# Borderline personality disorder: treatment and management

## NICE guideline

## Draft for consultation, June 2008

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

# Contents

# Introduction

This guideline makes recommendations for the treatment and management of borderline personality disorder in adults and young people (under the age of 18) in primary, secondary and tertiary care.

Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image, affects and impulsivity, and is associated with substantial impairment. There is a pattern of fluctuations from periods of confidence to times of absolute despair, markedly unstable self-image, rapid changes in mood, with fears of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. The cluster of symptoms and behaviour associated with the disorder include striking fluctuations in self-perception ranging from over-confidence to self-loathing, a tendency to self-harm and suicidal ideation, uncertain identity, periods of intolerable distress, and occasional brief psychotic episodes. It is present in just under 1% of the population, with greater frequency in early adulthood. Women present to services more often than men. Borderline personality disorder is often not formally diagnosed before the age of 18 but the features of the disorder can be identified earlier. Its course is variable and although recovery is attainable over time, some people may continue to experience social and interpersonal difficulties.

Borderline personality disorder is often comorbid with depression, anxiety, eating disorders, post-traumatic stress disorder, alcohol and drug misuse, and bipolar disorder (the symptoms of which are often confused with borderline personality disorder). This guideline does not cover the separate management of comorbid conditions.

This guideline draws on the best available evidence. However it should be noted that there are significant limitations to the evidence base (notably a relatively small number of randomised controlled trials (RCTs) of interventions with few outcomes in common), some of which are addressed by recommendations for further research.

At the date of consultation (June 2008), no drug has UK marketing authorisation for the treatment of borderline personality disorder. The guideline assumes that prescribers will use a drug's summary of product characteristics to inform their decisions for individual patients.

A separate guideline on antisocial personality disorder is being developed by NICE (see section 6 – related NICE guidance).

## Person-centred care

This guideline offers best practice advice on the care of adults and young people with borderline personality disorder.

Treatment and care should take into account people's needs and preferences. People with borderline personality disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk). Healthcare professionals should also follow a code of practice accompanying the Mental Capacity Act (summary available from www.publicguardian.gov.uk).

If the service user is under 16, healthcare professionals should follow guidelines in 'Seeking consent: working with children' (available from www.dh.gov.uk). If the service user is 16 or 17 years of age, full access should be provided to the treatment and care pathway that follows but within child and adolescent mental health services.

Good communication between healthcare professionals and service users is essential. It should be supported by evidence-based written information tailored to the service user's needs. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

# Key priorities for implementation

### Access to services

- People with borderline personality disorder should not be excluded from any services because of their diagnosis, gender or because they have self-harmed. **[1.1.1.1]**

### Autonomy and choice

- Healthcare professionals should work in partnership with people with borderline personality disorder with the aim of developing their autonomy and encouraging choice by:
  - ensuring that individuals remain actively involved in finding solutions to their problems, even during crises
  - encouraging individuals to consider the different treatment options and life choices available to them, and the consequences of the choices they make. **[1.1.3.1]**

### Developing an optimistic and trusting relationship

- Healthcare professionals working with people with borderline personality disorder should:
  - explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
  - build up a trusting relationship, work in an open, engaging and non-judgmental manner, and be consistent and reliable
  - be aware of sensitive issues, including rejection, possible abuse and trauma, and the stigma often associated with self-harm and borderline personality disorder. **[1.1.4.1]**

### Managing endings and transitions

- Healthcare professionals should ensure that withdrawal and ending of treatments, and transition from one service to another, is discussed carefully

and in advance with the person (and carers if appropriate) and anticipate that endings may evoke strong emotions and reactions for the person. They should ensure that:

- ending or withdrawal of treatments or services is structured and phased over a period of time
- the care plan maintains effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis. **[1.1.7.1]**

**Assessment**

- Community mental health services (community mental health teams, related community-based services, and tier 2/3 services in CAMHS) should be responsible for the routine assessment, treatment and management of people with borderline personality disorder. **[1.3.2.1]**

**Care planning in community mental health teams**

- Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user and their carers, where agreed with the person. The care plan should:
  - clearly identify the roles and responsibilities of all health and social care professionals
  - identify manageable short-term treatment aims and specify steps that the person and others may take in order achieve them
  - identify long-term goals that the person would like to achieve, which should underpin the overall treatment strategy; these goals should be realistic, and linked to the short-term treatment aims
  - develop a crisis plan that specifies potential triggers that could lead to a crisis, identifies self-management strategies likely to be effective and establishes an agreed plan for accessing services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are insufficient. **[1.3.4.1]**

**The role of psychological treatment**

- When a decision has been made to offer psychological treatment to a person with borderline personality disorder, healthcare professionals should offer one that provides therapy in at least two modalities (for example, individual or group), has a well-structured programme and a coherent theory of practice. Therapist supervision should be included within the framework of the service. **[1.3.5.4]**
- Brief psychotherapeutic interventions (of less than 3 months' duration) should not be used specifically for borderline personality disorder or for the individual symptoms of the disorder. **[1.3.5.7]**

**The role of drug treatment**

- Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour, and transient psychotic symptoms). **[1.3.6.2]**

**The role of specialist personality disorder services within trusts**

- Mental health trusts should consider developing multidisciplinary specialist teams and/or services for people with personality disorders. These teams/clinics should have specific expertise in the diagnosis and management of borderline personality disorder and should:

  - provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
  - provide consultation and advice to primary and secondary care services
  - offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder
  - develop systems of communication and protocols for information sharing among different parts of mental health services for people with borderline personality disorder, including forensic services

- be able to provide and/or advise on an appropriate range of social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia
- work with CAMHS to develop local protocols to govern arrangements for the transition of young people with borderline personality disorder from CAMHS to adult services
- ensure that clear lines of communication between primary and secondary care are established and maintained
- support, lead and participate in the local and national development of potential treatments for people with borderline personality disorder, including multi-centre research
- oversee the implementation of this guideline
- develop training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline for general mental health, social care, forensic and primary care providers and other professionals who have contact with people with borderline personality disorder. Training programmes should also address problems around stigma and discrimination as these apply to people with borderline personality disorder.

The size and time commitment of these teams will depend on local circumstances (for example, the size of trust, the population covered and the estimated referral rate for people with borderline personality disorder). **[1.5.1.1]**

# 1 Guidance

The following guidance is based on the best available evidence. The full guideline ([add hyperlink]) gives details of the methods and the evidence used to develop the guidance.

## *1.1 General principles to be considered when working with people with borderline personality disorder*

### 1.1.1 Access to services

1.1.1.1 People with borderline personality disorder should not be excluded from any services because of their diagnosis, gender or because they have self-harmed.

1.1.1.2 Young people with a diagnosis of borderline personality disorder, or symptoms and behaviour suggestive of the diagnosis, should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS).

1.1.1.3 Healthcare professionals should ensure that people from black and minority ethnic groups with borderline personality disorder have equal access to services based upon clinical need.

1.1.1.4 If language is a barrier to accessing or engaging with services for people with borderline personality disorder, healthcare professionals should provide the person with:

- information in their preferred language and/or in an accessible format
- psychological or other interventions in their preferred language
- independent interpreters.

### 1.1.2 People with borderline personality disorder and learning disabilities

1.1.2.1 For people with mild or moderate learning disabilities who present with symptoms and behaviour that suggest the diagnosis of borderline personality disorder, assessment and diagnosis should be undertaken in consultation with a specialist in learning disabilities.

1.1.2.2 When a person with a mild or moderate learning disability has been diagnosed with borderline personality disorder they should be treated within mainstream services and have access to the same services as other people with borderline personality disorder.

1.1.2.3 Care planning for people with a moderate learning disability and borderline personality disorder should take place within the framework of the enhanced care programme approach (CPA). Healthcare professionals should consider consulting with a specialist in learning disabilities in developing care plans and in managing behaviour that challenges.

1.1.2.4 People with a severe learning disability should not normally be diagnosed with borderline personality disorder, but where they have behaviour and symptoms suggestive of borderline personality disorder they should be referred for assessment and treatment by a specialist in learning disabilities.

### 1.1.3 Autonomy and choice

1.1.3.1 Healthcare professionals should work in partnership with people with borderline personality disorder with the aim of developing their autonomy and encouraging choice by:

- ensuring that individuals remain actively involved in finding solutions to their problems, even during crises

- encouraging individuals to consider the different treatment options and life choices available to them, and the consequences of the choices they make.

### 1.1.4 Developing an optimistic and trusting relationship

1.1.4.1 Healthcare professionals working with people with borderline personality disorder should:

- explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
- build up a trusting relationship, work in an open, engaging and non-judgmental manner, and be consistent and reliable
- be aware of sensitive issues, including rejection, possible abuse and trauma, and the stigma often associated with self-harm and borderline personality disorder.

### 1.1.5 Involving carers

1.1.5.1 Healthcare professionals should ask directly whether the person with borderline personality disorder wishes carers to be involved in their care, and

- encourage carers to be involved where the individual has agreed to this
- ensure that the involvement of carers does not lead to withdrawal of, or lack of access to, services.

1.1.5.2 CAMHS professionals working with young people with borderline personality disorder should:

- balance the developing autonomy and capacity of the young person with the responsibilities of parents and carers

- be familiar with the legal framework applying to young people, including the Mental Capacity Act (2005), the Children Act (1989) and the Mental Health Act (2007).

### 1.1.6 Principles for healthcare professionals undertaking assessment

1.1.6.1 When assessing a person with borderline personality disorder, healthcare professionals should:

- explain the process of the assessment clearly to enable the individual to have some control in the process
- offer post-assessment support, particularly if sensitive issues, such as childhood trauma, have been discussed
- use non-technical language wherever possible
- explain the diagnosis and the use and meaning of the term borderline personality disorder.

### 1.1.7 Managing endings and transitions

1.1.7.1 Healthcare professionals should ensure that withdrawal and ending of treatments, and transition from one service to another, is discussed carefully and in advance with the person (and carers if appropriate) and anticipate that endings may evoke strong emotions and reactions for the person. They should ensure that:

- ending or withdrawal of treatments or services is structured and phased over a period of time
- the care plan maintains effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis.

1.1.7.2 CAMHS and adult healthcare professionals should work collaboratively to minimise the negative impact of transferring young people from CAMHS to adult services by:

- timing the transfer based on when this is best for the young person even if this is after they have turned 18
- continuing treatment in CAMHS beyond 18 years if there is a realistic possibility that this may obviate the need for referral to adult mental health services.

### 1.1.8 Managing self-harm and attempted suicide

1.1.8.1 Healthcare professionals should use existing NICE guidance on self-harm (CG16) following episodes of self-harm or attempted suicide in adults and young people.

## *1.2 Recognition and management in primary care*

### 1.2.1 Recognition of borderline personality disorder

1.2.1.1 If a person presents in primary care with repeated self-harm, persistent risk-taking behaviour or marked emotional instability, healthcare professionals should consider referral to community mental health services for assessment for borderline personality disorder. If the person is younger than 18 years old they should be referred to CAMHS for assessment and treatment.

### 1.2.2 Crisis management in primary care

1.2.2.1 When a person with an established diagnosis of borderline personality disorder presents to primary care in a crisis, healthcare professionals should:

- assess the current level of risk

- enquire about previous similar episodes and successful management strategies used in the past
- help to manage the person's anxiety by enhancing coping skills and helping them to focus upon the current problems
- encourage the person to identify manageable changes that will enable them to deal with the current problems
- offer a follow-up appointment at a time agreed with the person.

### 1.2.3 Referral to community mental health services

1.2.3.1 Primary healthcare professionals should consider referring a person with an established or suspected diagnosis of borderline personality disorder who is in crisis to a community mental health service when:

- levels of distress and/or risk of harm to self or others are increasing
- levels of distress and/or risk have not subsided despite attempts to reduce anxiety and improve coping
- further help from specialist services is requested by the person.

## *1.3 Assessment and management by community mental health services*

### 1.3.1 Training

1.3.1.1 Mental health trusts should ensure that professionals working in secondary services, including CAMHS services, especially in community-based services and teams, are trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline. Training should be provided by specialist personality disorder teams based within mental health trusts.

### 1.3.2 Assessment

1.3.2.1 Community mental health services (community mental health teams, related community-based services, and tier 2/3 services in CAMHS) should be responsible for the routine assessment, treatment and management of people with borderline personality disorder.

1.3.2.2 When assessing a person with possible borderline personality disorder in community mental health services, healthcare professionals should conduct a full assessment of:

- personality functioning, coping strategies, strengths and vulnerabilities
- comorbid mental disorders and social problems
- need for psychological treatment, social care and support, and occupational rehabilitation or development.

A comprehensive care plan should be developed.

### 1.3.3 Risk assessment and management

1.3.3.1 Risk assessment in people with borderline personality disorder should:

- be undertaken in the context of a needs assessment
- differentiate between long-term and acute risks for the individual
- identify the risks posed to self and others, including the welfare of dependent children.

1.3.3.2 Healthcare professionals should explicitly agree the risks being assessed with the person with borderline personality disorder and collaboratively develop risk management plans for them that:

- address both the long-term and acute risks
- are explicitly related to the long-term treatment strategies

- take account of changes in personal relationships including the therapeutic relationship.

1.3.3.3 When managing risk in people with borderline personality disorder, healthcare professionals should:

- be cautious when evaluating risk if the person is not well known to the healthcare professional
- involve other members of the healthcare team in order to assess the seriousness of the risk, especially in the context of frequent suicidal crises
- ensure that risk is managed by a multidisciplinary team with adequate supervision arrangements, especially for team members who have less experience.

1.3.3.4 Teams working with people with borderline personality disorder should regularly review their tolerance and sensitivity to working with risk. This should be reviewed annually (or more frequently if a team is regularly working with people with high levels of risk).

### 1.3.4 Care planning in community mental health teams

All people with borderline personality disorder should have a comprehensive care plan, developed within community services and used to organise care throughout services. It should include long-term treatment strategies, shorter-term aims, risk management, crisis plans and should outline the roles and responsibilities of all healthcare professionals involved. It should be developed in collaboration with the service user.

1.3.4.1 Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user and their carers, where agreed with the person. The care plan should:

- clearly identify the roles and responsibilities of all health and social care professionals
- identify manageable short-term treatment aims and specify steps that the person and others may take in order to achieve them
- identify long-term goals that the person would like to achieve, which should underpin the overall treatment strategy; these goals should be realistic, and linked to the short-term treatment aims
- develop a crisis plan that specifies potential triggers that could lead to a crisis, identifies self-management strategies likely to be effective and establishes an agreed plan for accessing services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are insufficient.

1.3.4.2 All healthcare professionals working with people with borderline personality disorder should ensure that treatment and service delivery are well integrated. The enhanced CPA should be used when individuals are routinely in contact with more than one service.

### 1.3.5 The role of psychological treatment

1.3.5.1 When considering psychological treatment for any reason for a person with borderline personality disorder, and to ensure that properly informed consent can be given, healthcare professionals should give the individual written material about the treatment model and the evidence for its effectiveness in the treatment of borderline personality disorder, and should offer the opportunity to discuss this. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video.

1.3.5.2 When considering psychological treatment for a person with borderline personality disorder healthcare professionals should take into account the following factors:

- individual choice and preference
- degree of impairment and severity of the disorder
- frequency and extent of service use by the person
- the person's willingness to engage with therapy and their motivation to change
- the person's ability to remain within the boundaries of a therapeutic relationship
- personal and professional support.

1.3.5.3 When a decision has been made to refer a person with borderline personality disorder for assessment for psychological treatment, healthcare professionals should ensure that the individual is provided with support during the period of referral, and that arrangements for support are agreed in advance by the referring team and the service user.

1.3.5.4 When a decision has been made to offer psychological treatment to a person with borderline personality disorder, healthcare professionals should offer one that provides therapy in at least two modalities (for example, individual or group), has a well-structured programme and a coherent theory of practice. Therapist supervision should be included within the framework of the service.

1.3.5.5 For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, healthcare professionals may consider a comprehensive dialectical behaviour therapy treatment programme.

1.3.5.6 When a decision has been made to provide psychological treatment to a person with borderline personality disorder as a specific intervention in their overall treatment and care, healthcare professionals should use the enhanced CPA to ensure clarity of roles among different services, professionals providing psychological treatment and other healthcare professionals.

1.3.5.7 Brief psychotherapeutic interventions (of less than 3 months' duration) should not be used specifically for borderline personality disorder or for the individual symptoms of the disorder.

### 1.3.6 The role of drug treatment

1.3.6.1 When considering drug treatment for any reason for a person with borderline personality disorder, and to ensure that properly informed consent can be given, healthcare professionals should give the person written material about the drug and the evidence for its effectiveness in the treatment of borderline personality disorder and comorbid conditions, and should offer the opportunity to discuss this. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video.

1.3.6.2 Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour, and transient psychotic symptoms).

1.3.6.3 Short-term use of sedative medication may be considered cautiously as part of the overall treatment plan for people with borderline personality disorder in a crisis. The duration of treatment should be agreed with the individual, but should be no longer than a week.[1]

1.3.6.4 Antipsychotic drugs should not be used for the medium- and long-term treatment of borderline personality disorder.

### 1.3.7 The management of comorbidities

1.3.7.1 Before starting treatment for a comorbid condition in people with borderline personality disorder healthcare professionals should review:

[1] For the overall management of crises for people with borderline personality disorder see section 1.3.8 below.

- the diagnosis of borderline personality disorder and the comorbid condition especially if either diagnosis has been made during a crisis or emergency presentation
- previous and current treatments to identify those that are ineffective; ineffective treatments should be discontinued.

1.3.7.2 Healthcare professionals should consider treating comorbid depression, post-traumatic stress disorder or anxiety within a well-structured treatment programme for borderline personality disorder.

1.3.7.3 Psychological and/or drug treatments may be considered for people with borderline personality disorder to treat comorbid conditions. Healthcare professionals should follow the appropriate NICE guideline for the comorbid condition.

1.3.7.4 Healthcare professionals should consider referral to the relevant service for people with borderline personality disorder who also have major psychosis, dependence on alcohol or Class A drugs, or a severe eating disorder. A care coordinator should keep in contact with people already engaged in treatment for the comorbid condition so that they can continue with treatment for borderline personality disorder when appropriate.

### 1.3.8 The management of crises

The following principles and guidance on the management of crises apply to secondary care and specialist services for personality disorder. They may also be of use to general practitioners with a special interest in the management of borderline personality disorder within primary care.

**Principles and general management of crises**

1.3.8.1 When a person with borderline personality disorder presents during a crisis, healthcare professionals should consult the crisis plan and use the following psychological approach:

- maintain a calm and non-threatening attitude
- try to understand the crisis from the person's point of view
- explore the person's reasons for distress
- use empathic open questioning and clarifying and validating statements to identify the onset and the course of the current problems
- seek to stimulate reflection about solutions
- avoid minimising the stated reasons for the crisis
- refrain from offering solutions before receiving full clarification of the problems
- explore alternative options before considering admission to a crisis unit or inpatient admission
- offer appropriate follow-up within a time frame agreed with the person.

**Use of drug treatment during crises**

Short-term use of drug treatments may be considered for people with borderline personality disorder during a crisis.

1.3.8.2 Before starting short-term drug treatments for people with borderline personality disorder during a crisis healthcare professionals should:

- ensure that there is consensus among treating professionals about the drug used and that the primary prescriber is identified
- take account of the psychological role of prescribing (both for the individual and for the prescriber) and the impact that prescribing decisions may have on the therapeutic relationship and the overall care plan, including long-term treatment strategies
- ensure that a drug is not used in the place of other more appropriate interventions
- use a single drug wherever possible and avoid polypharmacy.

1.3.8.3 When choosing a drug for people with borderline personality disorder in a crisis, clinicians should choose one that has:

- a low side-effect profile
- low addictive properties
- minimal potential for abuse
- relative safety in overdose.

1.3.8.4 When the decision has been made to use short-term drug treatment as part of the management of crisis for people with borderline personality disorder, prescribers should:

- agree with the person the target symptoms, monitoring arrangements and anticipated duration of treatment
- jointly agree with the person a plan for adherence
- use the minimum effective therapeutic dose
- prescribe fewer tablets more frequently if there is a significant risk of overdose
- discontinue a drug after a trial period if the target symptoms do not improve
- consider alternative treatment strategies, including psychological treatments, if target symptoms or the level of risk do not improve
- arrange an appointment to review the overall care plan, including a review of pharmacological and other treatments, after the crisis has subsided.

**Follow-up after a crisis**

1.3.8.5 After a crisis has resolved or subsided, ensure that crisis plans within the overall care plan are updated to reflect current concerns and identify which treatment strategies have proved helpful. This should be done in conjunction with the person with borderline personality disorder and their carers where possible, and should include:

- a full review of drug treatment, including benefits, side effects, any safety concerns and its role in the overall treatment strategy
- a plan to stop drug treatment that has been started during a crisis, usually within a week
- a review of psychological treatments, including their role in the overall treatment strategy, any possible harm related to psychological treatments and their potential role in precipitating the crisis.

1.3.8.6 If drug treatments started during a crisis cannot be stopped within a week, there should be a regular review of the drug to monitor effectiveness, side effects, misuse and dependency. The frequency of the review should be agreed with the person and recorded in the overall care plan.

### 1.3.9 The management of insomnia

1.3.9.1 Healthcare professionals should provide people with borderline personality disorder who have sleep problems with general advice about sleep hygiene, including having a bedtime routine, avoiding caffeine, reducing activities likely to defer sleep (such as violent or exciting television programmes or films), and employing activities that may encourage sleep.

1.3.9.2 For the further short-term management of insomnia healthcare professionals should follow NICE technology appraisal guidance 77. However healthcare professionals should be aware of the abuse potential of many of the drugs used for insomnia and may wish to consider other drugs such as sedative antihistamines.

### 1.3.10 Discharge to primary care

1.3.10.1 When discharging a person with borderline personality disorder from secondary care to primary care, healthcare professionals should

discuss the process in advance with the person, and wherever possible, their carers. A care plan should be agreed beforehand and communicated to the primary care clinician specifying the steps the individual can take to try to manage their distress, how they can cope with future crises and how they can re-engage with community mental health services if needed.

## *1.4 Inpatient services*

1.4.1.1 Before considering admission to an acute psychiatric inpatient unit for a person with borderline personality disorder, healthcare professionals should refer the individual to a crisis resolution and home treatment team first.

1.4.1.2 People with borderline personality disorder should only be considered for admission to an acute psychiatric inpatient unit for:

- the management of crises involving significant risk to self or others that cannot be managed in other service contexts, or
- detention under the Mental Health Act.

1.4.1.3 When inpatient care is being considered for a person with borderline personality disorder, healthcare professionals should actively involve the person in the decision and:

- agree the length of the admission in advance
- ensure that where, in extreme circumstances, compulsory treatment is used, management on a voluntary basis should be resumed at the earliest opportunity.

1.4.1.4 Healthcare professionals should arrange a formal CPA review for people with borderline personality disorder who have experienced two or more admissions in the previous 6 months.

1.4.1.5 NHS trusts providing CAMHS should ensure that young people with severe borderline personality disorder have access to tier 4 specialist services if required, which may include:

- inpatient treatment tailored to the needs of young people with borderline personality disorder
- specialist outpatient programmes
- home treatment teams.

## *1.5 Organisation and planning of services*

The organisation and coordination of services, including training, should be led by a specialist multidisciplinary team, within each mental health trust.

### 1.5.1 The role of specialist personality disorder services within trusts

1.5.1.1 Mental health trusts should consider developing multidisciplinary specialist teams and/or services for people with personality disorders. These teams/clinics should have specific expertise in the diagnosis and management of borderline personality disorder and should:

- provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
- provide consultation and advice to primary and secondary care services
- offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder
- develop systems of communication and protocols for information sharing among different parts of mental health services for people with borderline personality disorder, including forensic services

- be able to provide and/or advise on an appropriate range of social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia
- work with CAMHS to develop local protocols to govern arrangements for the transition of young people with borderline personality disorder from CAMHS to adult services
- ensure that clear lines of communication between primary and secondary care are established and maintained
- support, lead and participate in the local and national development of potential treatments for people with borderline personality disorder, including multi-centre research
- oversee the implementation of this guideline
- develop training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline for general mental health, social care, forensic and primary care providers and other professionals who have contact with people with borderline personality disorder. Training programmes should also address problems around stigma and discrimination as these apply to people with borderline personality disorder.

The size and time commitment of these teams will depend on local circumstances (for example, the size of trust, the population covered and the estimated referral rate for people with borderline personality disorder).

1.5.1.2 Specialist personality disorder services should involve people with personality disorders and carers in planning service developments. With appropriate training and support, service users may also provide services, such as facilitating peer support groups.

# 2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from www.nice.org.uk/nicemedia/pdf/BPD_Final_scope.pdf

This guideline is relevant to adults and young people with a diagnosis of borderline personality disorder. The guideline will be of relevance to care provided within primary, community, secondary and specialist health care services within the NHS. It will comment on the interface with other services such as prison health services, forensic services, social services and the voluntary sector. It will not include recommendations relating to the services exclusively provided by these agencies; except insofar as the care provided in those institutional settings is provided by NHS healthcare professionals, funded or contracted by the NHS.

**How this guideline was developed**

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process: an overview for stakeholders, the public and the NHS' (third edition, published April 2007), which is available from www.nice.org.uk/guidelinesprocess or from NICE publications (phone 0845 003 7783 and quote reference N1233).

# 3 Implementation

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health' (available from www.dh.gov.uk). Implementation of

clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CGXXX). *[NICE to amend list as needed at time of publication]*

- Slides highlighting key messages for local discussion.
- Costing tools:
  - costing report to estimate the national savings and costs associated with implementation
  - costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives that support this locally.
- Audit criteria to monitor local practice.

# 4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and care of service users in the future.

## *4.1 Development of an agreed set of outcomes measures for borderline personality disorder*

A consensus building exercise should be conducted to determine the main clinical outcomes that should be assessed in future studies of interventions for people with borderline personality disorder. The study should involve people from a range of different backgrounds, including service users, carers, clinicians and academics. Recommendations for specific measures of these outcomes should be selected from among those that are valid, reliable and have already been used in this patient group.

**Why this is important**

Previous research examining the effects of psychological and pharmacological interventions for people with borderline personality disorder has used a wide range of different outcomes measures. This makes it difficult to synthesise data from different studies and to compare the relative effects of different types of interventions. By agreeing outcome measures to be used in future studies examining the impact of interventions for people with borderline personality disorder it will be easier to develop evidence-based treatment guidelines in the future.

## *4.2 Dialectical behaviour therapy and mentalisation-based therapy for people with borderline personality disorder*

A randomised trial of complex interventions (dialectical behaviour therapy and mentalisation-based therapy) versus high-quality community care delivered by general mental health services for people with borderline personality disorder in community settings should be undertaken. The study should examine medium-term outcomes (including cost effectiveness) over a period of at least 18 months. It should also pay particular attention to training and supervision of those providing interventions in order to ensure that systems for delivering them are both robust and generalisable.

**Why this is important**

Research conducted to date suggests that complex interventions, such as dialectical behaviour therapy and mentalisation-based therapy, may benefit people with borderline personality disorder. However trials conducted to date have been small, have often excluded men with borderline personality disorder, and have generally examined interventions delivered in centres of excellence. A pragmatic trial comparing these two complex interventions against high-quality outpatient follow-up by community mental health services would establish effectiveness and the costs and cost effectiveness of these interventions when they are delivered outside such centres. The impact of these interventions among men should also be examined.

## *4.3 Outpatient psychosocial interventions for people with borderline personality disorder*

Exploratory randomised controlled trials of outpatient psychosocial interventions (such as schema-focused therapy, cognitive analytical therapy, and modified therapeutic community approaches) should be conducted. Such studies should examine medium-term outcomes (for example, quality of life, psychosocial functioning, employment outcomes, and borderline personality disorder symptomatology) over a period of at least 18 months and pay particular attention to training and supervision of those delivering interventions.

**Why this is important**

The evidence base for the effectiveness of psychosocial interventions for people with personality disorder is at an early stage of development. Data collected from cohort studies and case series suggest that a variety of such interventions may be of benefit to people with borderline personality disorder. Exploratory trials of these interventions should be conducted in order to develop a better understanding of their efficacy. Such studies should also examine the process of treatment delivery in the context of an experimental study, and explore logistical and other factors that could have an impact on the likelihood of larger scale experimental evaluations of these interventions succeeding.

## *4.4 Mood stabilisers for people with borderline personality disorder*

A randomised placebo-controlled trial should be conducted to investigate the effectiveness and cost effectiveness of mood stabilisers in the treatment of borderline personality disorder. The study should examine the medium to long-term impact of such treatment. The study should be sufficiently powered to investigate both the effects and side effects of this treatment.

**Why this is important**

An evidence base for the effectiveness of pharmacological treatments for people with personality disorder does not exist. However encouraging findings from small-scale studies of mood stabilisers such as topiramate and lamotrigine indicate the need for further research. Emotional instability is a key feature of borderline personality disorder and the impact of such treatments on mood and other key features of this disorder. The findings of such a study would support the development of future recommendations on the role of pharmacological interventions in the treatment of borderline personality disorder.

## *4.5 Developing a care pathway for people with borderline personality disorder*

A mixed-methods cohort study examining the care pathway of a representative sample of people with borderline personality disorder should be undertaken. Such a study should include consideration of factors that should guide referral from primary to secondary care services, and examine the role of inpatient treatment. The study should examine the impact that patient and service-level actors have on transfer between different components of care and include collection and analysis of both qualitative and quantitative data.

**Why this is important**

The development of a care pathway for people with borderline personality disorder would help to ensure that available resources are used effectively and that people receive services that are appropriate to their needs. At present, service provision for people with borderline personality disorder varies greatly in different parts of the country, and factors that should be considered when deciding the type and intensity of care that people receive are poorly understood. A cohort study, in which qualitative and quantitative data from service users and providers are collected at the point of transfer to and from different parts of the care pathway would help to inform the decisions that patients and clinicians have to make about the type of services that people receive.

# 5 Other versions of this guideline

## *5.1 Full guideline*

The full guideline, 'Borderline personality disorder: treatment and management' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from www.nccmh.org.uk, our website (www.nice.org.uk/CGXXXfullguideline) and the National Library for Health (www.nlh.nhs.uk). **[Note: these details will apply to the published full guideline.]**

## *5.2 Quick reference guide*

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CGXXXquickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

## *5.3 'Understanding NICE guidance'*

Information for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CGXXXpublicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about borderline personality disorder.

# 6 Related NICE guidance

**Published**

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2004). Available from www.nice.org.uk/CG22

Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. NICE clinical guideline 38 (2006). Available from www.nice.org.uk/CG38

Depression: the management of depression in primary and secondary care. NICE clinical guideline 23 (2004). Available from www.nice.org.uk/CG23

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from www.nice.org.uk/CG52

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from www.nice.org.uk/CG51

Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004). Available from www.nice.org.uk/CG9

Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/CG31

Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/CG26

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002). Available from www.nice.org.uk/CG1

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004). Available from www.nice.org.uk/CG16

Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE clinical guideline 25 (2005). Available from www.nice.org.uk/CG25

Zaleplon, zolpidem and zopiclone for the management of insomnia. NICE technology appraisal guidance 77 (2004). Available from www.nice.org.uk/TA77

**Under development**

NICE is developing the following guidance (details available from www.nice.org.uk):

- Antisocial personality disorder: treatment, management and prevention. NICE clinical guideline (publication expected December 2008).
- Alcohol use disorders: the management of in adults and adolescents. NICE clinical guideline (publication expected TBC).

# 7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

# Appendix A: The Guideline Development Group

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# Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

[NICE to add]

**[Name; style = Unnumbered bold heading]**
[job title and location; style = NICE normal]