Unstable Personality Disorder (EUPD) for whom reducing recurrent self-harm is a priority.

Our direct treatment (i.e. treatment involving direct contact between HDBT and a patient) reflects a comprehensive programme comprising the four typical modes of DBT in the following forms:

- Weekly skills training group of up to 64 weeks duration (group treatment)
- Individual therapy sessions with a DBT therapist of up to 46 in number to be used flexibly (individual treatment)
- Skills coaching to enhance generalisation of DBT skills to daily life.
- Weekly Consultation meeting of HDBT clinicians to provide peer supervision and support.

HDBT employs a stepped care model such that patients typically enter group treatment initially, with patients only progressing to individual treatment if this is required following a period of group treatment.

Humber Teaching NHS Foundation Trust ('the Trust') has a policy regarding waiting times and waiting lists that states the interests of patients should be the guiding principle of the management of waiting times. HDBT's approach to managing waiting times and waiting lists is underpinned by this statement, and the wider principles of that policy, namely:

- An acknowledgment of the potential unhelpful effects of waiting for treatment on an individual's mental health and functioning.
- That short waiting periods can support the provision of routine and more urgent care.
- That HDBT will strive to keep waiting times to a minimum.
- That HDBT will monitor waiting times to identify and address decisively any emerging problems that may adversely affect waiting times.

HDBT's approach to managing waiting times and waiting lists is also underpinned by principles and ideas from the DBT model such as:

- **Behavioural specificity-** a focus on specific, definable behaviour, rather than subjective labels.
- **Reinforcement-** a desire to reduce outcomes that may increase harmful behaviour, and increase outcomes that may increase adaptive behaviour.
- **Consultation to the patient-** patients are not treated as 'fragile' and are encouraged to act on their own behalf.

- **Observing limits-** all individuals, and services, can be seen to have their own limits of what they will accept, which will differ between different individuals and services. Limits are however able to be broadened or narrowed dependent on the context, thus allowing flexibility.
- **Consistency agreement-** consistency between professionals and services is not seen as required, difference and change is an opportunity to learn how to operate within a world where inconsistency and change is inevitable.
- **Effectiveness-** a commitment to do what is effective for meeting goals, even where this is difficult and may have associated costs.
- **Dialectics-** a recognition that there is no 'one truth' and that there are multiple perspectives on any issue and multiple options for solving problems.
- **Being principles-driven-** rather than all elements of the service being managed within fixed rules, principles drive many of the service's functions, allowing flexibility.

2. SCOPE

This Standard Operating Procedure (SOP) sets out how HDBT manages the process of referral, waiting and treatment. It applies to treatment delivered in inpatient and community settings to patients who have been identified as potentially requiring the involvement of HDBT.

Application of the Trust's Waiting Lists and Waiting Times policy principles will ensure that each patient's journey is managed fairly and consistently in accordance with an agreed structured methodology. Treatment decisions will be fair and transparent. This translates into the adoption of the following key principles:

- Referrals will be accepted on the basis of clinical priority, and subsequently managed in chronological order, subject also to operational limitations and requirements.
- Patient choice will be facilitated where appropriate and possible.
- Patient consultation, referral and treatment will be defined by the service specification as agreed with commissioners where applicable.
- Management of patients will be fair, consistent and transparent. Communication with patients and/or carers will be clear and informative, and decisions taken regarding treatment will be based first and foremost on clinical need, which will be agreed within a robust multi-disciplinary approach.
- Patients will be seen at a local base anywhere in the Trust if this is their preference and deemed appropriate to need, and operational capacity allows. Due to operational limitations, group treatment is provided in a central location in the Trust with extensive transport links only. HDBT will support patients in considering how problems arising as a result of this may be overcome, and commits to monitoring referrals such that group treatment may be provided in other localities if there is sufficient demand.

3. DUTIES & RESPONSIBILITIES

The Board of Directors

The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for clinical risk assessment and management.

Chief Executive

The Board of Directors delegates to the chief executive the overall responsibility for ensuring the trust employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

Service Managers/Matrons

Service managers and matrons are responsible for:

- Familiarising themselves with the scope of this SOP.
- The dissemination of this SOP to their teams.
- Identifying the training needs of their staff in relation to this SOP.
- Releasing staff to attend for relevant training.
- Facilitating and offering support to staff working with patients presenting with self-harm and suicidal behaviour.

All Clinical Staff

All staff who work with patients should have a basic understanding of the potential relevance of DBT to the patients they support and the ways this can be accessed.

All staff working with patients should familiarise themselves with the scope of this SOP.

4. HOURS OF OPERATION

For routine and administrative enquires, the service operates Monday to Friday, 09.00-17.00.

Skills coaching to patients may extend beyond these hours and days, and may be provided by telephone, text messaging, or email, depending on clinician and patient preference. Skills coaching is not an ‘on call’ system or a substitute crisis or emergency provision; patients may be required to wait several hours for a response and the function of skills coaching is to consult to the patient about what DBT skills they can use in any given real-life situation. Patients are informed of alternative sources of support should a response not be timely to meet their needs, and the expectation that they access such alternative support where required is also made clear. Availability and use of skills coaching is at the discretion of each individual therapist and may differ between therapists, patients, and for the same patient at different times. Limits of this will be based on the therapist’s clinical opinion and communicated clearly to the patient.

Scheduling of treatment sessions will typically be Monday to Friday, 09.00-17.00, with some flexibility to respond to patient need outside of these hours where mutually agreed.

5. WAITING LIST MANAGEMENT AND EXCEPTIONS

HDBT aims to minimise the length of its waiting list. This aim is underpinned by awareness of the following, which also reflect the principles of the Trust's waiting times policy:

- Prolonged waiting times for direct DBT treatment for patients for whom reducing recurrent self-harm is a priority (as per NICE guidelines) may lead to significant deterioration whilst waiting, with a heightened risk of serious injury and/or death. Such waiting times can also lead to an absence of other intervention from other services during the wait between referral and treatment from HDBT.
- Historically, prioritisation has been requested for higher risk patients waiting for direct treatment, lengthening the waiting time for patients with lower levels of risk. This long and often unpredictable wait for lower risk patients may lead to them experiencing detrimental effects on their mental health.
- The detrimental impacts of such waiting times for patients for whom reducing self-harm is not the priority (e.g. where risk is lower) can be reduced by having a referral process that encourages consideration of alternative appropriate treatment approaches to direct DBT that may also meet the patient's needs.

In addition, whilst HDBT believes all patients can, in theory, benefit from direct DBT, there is a local discrepancy between service capacity and the number of patients presenting with self-harm or suicidal behaviour. The time and resource intensive nature of DBT enables a degree of flexibility and focus well-suited to working with high risk patients presenting with recurrent crises, whose mental health may not be considered stable enough to engage in other therapies, or who may struggle to engage with other therapies.

With these issues in mind, HDBT's referral process is designed to maximise timely access to direct DBT for such patients, whose behaviour presents the highest risk to life. In addition to being informed by Trust policy, this approach is based on the service's previous experience of operating a lengthy waiting list, consultation with other DBT providers at accredited training, and the external supervision provided to HDBT by an international DBT trainer.

5.1 Referral Criteria

DBT is a principle-based treatment and this is reflected in HDBT's referral criteria for direct treatment. Whilst HDBT has some fixed referral criteria, criteria related to the level of risk required for referral acceptance are not fixed, and are intended to be flexibly amended by the service at its discretion to effectively manage the balance between capacity and demand, underpinned by the principle above of maximising access to direct DBT for those for whom reducing recurrent self-harm is the priority and who present with the highest levels of risk.

Current fixed referral criteria are:

- The patient must not be currently engaged in another therapy, or in regular meetings with a psychological practitioner or therapist (unless as part of an assessment process e.g. inpatient assessment, mental health assessment). If they are, this must end in order to commence DBT.
- The patient must meet at least 5 of the 9 criteria for a diagnosis of Borderline Personality Disorder as outlined in the Diagnostic and Statistical Manual (DSM) IV. A diagnosis itself is not required.
- The patient must have a named clinician/access to duty from a mental health division community mental health service or similar within Humber Teaching NHS Foundation Trust, who takes responsibility for any issues that occur that require follow-up, for example but not limited to safeguarding investigation, onwards referrals due to risk to self or others, liaison and follow-up from unplanned care, access to medication reviews. Each circumstance will be assessed on a case-by-case basis.
- If the patient is not being referred to HDBT by their care co-ordinator/case manager, the care co-ordinator/case manager has been consulted and agrees with the referral, or if a care co-ordinator/case manager is not yet allocated, the clinical lead of the relevant community service has been consulted and agrees with the referral to HDBT.

DBT emphasises the importance of being behaviourally specific when describing a person's behaviour. This principle is reflected in the HDBT referral criteria for direct treatment, which represent a behaviourally specific approach to the definition of 'high risk', by asking patients to state how many times certain specific behaviours have occurred over a defined time period. These behaviours are:

- Behaviours with intent to end own life
- Behaviours with intent to cause non-suicidal self-harm
- Behaviours in preparation to cause non-suicidal or suicidal harm
- Admissions to mental health hospital
- Detention on section 136
- Contacting mental health advice and support team
- Having contact with mental health liaison service at hospital
- Going to emergency department to maintain safety or due to harm caused to self
- Contacting the community team between planned appointments due to difficulties maintaining own safety
- Having thoughts or urges to harm self or end own life

Numerical values have been assigned to each behaviour, with higher numbers reflecting higher risk to life or difficulties (for example, a suicide attempt is given greater value than a suicidal thought, and a hospital admission is given a greater value than

a call to the Community Mental Health Team (CMHT)). The numerical values for each type of behaviour are totalled for the patient, and compared to a referral threshold number which is flexibly altered to manage the balance between capacity and demand. Detailed up-to-date guidance (e.g. definition of terms) is available on the HDBT intranet page, https://intranet.humber.nhs.uk/dialectical-behaviour-therapy-service.htm .

The service may accept referrals that do not meet the current referral criteria, where it is considered that clinical need justifies this.

5.2 Mitigating reduction in access to direct DBT for patients not meeting referral criteria

HDBT regrets that the chosen referral strategy will mean that some patients who present with self-harm or suicidal behaviour, and/or a diagnosis of EUPD, may not be eligible for referral to HDBT for direct treatment at certain times, and that had they been, they may have benefitted from direct DBT treatment. In order to mitigate this impact, where capacity allows, the service commits to offering the following steps of a stepped care model for such patients:

- Providing regular training via the Trust training diary, accessible to all clinicians, on DBT principles, such that these can be incorporated into the work of other clinicians.
- Working with the wider Complex Emotional Needs Service (CENS) to deliver the Humber Family Connections Programme, which aims to support and teach skills to the supporters of individuals who experience emotion dysregulation, which may indirectly benefit the patient themselves.
- Providing ad-hoc consultation and supervision for clinicians who wish to incorporate DBT principles into their work.
- Orient clinicians to the availability of other established consultation forums which may support the development of formulation-driven care and identify other therapy options that may be appropriate for patients.

HDBT accepts responsibility for the potential impact of our model on some patients and is open to requests to be involved in communicating with patients where a referral for direct treatment has been declined or not been made due to a patient not meeting the referral criteria to explain the rationale for this.

HDBT's development of the stepped care model described throughout this SOP represents our most recent attempt to increase HDBT's capacity and efficiency; it has enabled a reduction in time without treatment from referral to, typically, a maximum of nine weeks, compared to several months in the past. HDBT commits to continuing to work with all stakeholders to explore initiatives to increase capacity further such that more patients potentially suitable for direct DBT treatment can access this with HDBT.

5.3 Referral and Triage Process

Referral to HDBT for direct treatment is via a questionnaire that can be found on the HDBT intranet page. This has sections for both the patient and referrer to complete. This should be sent to hnf-tr.humberdbt@nhs.net and uploaded to Lorenzo by the

referrer, alongside an electronic referral to ‘Humber DBT’. The patient should have a completed and up-to-date cluster and FACE risk assessment.

Prior to referral we would encourage potential referrers to check the up-to-date referral criteria on the HDBT intranet page. If the referral is for a patient who does not meet the current referral criteria, or indirect support is being requested, clinicians should email hnf-tr.humberdbt@nhs.net to arrange a suitable time to discuss this, including the patient’s name and NHS number where applicable. HDBT will not pursue contact with clinicians who do not reply to return emails from HDBT about potential referrals or queries about indirect treatment.

Received referrals and queries are aimed to be reviewed within 7 working days. The outcome of any referral will be communicated to the referrer (and care co-ordinator/case manager/clinical lead where they are not the referrer).

In line with DBT theory and principles, and practice elsewhere in the UK, HDBT may decline treatment to a patient whose risk has significantly increased to the extent they meet the referral criteria for direct DBT treatment with HDBT, subsequent to a documented conversation with a professional about the necessity for risk/degree of risk required for referral at a time they did not meet the criteria. This is to avoid HDBT and its processes inadvertently reinforcing increasing high-risk behaviour. In such cases, alternatives may be offered. This does not prohibit professionals from acknowledging the existence of the DBT service, or having a conversation about referral, nor is there a suggestion any clinician would discuss this with the intention of increasing a patient’s risk, but instead seeks to avoid the chances that awareness of the level of risk required for a referral deliberately or inadvertently leads to a patient’s risk increasing. Whilst professionals are ultimately required to make their own decision, this approach is informed by ideas from trauma-informed care that mental health services should attempt to avoid iatrogenic harm wherever possible, and HDBT will seek to ensure it does so by adhering to this process.

Patients whose referral is accepted will be added to a waiting list for a single screening appointment, to take place before the next group treatment intake point where possible, at which mutual expectations, goals, appropriateness of DBT, and outcome measures will be addressed. HDBT will make contact with the patient to arrange the screening appointment. If doing so by telephone, if HDBT have been unable to contact the patient within 7 days, an appointment letter will be sent to the patient. If a patient does not attend (DNAs) or cancels the initial screening appointment, the therapist will attempt to rearrange by telephone. If this is not possible within 7 days, a letter advising the patient to contact HDBT within 14 days will be sent. If no contact is received, the patient will be discharged from HDBT. If the patient DNAs or cancels a second screening appointment, they will be discharged from HDBT.

If direct DBT treatment is not offered following the screening appointment, alternatives may be offered in line with the stepped care model. Re-referral for direct DBT treatment would be permissible and considered on a case-by-case basis, though in the event of a third referral for a patient who has not been offered direct DBT treatment after two previous referrals, a period of 26 weeks should ordinarily have elapsed between the second screening appointment/discharge and any subsequent referral, and between any other subsequent screening appointments and referrals. This is also

applicable to patients who are discharged following non-attendance of screening appointments. If direct DBT treatment is considered appropriate, the patient will be added to the group treatment waiting list for commencement at the next available group intake date. The waiting list management procedures being implemented mean this should typically be no longer than 9 weeks post-referral, unless the patient expresses a wish for an alternative start date or is required to wait to enter a specific group day chosen by them. The patient will also be added to the individual treatment waiting list at this point. Patients may be offered a defined 'contracted' time period of group intervention initially (e.g. 32 weeks) with an offer of further treatment contingent on commitment. This is informed by DBT practice in other services and principles of reinforcement, with the intention that patients who want to continue with direct DBT will commit sufficiently to the group, thus maximising the chance of therapeutic benefit. Not attending 4 consecutive sessions ('4 week' rule) would result in discharge and removal from all other HDBT waiting lists, however attendance contingencies may be altered at the service's discretion in collaboration with the patient for therapeutic benefit at any time; ordinarily these should be discussed in DBT consultation team before being implemented, or if not, afterwards. Group sessions occur on a regular day and time which the patient will be made aware of.

Patients receiving group treatment only are provided with a shared inbox email address and offered support on completing their group homework. Whilst in group treatment only, patients should utilise existing and other services for all other issues (e.g. Mental Health Advice and Support Team (MHAST); duty clinicians at Community Mental Health Team).

If a patient meets their contracted commitments prior to being offered individual treatment, a new contract will be made with the patient if clinically indicated. If the patient has not met their agreed commitments they will be discharged at the point they do not meet them, and will be unable to be referred back to the service for direct treatment until 26 weeks have passed from their point of discharge; they will also be removed from the individual treatment waiting list, and email coaching will no longer be provided.

When a patient reaches the top of the individual treatment waiting list they will be offered (typically 4) pre-treatment appointments with a HDBT therapist. Typically, allocation to therapists will be on a chronological basis though the service may use flexibility where there are clinical or operational reasons to do so.

Patient preference (e.g. location of treatment, gender of therapist) may mean a patient declines an invite to pre-treatment but still wishes to engage in individual treatment. In such circumstances the service will support the patient to consider the pros and cons of the communicated preference, and commits to reviewing its service provision to determine if this preference can be accommodated. If HDBT is unable to accommodate the preference, the patient will be informed why this is not possible, and what HDBT is able to offer. If the patient declines this then the patient will remain on the individual treatment waiting list until their preference can be accommodated. If the preference is not able to be accommodated and the patient does not wish to engage with offered alternatives, the patient would be discharged from HDBT, or allowed to continue with group treatment only if appropriate.

If a patient requests their removal from any waiting list (including the screening waiting list) or discharge from the service, the therapist will discuss this in consultation team, and may agree to close the patient's referral/remove them from the relevant waiting list, or may inform the patient that they can take themselves out of DBT by missing four (or another agreed number of) consecutive sessions of treatment, or by not attending their screening appointments and not rearranging. Already arranged appointments during this time remain open for the patient to attend, depending on the outcome of the discussion in consultation team.

HDBT will accept referrals for patients aged 17.5 years and older, and whilst any patient can attend group treatment, patients will not be eligible for individual treatment sessions until they are 18 years old or greater. For patients referred to HDBT by CAMHS, one of the following should be the case:

- CAMHS should refer directly to HDBT with the agreement that CAMHS will remain involved as case managers/care co-ordinators, regardless of the patient's age, until the point that the patient is either case managed by HDBT, discharged by HDBT, or has a referral accepted to a community team in the mental health division. This is most likely to be appropriate when a young person's needs at referral appear to be able to be met solely by a referral to HDBT as opposed to requiring a community team.
- CAMHS should refer directly to HDBT with the agreement of the mental health division community service clinical lead or allocated adult services worker. This is most likely to be appropriate when a young person is considered to have needs initially beyond the input provided by HDBT.

5.4 Pre-Treatment Appointments

Pre-treatment appointments are used to assess and obtain commitment to individual treatment DBT, construct a target hierarchy of behaviours to focus on and treat in individual treatment, and identify goals, amongst other tasks.

The allocated individual therapist will make contact with the patient to arrange an initial appointment. If attempting to do so by telephone, if it is not possible to arrange the initial appointment by telephone within 7 days of initial contact, a letter will be sent offering a date and time for an initial appointment.

After meeting at the first appointment, subsequent pre-treatment appointments can be arranged and rearranged by communication methods as agreed between the therapist and patient. Where desired, therapists and patients may agree dates and times for all pre-treatment sessions at the initial meeting.

If a patient DNAs or cancels the initial pre-treatment appointment, the therapist will attempt to rearrange this by telephone. If the therapist is unable to do so within 7 days, the patient will be sent a letter advising that they have 14 days to contact the therapist to arrange a subsequent appointment otherwise they will be discharged from all elements of HDBT.

Where attendance is sporadic during pre-treatment, for example repeated DNAs or cancellations, it is likely this will be considered reflective of insufficient commitment to progress to individual treatment. Each therapist will respond according to their clinical judgement, and may choose to flexibly offer pre-treatment where a patient's personal

circumstances limit their engagement at that time. Ordinarily therapists should discuss engagement difficulties during pre-treatment in DBT consultation meeting.

At the conclusion of pre-treatment, the patient and therapist will decide on whether the patient will enter individual treatment. Where there is agreement that individual treatment with HDBT is appropriate, the therapist will make a new treatment contract with the patient, informed by their assessment during pre-treatment. The individual therapist will also offer DBT skills coaching, to help the patient generalise DBT skills into their daily life. At the discretion of each therapist, and with the consent of the patient, text messaging and email may also be used to provide coaching. In such cases therapists are expected to adhere to Trust policy on the acceptable use of electronic communications. HDBT's telephone coaching guidelines for therapists are found in the *Appendix A DBT Telephone Guidelines* which is also shared with patients.

Where patients wish to continue with group treatment only, the therapist may agree to this if the patient has made sufficient progress such that there is an absence of life-threatening behaviour to focus on in individual treatment. Such patients will be removed from the individual treatment waiting list, though can be re-added in future if required, at the place from which they were removed. Where individual treatment is not considered appropriate (e.g. due to insufficient commitment despite presence of continued high risk) and the patient does not remain appropriate for group treatment only, the patient will be discharged from all aspects of HDBT, and be unable to be re-referred for 26 weeks.

Where there is disagreement between a patient and therapist about the outcome of pre-treatment, HDBT therapists commit to discussing this in the HDBT consultation meeting.

Each patient is entitled under this SOP to receive up to 46 individual sessions. This does not preclude earlier discharge, either with or without the patient's agreement. The intention is for these sessions to be utilised flexibly. There may be periods when patients are invited to take a break from attending individual sessions, in order to consolidate their progress for a period of time, before returning to sessions for a period of time. Typically there will be clear behavioural goals for the patient to meet in order to return. The length of such a break will be determined between the patient and therapist on a case-by-case basis. Ordinarily a patient will retain access to skills coaching and skills training group during this time, and the therapist and patient will agree on arrangements for maintaining planned contact during this time.

Patients should have reviews in their individual appointments every 12 sessions, which should be an additional 30 minutes (as a minimum) separate to the patient's DBT session. At these review points, or at other points if appropriate, if the therapist or patient considers that DBT is not proving effective (e.g. due to an increase or no change in risk behaviour), the termination of all input from HDBT may be agreed. Ideally this will be with the patient's agreement, though this may occur without this. At this point:

- The patient's referral to HDBT on Lorenzo will be closed
- A discharge cluster (if open only to HDBT) and care plan and FACE will be updated/completed and letter will be completed

If the patient is not in agreement, clear expectations for maintaining ongoing sessions may be outlined and agreed, and reviewed in an agreed timescale. If these are met then treatment would proceed, if they are not then the patient's input from HDBT would be ended as above.

5.5 Offering Subsequent Appointments

Once individual treatment has commenced, each therapist and patient will decide together the most effective way of arranging and rearranging appointments. This may involve having a regular day and time that is confirmed on a week-by-week basis verbally, or the use of telephone, text messaging, email or letter.

5.6 Management Of Cancelled and Did Not Attend (DNA) Appointments Following Pre-Treatment

Once accepted into individual treatment, in accordance with the DBT treatment model, the service operates a '4 week' rule. This means that if a patient cancels or DNAs 4 consecutive group appointments or 4 consecutive individual appointments, they will be discharged from HDBT. All patients are made aware of this rule at the pre-treatment stage and are reminded of this if they are at risk of drop-out, with attempts to encourage the patient to return to treatment. HDBT may use their discretion if errors on the service's behalf have contributed to patients breaching the 4 week rule, or if there are extenuating circumstances as defined by DBT consultation team.

HDBT may implement alternative attendance/behaviour requirements with patients where it is considered that this is in the clinical interest of the patient, which may involve discharge from HDBT as an outcome if the requirements are not met. These will be clearly communicated to the patient and should be discussed in DBT consultation meeting prior to implementation.

When a patient cancels or DNAs an appointment, the individual therapist will respond as determined by their own limits and clinical judgement. This may include making attempts to contact the patient to arrange a subsequent appointment, or encouraging the patient to attend the next arranged appointment, by a range of communication methods. This would continue until the point at which the patient triggers the 4 week rule at which point they would be discharged.

Patients are expected to attend the agreed community base for treatment. Where there are potential barriers to attendance that are not under the influence of the patient (for example a prolonged physical illness), a 'vacation' from treatment may be offered, whereby the patient is permitted to be absent from treatment for a specified period of time without being discharged from the service. Barriers to attendance that are considered to be the result of the patient's own actions (or lack of) (e.g. not being granted leave from an inpatient admission following risk behaviour, being in police custody following risk behaviour, not using available skills coaching to overcome barriers, physical illness as a result of self-harm), will usually be treated as a 'miss' under the 4 week rule, as will missed sessions subsequent to an offer of a vacation that the patient declined. HDBT will agree with patients on vacation on a case-by-case basis arrangements for maintaining contact during the vacation. Contingencies to return from breaks or vacations from DBT may be set, typically focused on increasing adaptive behaviour or reducing harmful behaviour. Vacations and contingencies for return should be discussed in DBT consultation team prior to implementation.

When HDBT is responsible for the cancelling of an appointment (e.g. due to annual leave or sickness), patients will be informed of this at the earliest opportunity and offered alternative support if appropriate. Dependent on clinical need and length of absence from work this may entail the temporary or permanent transfer of care to another HDBT clinician. HDBT is responsible for rearranging appointments cancelled due to service reasons. Such appointment misses do not contribute to the four week rule.

Any patient who discharges themselves from HDBT following commencement of treatment for reasons other than agreed clinical progress, or who is discharged for breaching the 4 week rule or other attendance/behaviour contracts or due to lack of benefit of the treatment, is not eligible for re-referral until 26 weeks from the point of their discharge.

5.7 Re-referral

When a patient is discharged from HDBT due to a consideration from the patient and/or therapist that DBT is not effective for them at that time, or due to four missed appointments or other breaches of contingencies, the patient can self re-refer themselves to HDBT at any point after 26 weeks from their previous discharge, via email, telephone call or letter. Ordinarily the patient will have been given clear expectations for when a re-referral would be appropriate in their discharge letter. After receipt of a self re-referral, within 4 weeks a member of the HDBT team will arrange an appointment with the patient and review the FACE risk assessment. At this point, the appropriateness of DBT compared to/alongside other interventions will be considered, and appropriate signposting or onwards referrals made if required. If it is agreed that the patient is appropriate for return to HDBT, within 4 weeks they should have a contact that includes DBT intervention. The patient would then be eligible to receive up to whatever remains of their 64 group treatment sessions and 46 individual treatment sessions from prior to their referral closure, as agreed with the therapist.

The process above can also be used by patients who are discharged from HDBT due to their clinical progress, despite not having used the full amount of possible sessions (64 group sessions, 46 individual sessions). The only difference is that they do not need to wait for a period of 26 weeks from their previous discharge. However, they may only re-enter the service in this way once.

5.8 Interfaces

All patients referred to HDBT are required to have a named clinician/access to duty from a secondary care community mental health service within Humber Teaching NHS Foundation Trust mental health division, who takes responsibility for any issues that occur that require follow-up, for example but not limited to safeguarding investigation, onwards referrals due to risk to self or others, liaison and follow-up from unplanned care and in crisis, access to medication reviews. Each instance is assessed on a case-by-case basis. The exception to this is for young people under CAMHS, where CAMHS would be expected to provide this input.

When a patient is attending group treatment only, the care co-ordinator/case manager/allocated worker/duty should offer their treatment as usual, other than not offering or referring to other therapies. If a patient subsequently commences individual

treatment, the HDBT therapist, patient and care co-ordinator/case manager/allocated worker/clinical lead will typically meet or communicate to agree roles and responsibilities. Where clinically appropriate HDBT will consider case managing patients receiving direct DBT treatment (e.g. where risk has substantially reduced and there are few services involved in a patient's care). In such cases patients should retain access to locality CMHT multidisciplinary services as required (e.g. occupational therapy, psychiatry), accessed via a referral from HDBT to the secondary care service for that specific purpose. The appropriateness of case management by HDBT, and a plan towards this, should be discussed at the initial 12 week review point in individual treatment.

If a patient commences a different therapy that may impact on the efficacy of DBT during their treatment with HDBT, the patient will be reminded that they are unable to engage in direct DBT simultaneously with this other approach, and encouraged to consider which treatment they wish to engage in. HDBT will not accept into treatment, or continue to treat, any patient who chooses to indefinitely continue or subsequently engage in another therapeutic approach/regular appointments with another psychologist or therapist if it is considered that it may impact on the efficacy of DBT. Consideration would be given to agreeing a discharge plan from another therapy that may overlap to a limited extent with the provision of DBT; such consideration would be based on clinical need and decided on a case-by-case basis.

A principle of DBT is to encourage patients to act on their own behalf in communicating with other services and agencies, therefore HDBT will not advise others in their treatment of individual patients in direct DBT treatment unless it is considered vital that this occurs (e.g. to prevent imminent harm or progress treatment) or the patient is unable to speak for or achieve the ends of the communication themselves. This does not prohibit communication between HDBT and other services and agencies. Patients will be offered the opportunity to invite anyone they wish (family, friends or professionals) to review appointments where appropriate, for example following successful completion of pre-treatment. HDBT welcomes invites to Care Programme Approach (CPA) meetings and other meetings at which the patient will be present, and will consider informal enquiries/invites to professionals meetings with the aim of providing information on the general approach of HDBT. HDBT also aims to provide training and workshops to clinicians from other services within the organisation and external partners, and supports the provision of the Humber Family Connections programme to encourage a DBT approach in general life for our patients.

DBT allows each therapist providing DBT flexibility in how to do so, therefore interfaces and contact with other services and agencies, beyond those required by organisational policy or law (which all DBT clinicians are expected to adhere to), may vary between therapists, patients and time.

DBT is a psychological therapy and encourages patients to act on their own behalf and to become their own 'care co-ordinator'. Whilst patients in HDBT have an allocated care co-ordinator, case manager or keyworker in a community mental health service, that clinician/service remain responsible for all non-DBT tasks required in the patient's care, including but not limited to responding to unplanned service contact, following up hospital admissions, ongoing liaison or referral to other agencies such as local authority or Multi-Agency Public Protection Arrangements (MAPPA), and completion

of the Trust risk assessment, care plan and cluster. Where information is provided to HDBT clinicians by the patient, for example related to safeguarding concerns or level of risk to self, the HDBT clinician is responsible for making initial enquiries and documenting fully in the patient's electronic patient record and risk assessment that information, unless otherwise agreed with the care co-ordinator/case manager/keyworker.

If a patient in HDBT is case managed by HDBT, given the principles of DBT, HDBT will not act as a gatekeeper to unplanned care, act on the patient's behalf in accessing such services, or follow-up patients outside of the service's planned contact. If such patients contact unplanned care services directly, they should be triaged and responded to as deemed appropriate by the unplanned care service, as agreed with Mental Health Crisis and Intervention Team (MHCIT); the patient should not be redirected to HDBT before unplanned care is discussed or provided. Where possible, we will support conversation with the patient about the use of unplanned care and provide information to unplanned care services about DBT, however in most cases the provision of unplanned care should not be delayed by unplanned care clinicians seeking contact with the HDBT clinician, given the above. The role of the HDBT clinician is to offer support to the patient in navigating the unplanned care system and making the most helpful choice for them. If case managed by HDBT, HDBT are responsible for ensuring that all organisational requirements are completed (e.g. FACE, cluster, care plan) and also that relevant policies and laws are adhered to (e.g. safeguarding). Where there are repeated issues that HDBT are required to respond to, HDBT will determine whether the patient remains suitable for case management; this may lead to discharge from HDBT or re-referral to community mental health services.

As a minimum, discharge from HDBT will be confirmed in writing to the patient and care co-ordinator/case manager (if one remains involved); if there is no care co-ordinator or case manager, discharge should be confirmed in writing to the patient's registered general practitioner (GP) on Lorenzo. Other services may be informed where appropriate. The FACE and care plan should be reviewed prior to discharge, and if the only service involved, a discharge cluster should also be completed.

HDBT is committed to monitoring and improving the quality of the service provided. Patients are requested to complete the Recovering Quality of Life 10 (ReQoL-10), the Work and Social Adjustment Scale (WSAS), and the Difficulties in Emotion Regulation Scale (DERS) at regular intervals. Return of the completed questionnaires is considered consent to the anonymous use of the patient's outcome measures as part of an ongoing service evaluation approved by the Mental Health Division Practice Network. Patients can opt-out of this by discussing with their clinician, as described on an information sheet distributed with the questionnaires.

Patients who have successfully completed their contracted period of direct treatment with HDBT and have been discharged, or who have been discharged prior to the end of this due to clinical progress, and have completed at least one cycle (32 weeks) of the group treatment ('Graduates') may be offered ongoing skills coaching by their individual therapist at the therapist's discretion. The length of and content of this agreement is to be agreed between the therapist and patient and should be clearly

documented in the patient's discharge care plan. Deciding not to offer ongoing coaching should also be documented with a rationale.

Graduates from HBDT will also be invited to Graduate Group, a collaboratively provided group focused on encouraging continued use of DBT skills in graduates' lives. The group has group guidelines defined by the group, however attendance at the group under the noticeable influence of alcohol or drugs, or presenting at Graduate Group having undertaken risk behaviour that is communicated to other attendees, will result in the permanent revoking of that graduate's invite to Graduate Group.. Individuals attending graduate group will not have an open referral to HDBT and HDBT's role with that individual is solely the provision of graduate group, however risks evident during the Graduate Group will initially be managed at the time with escalation via usual processes and other services if required e.g. referral to crisis services or emergency service contact. The running of graduate group depends on the capacity of the service to do so.

Discharged patients who completed their treatment contract can request top-up contact, limited to one group module post-discharge, and 4 individual sessions within any 52 week period. For group top-up, the patient will be added to the waiting list for the next available space. For individual top-up, this will be offered at the discretion of the relevant individual therapist. Patients should be informed at discharge from HDBT by their therapist how they can request top-up input, and any decision not to offer this should be clearly documented with a rationale.

Unless there are exceptional circumstances, re-referrals for the full treatment programme for patients who have already (or very nearly) completed the maximum available direct treatment are unlikely to be accepted. Each instance would be assessed on a case-by-case basis taking into account factors such as clinical need and other available options.

Access to Graduate Group and top-up contact can occur in the absence of the involvement of other Trust services, and does not require an open referral. In all the above cases, graduate contact will be documented in the Graduate's mental health notes, irrespective of whether there are open referrals; this may involve adding information to the FACE risk assessment where necessary. HDBT will also consider, on a case-by-case basis, offering Graduate Group to patients who have completed at least 1 cycle of DBT group treatment with other providers delivering DBT treatment.

The service maintains an active Twitter account which is used to engage with stakeholders and the wider community. No references to confidential content of treatment will be made on the Twitter account, and any posts by others doing so will be removed. The account may be used to augment patient treatment with the patient's consent (e.g. polls or surveys), though these would remain anonymous. Posts by individuals currently in treatment with HDBT that suggest increased risk will be highlighted to the patient's individual therapist or, if the patient is in group treatment only, their care co-ordinator or other relevant clinician, whose actions should then be based on their clinical judgement. Such posts by individuals not currently in treatment with HDBT will be responded to privately offering the contact details of appropriate services that can offer support to the individual, and removed; in addition, if it is known to HDBT that the individual is currently receiving treatment from another Trust service,

a relevant clinician would be informed however HDBT will not seek information on whether individuals posting on the Twitter account are open to other Trust services. The account home page states the account is not monitored 24/7 and should not be used to access crisis support. The Twitter account is managed in accordance with the Trust's Media and Social Media Policy.

HDBT aims to work with local businesses, individuals and charities to offer patients incentives to undertake behavioural change, through donations of items and charitable donations. Such arrangements are managed in conjunction with Healthstars as the charitable arm of the Trust. In addition, the team engage in fundraising activity, in conjunction with Healthstars, to support the provision of the service.

HDBT offers on a case-by-case basis training to other agencies on the application of DBT principles.

Where Humber DBT are contacted to provide advice or consultation (e.g. regarding the appropriateness of referral), it is the responsibility of the person seeking the advice/consultation to document the outcome in the patient's electronic patient record.

5.9 Supervision and Quality Assurance

Each therapist working in HDBT is provided DBT clinical supervision by a HDBT clinician trained in DBT supervision. Two clinicians are in turn supervised by Dr Janet Feigenbaum, an international DBT trainer employed by another Trust in the UK, with whom the Trust has a contractual agreement for the provision of supervision. DBT supervision will typically involve the review of an audio recorded individual therapy session with a patient. Information Governance have been consulted regarding the provision of such recordings to Dr Feigenbaum, and HDBT and Dr Feigenbaum are required to adhere to the Trust Photographing, Video and Audio Recording Procedure and other relevant policy (e.g. Information Governance, Supervision Policy). HDBT clinicians may also participate in local or regional DBT consultation meeting for peer supervision with clinicians from other DBT services; identifiable information is not disclosed at such meetings and discussions about patients should be documented in the patient record as usual.

The DBT team leader will undertake regular reviews of electronic patient records to monitor the adherence to the procedures outlined in this SOP. All clinicians (both individual therapists and those whose role is to deliver skills group only) meet individually on a regular basis with the DBT team leader, at which outcomes of such reviews will be discussed, in addition to issues including but not limited to clinical practice issues in DBT, use of DBT time, and potential DBT training.

HDBT recognise that the Trust standard for documenting patient contact is within 24 hours. At the same time, HDBT provide skills coaching outside of usual working hours and during annual leave at times. To balance the need for clinicians to maintain limits around their work and home lives, and for contemporaneous documentation of patient contact, the following process will be adhered to:

- Patient contact within the working hours of the clinician is expected to be documented within 24 hours.
- Patient contact received out of working hours, but within 24 hours of the next time the clinician is in work, should be documented within 24 hours.
- Patient contact received out of working hours, but not within 24 hours of the clinician next being in work, will be documented when the clinician returns to work, unless:
    - The patient has caused harm to themselves or others
    - The patient is unable to act on their own behalf to access other services and documentation of the contact aids access/provision of clinical care
    - The patient reports imminent plans to harm themselves or others and refuses/declines to commit to a more skilful plan of action
    - The patient reports urges to harm themselves or others and refuses/declines to commit to a more skilful plan of action
    - A presentation is noted that is not consistent with the patient's longitudinal risk pattern as documented in their FACE risk assessment
    - The contact involves or leads to the withdrawal of DBT skills coaching

In these cases, the contact should be documented within 24 hours, ideally sooner. Where timely documentation is not possible this information should be handed over verbally to relevant other services as soon as possible.

5.10 Management Of Patient Risk And Escalation

At the initial screening appointment following referral, all patients' potentially life-threatening behaviour will be assessed. This information should be added to patients' FACE risk assessments by the screening therapist where it is not already documented. Such risk behaviours should be reviewed again during pre-treatment. During pre-treatment and individual treatment the individual therapist is responsible for updating the FACE risk assessment where relevant information is disclosed in the course of HDBT contact (including group treatment). Contact with patients following discharge from the service that includes information relevant for a FACE assessment should also be documented in the FACE.

Any instances of physical aggression from a patient to another patient or staff member will result in removal from group treatment, and may result in discharge from HDBT. Patients are expressly asked not to encourage or facilitate other patients to undertake risk behaviours or use illicit substances. Repeated behaviour in contravention of this may lead to discharge from HDBT.

Whilst psychiatric inpatient admissions are not proscribed within DBT, where possible HDBT will encourage patients to remain in the community and implement DBT skills to manage difficulties; DBT provides a crisis and suicide protocol for management of such scenarios in individual therapy and use of this may entail positive risk taking. Where possible, and in the clinical opinion of the HDBT therapist, patients will be encouraged to take responsibility for contacting other services and agencies at times of increased risk or implementing other solutions, however HDBT may contact other

services or agencies on the patient's behalf if deemed appropriate in order to ensure the safety of the patient or that of others. This is influenced by the individual therapist's limits and clinical judgement at the time, including where this fits with the patient's broader treatment and long-term goals; where this entails 'positive risk taking' the principles of this response should have been agreed with the patient e.g. during contracting. Ideally, patients will attempt to contact their HDBT skills coaching therapist prior to contacting other services or agencies. Where such situations occur outside of the hours or limits that the patient's DBT therapist provides skills coaching, patients are informed and expected to contact alternative services or agencies to support them.

In line with DBT and reinforcement principles, patients who undertake self-harm, suicidal behaviour or harmful behaviour towards others, are unable to access skills coaching for a period of 24 hours; patients should be informed of the time coaching will recommence. Within this time, the patient continues to have access to other services as standard who can provide assistance at times of elevated risk, and patients should be made aware of these options where required. Within the 24 hour period, if the therapist considers that the patient's life (or that of someone else) is in imminent danger they may intervene in order to maintain safety. Group and individual appointments remain available to patients during this 24 hour period and any planned appointments should be attended.

Given DBT works with people who regularly self-harm, we have agreed with senior managers the following thresholds for submitting a Datix in relation to non-lethal self-harm:

- Results in admission to a physical health hospital bed, not including emergency department presentation
- Results in irreversible damage (e.g. permanent disability)
- Is above and beyond the usual risk presentation as referenced in the patient's FACE risk assessment

In addition, HDBT will submit a Datix for:

- Any self-harm that occurs on Trust premises
- Any self-harm that occurs whilst the patient is in the presence of a HDBT clinician

5.11 Consideration Of The Safeguarding Of Vulnerable Service Users With Regard To The Management Of Do Not Attend Appointments/Discharge Back To Referrer

Whilst the 4 week rule applies to all patients, the vulnerability of patients will be considered by HDBT in determining the service's response to cancelled appointments and DNAs. For example, patients considered to be more vulnerable may be more likely to receive contact encouraging them to attend or exploring barriers to attendance. As with all patients, risk and vulnerability should be documented and disseminated appropriately for viewing by other involved clinicians, and relevant services and agencies should be informed of discharge in order that the patient, and any relevant outstanding issues of vulnerability, can be followed up by other services or agencies.

5.12 DBT clinicians' adherence to the model and this SOP

HDBT requires commitment from itself and its clinicians in the same way as commitment from patients is expected.

Where a HDBT clinician is required to be present to deliver an element of the direct treatment programme (e.g. an individual session or group session), they must make every effort to attend. Where there are repeated issues in this regard, HDBT may implement attendance contracts with each other, as it does with patients, such that if the contract is breached the therapist's activity within DBT may be limited by the team. Where necessary this may involve the application of Trust policies e.g. Disciplinary Policy.

Attendance at the consultation meeting is considered an integral part of the direct DBT treatment approach. To maintain the quality of the service provided, HDBT clinicians hold each other to the requirement to attend consult regularly, and to limit each other's provision of DBT in the event of difficulties or failure to attend consult regularly.

The operational responsibility for clinicians working into HDBT remains at all times with their line manager as identified on ESR or delegated other. The DBT team leader should liaise with clinicians' line managers where required if there are concerns about the clinician's practice within HDBT. The responsibility for appraisal, annual leave, sick leave, and other line management tasks, remains with the assigned ESR manager, rather than the DBT team leader. The DBT team leader should be invited by the clinician and/or assigned ESR manager/delegated other to contribute to or attend the annual appraisal of any clinician working within HDBT.

5.13 Service Adaptations

Patients may request adaptations to the DBT treatment programme due to communication or other identified needs. HDBT commit to discussing with such patients the degree to which their requests can be accommodated whilst still remaining adherent to the principles of DBT in such a way as to not detrimentally impact the treatment of other patients. This particularly applies to the group treatment element of the programme, where the needs of other patients in ensuring the group runs effectively must be balanced with individual needs.

Appendix A - DBT telephone consultation guidelines for Humber DBT

(*Adapted from guidelines kindly shared by Dr Janet Feigenbaum on behalf of IMPART (North East London Partnership Foundation Trust)*

1. The purpose of providing coaching contact to clients between sessions is to assist clients with generalizing their use of skills across a range of naturalistic situations.
2. The therapist will identify with the team leader/consultation team the limits of their coaching contact (e.g. hours when phone will be on).
3. The therapist will not accept or return telephone calls in public or home situations where other individuals (outside the team) can overhear the phone call.
4. The therapist will work with the client to ensure that phone calls are contained to approximately 5-10 minutes.
5. The therapist will work with the client to ensure that coaching contact is focussed on identifying a skill to be used, and does not become a 'therapy session' on the telephone.
6. The therapist will assess for imminent risk where required and if necessary contact the appropriate person on the crisis plan or emergency services.
7. The therapist will attempt to get cover for DBT coaching when they are on annual leave, if they are not willing or able to continue providing coaching themselves whilst on annual leave.
8. The therapist will not take coaching contacts when on sick leave; if sick leave extends beyond one day a nominated clinician from the team will inform the client of coaching arrangements until the therapist's return to work.
9. The therapist will state clearly when a client has crossed a therapist's limits, and include a clear statement of the limit, the breach of limit, and the consequence. This may be followed up in writing.
10. The therapist will abide by the 24 hour rule when a client has self harmed, attempted suicide, or acted violently towards another person.
11. If the therapist receives an abusive or threatening message or phone call, they will stop providing skills coaching to that individual immediately, will document the content of the message on Lorenzo, and will then write to or discuss with the client the details of the breach of acceptable behaviour and the consequences, which should be agreed with the team leader.
12. If a therapist is receiving more than three coaching contacts a week from a client in the first six months of DBT or one coaching contact a week from a client in the second six months or more of DBT, then they are required to bring this issue to consultation and to their supervision.
13. If the therapist is aware of any significant gaps in time when they will be unavailable for coaching contact (e.g. a wedding, Christmas day, etc.) they will inform their clients of the change to the normal hours in which contact is available and agree a plan to cover that period if possible.
14. The therapist will remain mindful that the coaching agreement does not state that the therapist must contact back immediately, but that they will contact back as soon as possible, preferably the same day but sometimes the next day. The therapist will need to regularly remind some clients that skills coaching is for skills generalization, not crisis resolution.
15. The therapist will ensure information relevant for other services (e.g. crisis services, emergency services) is documented as soon as possible, and handed over verbally if documentation is not possible immediately.