NICE National Institute for Health and Care Excellence

NICE quality standard

Personality disorders: borderline and antisocial

Quality standard

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Contents

This standard is based on CG77 and CG78.

This standard should be read in conjunction with QS11, QS14, QS23, QS34, QS43, QS53, QS59, QS8, QS102, QS99, QS95, QS115, QS116, QS154 and QS39.

Introduction

This quality standard covers treatment and management of borderline and antisocial personality disorders. For borderline personality disorder, this quality standard applies to adults aged 18 and over and young people post puberty. For antisocial personality disorder, this quality standard applies only to adults aged 18 and over. NICE's quality standard on antisocial behaviour and conduct disorders in children and young people covers antisocial behaviour and conduct disorder in children and young people under 18 years. For more information see the personality disorders topic overview.

Why this quality standard is needed

NICE was asked by NHS England to develop a quality standard on 2 specific personality disorders, that is, borderline personality disorder and antisocial personality disorder. Borderline and antisocial personality disorders are 2 distinctive conditions that affect people differently and have different care pathways. The diagnosis affects how the condition is managed and the interventions and services that are appropriate. The 2 disorders have been grouped into 1 quality standard to reflect similarity in approaches, not to imply that the 2 conditions are the same.

Antisocial personality disorder can only be diagnosed in adults, whereas borderline personality disorder can also be diagnosed in young people post puberty. For borderline personality disorder, statements within this quality standard apply to young people post puberty as well as adults recognising that young people would be supported by age-appropriate services (child and adolescent mental health services).

Borderline personality disorder

Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is sometimes a pattern of rapid fluctuation from periods of confidence to despair, with fear of abandonment,

rejection, and a strong tendency towards suicidal thinking and self-harm. 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 can often be confused with borderline personality disorder).

Borderline personality disorder is present in just under 1% of the population. It most commonly presents in early adulthood, with women presenting to services more often than men. It is not usually diagnosed formally before the age of 18 years, but features of the disorder can be identified earlier.

Most people with borderline personality disorder show symptoms in late adolescence or early adult life, although some may not come to the attention of mental health services until much later. With formal psychiatric assessment and appropriate treatment, symptoms improve sufficiently so that at least 50% of people no longer meet the criteria for borderline personality disorder 5–10 years after diagnosis.

Antisocial personality disorder

Traits of antisocial personality disorder include impulsivity, high negative emotionality, low conscientiousness and associated behaviours, including irresponsible and exploitative behaviour, recklessness and deceitfulness. As a result of antisocial personality disorder, people may experience unstable interpersonal relationships and may disregard the consequences of their behaviour and the feelings of others. The disorder may also result in a failure to learn from experience and in egocentricity. Antisocial personality disorder is often comorbid with depression, anxiety, and alcohol and drug misuse.

The prevalence of antisocial personality disorder in the general population is 3% in men and 1% in women. The prevalence among people in prison is around 47%, with serious crimes being less common than a history of aggression, unemployment, and unstable and short-term relationships.

The course of antisocial personality disorder is variable and although recovery is achievable over time, some people continue to experience social and interpersonal difficulties.

Most people with antisocial personality disorder receive the majority of their care outside the health service. They may be supported by education, social care and housing services and, as result of offending, by the criminal justice system.

Care for people with borderline and antisocial personality disorder

Although borderline and antisocial personality disorders are both associated with significant morbidity and increased mortality, the care people receive is often fragmented. Borderline and antisocial personality disorders are frequently misdiagnosed because of comorbid conditions, and people are often prescribed medication or therapies that are unsuitable for them. Sometimes they are excluded from health or social care services because of their diagnosis or their behaviour. This may be because staff lack the confidence and skills to deal with these conditions or have negative attitudes towards people with borderline or antisocial personality disorder. Some topic experts and people with personality disorder feel that the stigma attached to borderline and antisocial personality disorders still prevails even within mental health services.

In 2011, the government published its mental health strategy, No health without mental health (Department of Health and Social Care), which set out long-term ambitions for transforming mental healthcare and the way people with mental health problems are supported in society as a whole. The strategy was built around 6 objectives:

- more people will have good mental health
- more people with mental health problems will recover
- more people with mental health problems will have good physical health
- more people will have a positive experience of care and support
- fewer people will suffer avoidable harm
- fewer people will experience stigma and discrimination.

The quality standard is expected to contribute to improvements in the following outcomes:

- quality of life for people with serious mental illness
- service user experience of health/care services
- excess under 75 mortality rate in adults with serious mental illness
- employment of people with mental illness
- experience of integrated care.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult Social Care Outcomes Framework 2015 to 16
- NHS Outcomes Framework 2015 to 16
- Public Health Outcomes Framework 2013 to 16.

Service user experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to people with borderline or antisocial personality disorder.

NICE has developed guidance and associated quality standards on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE Pathways on patient experience in adult NHS services and service user experience in adult mental health services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience will not usually be included in topic-specific quality standards. However, recommendations in the development sources for quality standards that impact on service user experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for borderline and antisocial personality disorders specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole borderline or antisocial personality disorder care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with borderline or antisocial personality disorder in a range of settings.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality borderline or antisocial personality disorder service are listed in related NICE quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in assessing, caring for and treating people with borderline or antisocial personality disorder should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with borderline or antisocial personality disorder. If appropriate, health and social care practitioners should ensure that family members and carers are involved in making decisions about assessment, care planning and provision of treatment.

List of quality statements

Statement 1 Mental health professionals use a structured clinical assessment to diagnose borderline or antisocial personality disorder.

Statement 2 People with borderline personality disorder are offered psychological therapies and are involved in choosing the type, duration and intensity of therapy.

Statement 3 People with antisocial personality disorder are offered group-based cognitive and behavioural therapies and are involved in choosing the duration and intensity of the interventions.

Statement 4 People with borderline or antisocial personality disorders are prescribed antipsychotic or sedative medication only for short-term crisis management or treatment of comorbid conditions.

Statement 5 People with borderline or antisocial personality disorder agree a structured and phased plan with their care provider before their services change or are withdrawn.

Statement 6 People with borderline or antisocial personality disorder have their long-term goals for education and employment identified in their care plan.

Statement 7 Mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision.

Quality statement 1: Structured clinical assessment

Quality statement

Mental health professionals use a structured clinical assessment to diagnose borderline or antisocial personality disorder.

Rationale

Borderline and antisocial personality disorders are complex and difficult to diagnose. Even when borderline or antisocial personality disorder is identified, significant comorbidities are frequently not detected. People often need support that goes beyond healthcare and this makes care planning complex. Carrying out a structured assessment using recognised tools is essential to identify a range of symptoms, make an accurate diagnosis and recognise comorbidities.

Quality measures

Structure

Evidence of local arrangements to ensure that mental health professionals use a structured clinical assessment to diagnose borderline or antisocial personality disorder.

Data source: Local data collection.

Process

Proportion of people with a diagnosis of borderline or antisocial personality disorder who had the diagnosis made by a mental health professional using a structured clinical assessment.

Numerator – the number in the denominator who had the diagnosis made by a mental

health professional using a structured clinical assessment.

Denominator – the number of people with a diagnosis of borderline or antisocial personality disorder.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (mental health trusts) ensure that mental health professionals are trained and competent to carry out a structured clinical assessment to diagnose borderline or antisocial personality disorder.

Mental health professionals carry out and document a structured clinical assessment to diagnose borderline or antisocial personality disorder.

Commissioners (clinical commissioning groups, NHS England local area teams) ensure that they commission services with mental health professionals who are trained and competent to carry out and document a structured clinical assessment to diagnose borderline or antisocial personality disorder.

People with possible borderline or antisocial personality disorder have a structured assessment by a specialist in mental health before they are given a diagnosis. The results of the assessment are written in their records. This means that the diagnosis is accurate and that their needs and other health problems are identified from the outset.

Source guidance

- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013), recommendations 1.3.1.1 and 1.3.1.2
- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009), recommendation 1.3.1.2

Definitions of terms used in this quality statement

Structured clinical assessment

Structured clinical assessment should be undertaken using a standardised and validated tool. The main tools available for diagnosing borderline and antisocial personality disorders include:

- Diagnostic Interview for DSM–IV Personality Disorders (DIPD–IV)
- Structured Clinical Interview for DSM–IV Personality Disorders (SCID–II)
- Structured Interview for DSM–IV Personality (SIDP–IV)
- International Personality Disorder Examination (IPDE)
- Personality Assessment Schedule (PAS)
- Standardised Assessment of Personality (SAP).

[Adapted from NICE's full guideline on borderline personality disorder and NICE's full guideline on antisocial personality disorder]

Equality and diversity considerations

People with borderline or antisocial personality disorder frequently experience a range of comorbid conditions. These may be physical as well as mental health problems. Those working with people with borderline or antisocial personality disorder should always assess all of their needs and offer support accordingly. Diagnosis of borderline or antisocial personality disorder should never exclude people from receiving the help they need.

Quality statement 2: Psychological therapies – borderline personality disorder

Quality statement

People with borderline personality disorder are offered psychological therapies and are involved in choosing the type, duration and intensity of therapy.

Rationale

The NICE guideline on borderline personality disorder recommends psychological therapies for managing and treating the disorder. Because of the variety of symptoms and the variation in needs, flexible approaches that are responsive to the needs of each person with personality disorder are important. Involving people with borderline personality disorder in decisions regarding their own care is key for their engagement with treatment.

Quality measures

Structure

a) Evidence of local arrangements to ensure that psychological therapies are available to people with borderline personality disorder.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people with borderline personality disorder are involved in choosing the type, duration and intensity of psychological therapies that they receive.

Data source: Local data collection.

Process

a) Proportion of people with borderline personality disorder who received psychological therapies.

Numerator – the number in the denominator who received psychological therapies.

Denominator – the number of people with borderline personality disorder.

Data source: Local data collection.

b) Proportion of people with borderline personality disorder who chose the type, duration and intensity of psychological therapy they received.

Numerator – the number in the denominator who chose the type, duration and intensity of psychological therapy they received.

Denominator – the number of people with borderline personality disorder who received psychological therapies.

Data source: Local data collection.

Outcome

Evidence from experience surveys and feedback that service users feel actively involved in shared decision-making.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (mental health trusts) offer people with borderline personality disorder psychological therapies that are defined by the service user in terms of type, duration and intensity.

Healthcare professionals offer people with borderline personality disorder psychological

therapies that are defined by the service user in terms of type, duration and intensity.

Commissioners (clinical commissioning groups, NHS England local area teams) commission services that have sufficient resources to provide psychological therapies for people with borderline personality disorder that are defined by the service user in terms of type, duration and intensity.

People with borderline personality disorder are offered psychological therapies that help them manage their condition. They can choose the type, the length of the sessions, treatment and frequency of the therapy they receive.

Source guidance

Borderline personality disorder: recognition and management. NICE guideline CG78, (2009), recommendations 1.1.3.1, 1.3.4.1 and 1.3.4.3

Equality and diversity considerations

Adults within the prison population who present with symptoms of borderline personality disorder should have equitable access to services received by people in the community.

Specialist mental health services should ensure that culturally appropriate psychological interventions are provided to people from diverse ethnic and cultural backgrounds and that interventions address cultural and ethnic differences in beliefs regarding biological, social and family influences on mental states and functioning.

Quality statement 3: Psychological therapies – antisocial personality disorder

Quality statement

People with antisocial personality disorder are offered group-based cognitive and behavioural therapies and are involved in choosing the duration and intensity of the therapy.

Rationale

The NICE guideline on antisocial personality disorder recommends psychological therapies for managing and treating the symptoms and behaviours associated with antisocial personality disorder. Group-based cognitive and behavioural therapies help to address problems such as impulsivity, interpersonal difficulties, and antisocial behaviour, and can help to reduce offending behaviours. Because of the variety of symptoms and the variation in needs, flexible approaches that are responsive to the needs of each person with the disorder are important. Involving people with antisocial personality disorder in decisions about their own care is key for their engagement with treatment.

Quality measures

Structure

a) Evidence of local arrangements to ensure that group-based cognitive and behavioural therapies are available to people with antisocial personality disorder.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people with antisocial personality disorder are involved in choosing the duration and intensity of group-based cognitive and behavioural therapy that they receive.

Data source: Local data collection.

Process

a) Proportion of people with antisocial personality disorder who received group-based cognitive and behavioural therapy.

Numerator – the number in the denominator who received group-based cognitive and behavioural therapy.

Denominator – the number of people with antisocial personality disorder.

Data source: Local data collection.

b) Proportion of people with antisocial personality disorder who chose the duration and intensity of group-based cognitive and behavioural therapy they received.

Numerator – the number in the denominator who chose the duration and intensity of the group-based cognitive and behavioural therapy they received.

Denominator – the number of people with antisocial personality disorder who received group-based cognitive and behavioural therapy.

Data source: Local data collection.

Outcome

Evidence from experience surveys and feedback that service users feel actively involved in shared decision-making.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (mental health trusts) offer people with antisocial personality disorder group-based cognitive and behavioural therapies that are defined by the service user in terms of duration and intensity.

Healthcare professionals offer people with antisocial personality disorder group-based cognitive and behavioural therapies that are defined by the service user in terms of duration and intensity.

Commissioners (clinical commissioning groups, NHS England local area teams) commission services that have sufficient resources to provide group-based cognitive and behavioural therapies for people with antisocial personality disorder that are defined by the service user in terms of duration and intensity. They also ensure that referral pathways are in place for people with antisocial personality disorder to be referred to these services.

People with antisocial personality disorder are offered group therapy that helps them manage their condition. They can choose the length of the sessions, treatment and frequency of the therapy they receive.

Source guidance

Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013), recommendations 1.1.3.1, 1.4.2.1, 1.4.2.2 and 1.4.2.4

Equality and diversity considerations

Consideration should be given to the provision of services for adults within the prison population who present with symptoms of antisocial personality disorder.

Specialist mental health services should ensure that culturally appropriate psychological interventions are provided to people from diverse ethnic and cultural backgrounds and that interventions address cultural and ethnic differences in beliefs regarding biological, social and family influences on mental states and functioning.

Quality statement 4: Pharmacological interventions

Quality statement

People with borderline or antisocial personality disorders are prescribed antipsychotic or sedative medication only for short-term crisis management or treatment of comorbid conditions.

Rationale

No drugs have established efficacy in treating or managing borderline or antisocial personality disorder. However, antipsychotic and sedative medication can sometimes be helpful in short-term management of crisis (the duration of treatment should be no longer than 1 week) or treatment of comorbid conditions.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people with borderline or antisocial personality disorder are prescribed antipsychotic or sedative medication only for short-term crisis management or treatment of comorbid conditions.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that when people with borderline or antisocial personality disorder are prescribed antipsychotic or sedative medication, there is a record of the reason for prescribing the medication and the duration of the treatment.

Data source: Local data collection.

Process

a) Proportion of people with borderline or antisocial personality disorder prescribed antipsychotic or sedative medication in a crisis or to treat comorbid conditions.

Numerator – the number in the denominator who were prescribed the antipsychotic or sedative medication in a crisis or to treat comorbid conditions.

Denominator – the number of people with borderline or antisocial personality disorder prescribed antipsychotic or sedative medication.

Data source: Local data collection.

b) Proportion of people with borderline or antisocial personality disorder prescribed antipsychotic or sedative medication in a crisis and who had it prescribed for no longer than a week.

Numerator – the number in the denominator prescribed antipsychotic or sedative medication for no longer than a week.

Denominator – the number of people with borderline or antisocial personality disorder prescribed antipsychotic or sedative medication in a crisis.

Data source: Local data collection.

Outcome measure

Antipsychotic and sedative medication prescribing rates.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (GPs and mental health trusts) ensure that staff only prescribe antipsychotic or sedative medication for people with borderline or antisocial personality disorder for short-term crisis management or treatment of comorbid conditions.

Healthcare professionals only prescribe antipsychotic or sedative medication for people with borderline or antisocial personality disorder for short-term crisis management or treatment of comorbid conditions.

Commissioners (clinical commissioning groups, NHS England local area teams) commission services that only prescribe antipsychotic or sedative medication for people with borderline or antisocial personality disorder for short-term crisis management or treatment of comorbid conditions.

People with borderline or antisocial personality disorder are only prescribed antipsychotic or sedative medication for a short time if they have a crisis or if they have another condition that needs that medication.

Source guidance

- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013), recommendations 1.4.3.1 and 1.4.3.2
- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009), recommendations 1.3.5.1, 1.3.5.2, 1.3.5.3 and 1.3.5.4

Definitions of terms used in this quality statement

Short-term crisis management

Using sedative or antipsychotic medication for short-term crisis management means using it cautiously in a crisis as part of the overall treatment plan for people with borderline or antisocial personality disorder. The duration of treatment should be agreed with the person, but should be no longer than 1 week. [NICE's guideline on borderline personality disorder]

Crisis may be suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control, or irrational and likely to endanger the person or others. [Department of Health Mental health crisis care concordat (2014) and expert opinion]

Quality statement 5: Managing transitions

Quality statement

People with borderline or antisocial personality disorder agree a structured and phased plan with their care provider before their services change or are withdrawn.

Rationale

Once in treatment, people with borderline or antisocial personality disorder may build a strong attachment with practitioners and services that support them. Any change to the familiar arrangements is likely to cause anxiety and be associated with an increased risk of crisis. Self-harming behaviour and suicide attempts often occur at the time of change. Discussing changes in advance and coming up with a structured and phased plan acceptable to the service user, gives them a greater sense of control and reduces associated anxiety. People with borderline or antisocial personality disorder also need to know that they can access services easily in time of crisis. Integrating services is important to establish clear pathways for transitions between services and agencies, and facilitating well-organised services, care and support.

Quality measures

Structure

a) Evidence of local arrangements that people with borderline or antisocial personality disorder agree with their care provider a structured and phased plan before their services change or are withdrawn.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people with borderline or antisocial personality disorder can easily access services in time of crisis.

Data source: Local data collection.

Process

Proportion of changes to services or service withdrawals that have been planned and agreed beforehand by people with borderline or antisocial personality disorder and their care provider.

Numerator – number in the denominator planned and agreed beforehand by people with borderline or antisocial personality disorder and their care provider.

Denominator – changes to services or service withdrawals for people with borderline or antisocial personality disorder.

Data source: Local data collection.

Outcome

a) Service user experience of integrated care.

Data source: Adult Social Care Outcomes Framework

b) Frequency of crisis situations linked to transitions.

Data source: Local data collection.

c) Evidence from experience surveys and feedback that service users feel actively involved in shared decision-making.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (mental health trusts, primary care services, social services, care homes, probation and prison services) ensure that systems and processes are in place for people with borderline or antisocial personality disorder to agree with their care provider a structured and phased plan before their services change or are withdrawn. This should include plans for accessing services at times of crisis.

Health and social care practitioners ensure that they agree with people with borderline or antisocial personality disorder a structured and phased plan before their services change or are withdrawn. This should include plans for accessing services at times of crisis.

Commissioners (clinical commissioning groups, local authorities and NHS England local area teams) commission services that allow people with borderline or antisocial personality disorder to agree with their care provider a structured and phased plan before their services change or are withdrawn. This should include plans for accessing services at times of crisis.

People with borderline or antisocial personality disorder agree with the people providing their care a plan setting out how their services will change before any changes happen. The plan includes what will happen if services are stopped and how they can get help if they have a crisis.

Source guidance

- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013), recommendation 1.6.1.1
- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009), recommendation 1.1.7.1

Definitions of terms used in this quality statement

Changes to services

Changes to services include but are not limited to:

- transition from 1 service to another
- transfers from inpatient and detention settings to community settings
- transition from child and adolescent mental health services to adult mental health services
- discharges after crisis

- withdrawal of treatment or services
- ending of treatments or services
- changes to therapeutic relationship.

Any changes need to be discussed, agreed and documented in a care plan written in collaboration with the service user to enable smooth transitions. The care plan should clearly identify the roles and responsibilities of all health and social care practitioners involved for each person with a personality disorder. [Adapted from NICE's guideline on antisocial personality disorder and NICE's guideline on borderline personality disorder]

Equality and diversity considerations

Specialist mental health services should ensure that interpreters and advocates are present if any changes need to be discussed with a service user who may have difficulties in understanding the meaning and implications of these changes.

Quality statement 6: Education and employment goals

Quality statement

People with borderline or antisocial personality disorder have their long-term goals for education and employment identified in their care plan.

Rationale

The symptoms of borderline and antisocial personality disorders can often be improved with a range of interventions yet people still find it difficult to live well in the community. Health and social care practitioners develop comprehensive multidisciplinary care plans in collaboration with service users, which identify short-term aims such as social care and housing support. However, these care plans should also look at long-term goals for education and employment.

Quality measures

Structure

Evidence of local arrangements to ensure that people with borderline or antisocial personality disorder have their long-term goals for education and employment identified in their care plan.

Data source: Local data collection.

Process

Proportion of people with borderline or antisocial personality disorder who have their long-term goals for education and employment identified in their care plan.

Numerator – number in the denominator who have their long-term goals for education and

employment identified in their care plan.

Denominator – number of people with borderline or antisocial personality disorder.

Data source: Local data collection.

Outcome

Proportion of people in contact with secondary mental health services who are able and fit to work and are in paid employment.

Data source: Adult Social Care Outcomes Framework.

What the quality statement means for different audiences

Service providers (mental health trusts, primary care services, social services, care homes, probation and prison services) ensure that systems are in place for people with borderline or antisocial personality disorder to have their long-term goals for education and employment identified in their care plan.

Health and social care practitioners ensure that people with borderline or antisocial personality disorder have their long-term goals for education and employment identified in their care plan.

Commissioners (clinical commissioning groups, local authorities and NHS England local area teams) commission services that ensure that people with borderline or antisocial personality disorder have their long-term goals for education and employment identified in their care plan.

People with borderline or antisocial personality disorder have a care plan that sets out their goals for education and employment.

Source guidance

- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013), recommendation 1.3.1.1

- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009), recommendations 1.3.1.2 and 1.3.2.1

Equality and diversity considerations

Services should work in partnership with local stakeholders, including those representing minority ethnic groups, to enable people with borderline or antisocial personality disorder to stay in work or education or access new employment, volunteering and educational opportunities.

Some people may be unable to work or may be unsuccessful in finding employment. In these cases, other occupational or education activities should be considered, including pre-vocational training.

Quality statement 7: Staff supervision

Quality statement

Mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision.

Rationale

Some mental health professionals may find working with people with borderline or antisocial personality disorder challenging. People with personality disorder can experience difficulties in communication, building trusting relationships and respecting boundaries. This can be stressful for staff and may sometimes result in negative attitudes. Mental health professionals have a varied remit when supporting people with borderline or antisocial personality disorder. This means that the level and frequency of support and supervision that mental health professionals receive from their managers needs to be tailored to their role and individual needs.

Quality measures

Structure

a) Evidence of local arrangements to ensure that mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that the level and frequency of supervision of mental health professionals supporting people with borderline or antisocial personality disorder is monitored.

Data source: Local data collection.

Process

Proportion of mental health professionals supporting people with borderline or antisocial personality disorder who have an agreed level and frequency of supervision.

Nominator – number in the denominator who have an agreed level and frequency of supervision.

Denominator – number of mental health professionals supporting people with borderline or antisocial personality disorder.

Data source: Local data collection.

Outcome

a) Staff retention among mental health professionals.

b) Job satisfaction among mental health professionals.

Data source:NHS Outcomes Framework and NHS Staff Survey.

What the quality statement means for different audiences

Service providers (mental health trusts) ensure that mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision with their managers. This is recorded and reflects the individual professional's needs.

Mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision with their managers. This is recorded and reflects the individual professional's needs.

Commissioners (clinical commissioning groups and NHS England local area teams) commission services that ensure that mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision with their managers. This is recorded and reflects the individual professional's

needs.

People with borderline or antisocial personality disorder are supported by mental health professionals who are supervised by their managers to make sure they provide a good level of care.

Source guidance

- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013), recommendation 1.6.3.4
- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009), recommendation 1.1.9.2

Definitions of terms used in this quality statement

Staff supervision

Staff supervision can be focused on monitoring performance, supporting the individual professional or a mix of both these objectives. Staff supervision should:

- make use of direct observation (for example, recordings of sessions) and routine outcome measures
- support adherence to the specific intervention
- promote general therapeutic consistency and reliability
- counter negative attitudes among staff.

[Adapted from NICE's guideline on antisocial personality disorder]

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

See NICE's how to use quality standards for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments for this quality standard are available.

Good communication between health, mental health and social care practitioners and people with borderline or antisocial personality disorder is essential. Treatment, care and support, and the information 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. People with borderline or antisocial personality disorder and their families or carers (if appropriate) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013)
- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009)

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health. Closing the gap: priorities for essential change in mental health (2014)
- Emergence. 'Meeting the challenge – making a difference': a new personality disorder practitioner guide (2014)
- Department of Health. No health without mental health: implementation framework (2012)
- Department of Health. No health without mental health: a cross-government mental health outcomes strategy for people of all ages (2011)

Definitions and data sources for the quality measures

- Adult Social Care Outcomes Framework
- NHS Outcomes Framework
- Antisocial personality disorder: prevention and management. NICE guideline CG77 (2009, updated 2013)
- Borderline personality disorder: recognition and management. NICE guideline CG78 (2009)

Related NICE quality standards

- Bipolar disorder in adults. NICE quality standard 95 (2015)
- Alcohol: preventing harmful use in the community. NICE quality standard 83 (2015)
- Psychosis and schizophrenia in adults. NICE quality standard 80 (2015)
- Antisocial behaviour and conduct disorders in children and young people. NICE quality standard 59 (2014)
- Anxiety disorders. NICE quality standard 53 (2014)
- Smoking: supporting people to stop. NICE quality standard 43 (2013)
- Self-harm. NICE quality standard 34 (2013)
- Drug use disorders in adults. NICE quality standard 23 (2012)
- Service user experience in adult mental health services. NICE quality standard 14 (2011, updated 2019)
- Alcohol-use disorders: diagnosis and management. NICE quality standard 11 (2011)
- Depression in adults. NICE quality standard 8 (2011)

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

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The following specialist members joined the committee to develop this quality standard:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

This quality standard has been included in the NICE Pathway on personality disorders, which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- BPDWORLD
- Royal College of General Practitioners (RCGP)
- Royal College of Nursing (RCN)
- Royal College of Psychiatrists (RCPsych)
- Royal College of Paediatrics and Child Health