Personality disorders (borderline and antisocial)

NICE quality standard

Draft for consultation

November 2014

Introduction

This quality standard covers treating and managing borderline and antisocial personality disorders. For borderline personality disorder, this quality standard applies to adults and young people under 18 years. For antisocial personality disorder, this quality standard applies only to adults aged 18 years and over. NICE quality standard 59 covers antisocial behaviour and conduct disorder in children and young people under 18 years. For more information see the topic overview.

Why this quality standard is needed

Personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the person's culture. It is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (this is the DSM–IV classification which was used in the development of the NICE guidelines on antisocial personality disorder (CG77) and borderline personality disorder (CG78)).

Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes 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 are often 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 usually not diagnosed formally before the age of 18 years, but the 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 treatment or formal psychiatric assessment, symptoms improve sufficiently for at least 50% of people not to meet the criteria for borderline personality disorder 5–10 years after diagnosis.

Some 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 the disorder, people with antisocial personality disorder often experience unstable interpersonal relationships and may show disregard for the consequences of their behaviour and the feelings of others. Further traits of the disorder may result in a failure to learn from experience and 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 promiscuity.

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

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

Although borderline and antisocial personality disorders are associated with significant morbidity and increased mortality, the care provided to people with personality disorders is often fragmented. Borderline and antisocial personality

disorder are frequently misdiagnosed because of comorbid conditions and people with personality disorders are often prescribed medication or therapies unsuitable for them. Moreover, they are sometimes excluded from health or social care services because of their diagnosis. This may be because staff lack the confidence and skills to work with this group of people and because their challenging behaviours may result in negative attitudes amongst some staff. Some topic experts and people with personality disorder feel that there is stigma attached to borderline and antisocial personality disorders, even in mental health services.

In 2011, the government published its mental health strategy, No health without mental health, 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 quality improvements within 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 2014–15
- NHS Outcomes Framework 2014–15
- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, Parts 1A, 1B and 2

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* ***Outcome measures*** **People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life.** 1D Carer-reported quality of life **People are able to find employment when they want, maintain a family and social life and contribute to community life and avoid loneliness or isolation.** 1F Proportion of adults in contact with secondary mental health services in paid employment** 1H Proportion of adults in contact with secondary mental health services living independently, with or without support* 1I Proportion of people who use services and their carers who reported that they had as much social contact as they would like*
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population

3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with the experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support. 3B Overall satisfaction of carers with social services 3E Improving people's experience of integrated care** ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process.** 3C The proportion of carers who report that they have been included or consulted in discussion about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.** 3D Proportion of people who use services and carers who find it easy to find information about services **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.**
4 Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm	***Overarching measure*** 4A. The proportion of people who use services who feel safe** ***Outcome measures*** **Everyone enjoys physical safety and feels secure.** **People are free from physical and emotional abuse, harassment, neglect and self-harm.** **People are protected as far as possible from avoidable harm, disease and injuries.** **People are supported to plan ahead and have the freedom to manage risks the way they wish.** 4B Proportion of people who use services who say that those services have made them feel safe and secure
Aligning across the health and care system * Indicator complementary ** Indicator shared	

Table 2 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare **Reducing premature death in people with serious mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness*
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition** **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness****
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care 4b Patient experience of hospital care ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to in-patients' personal needs **Improving experience of healthcare for people with mental illness** 4.7 Patient experience of community mental health services **Improving people's experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving people's experience of integrated care** 4.9 People's experience of integrated care**
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF) **** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation 1.07 - People in prison who have a mental illness or a significant mental illness 1.08iii – Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate 1.13i - % of offenders who re-offend from a rolling 12 month cohort 1.13ii - Average no. of re-offences committed per offender from a rolling 12 month cohort
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities 2.15i Successful completion of drug treatment – opiate users 2.15ii Successful completion of drug treatment – non-opiate users 2.18 Alcohol related admissions to hospital
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.09 Excess under 75 mortality in adults with serious mental illness 4.10 Suicide rate

Patient 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 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 be 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 patient experience and are specific to the topic will be considered during quality statement development.

Coordinated services

The quality standard for personality disorders (borderline and antisocial) 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 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 will be 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, public health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. People have a structured assessment before they are given a diagnosis of borderline or antisocial personality disorder.

Statement 2. People with borderline or antisocial personality disorder are offered psychological therapies relevant to the disorder or individual symptoms of the disorder.

Statement 3. People with borderline or antisocial personality disorders are not prescribed antipsychotic or sedative medication for medium or long term management unless there is a diagnosed psychotic disorder.

Statement 4. People with borderline or antisocial personality disorder have the risks associated with transitions and changes to services addressed in their care plan.

Statement 5. People with borderline or antisocial personality disorder have their social care, social support and occupational needs identified in their care plan.

Statement 6. Mental health professional supporting people with borderline or antisocial personality disorder are routinely supervised.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers?

Questions about the individual quality statements

Question 4 For statement 2, could you provide a list of psychological therapies that are relevant to borderline or antisocial personality disorder.

Question 5 Is statement 5 aspirational or are all mental health professionals already routinely supervised?

Question 6 For statement 5, could you specify what level of intensity or what frequency of supervision would be required to achieve quality improvement?

Quality statement 1: Structured assessment

Quality statement

People have a structured assessment before they are given a diagnosis of 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 before diagnosis is essential to identify all the symptoms, make an accurate diagnosis and identify comorbidities.

Quality measures

Structure

Evidence of local arrangements to ensure that a structured assessment is carried out before a diagnosis of borderline or antisocial personality disorder is given and that the process is documented.

Data source: Local data collection.

Process

The proportion of people with borderline or antisocial personality disorder diagnosed following a structured and documented assessment.

Numerator – the number in the denominator who were diagnosed following a structured and documented assessment.

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

Data source: Local data collection

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (mental health trusts) ensure that staff are trained and competent to carry out and document a structured assessment before diagnosing borderline or antisocial personality disorder.

Health and social care practitioners carry out and document a structured assessment before making a diagnosis of borderline or antisocial personality disorder.

Commissioners (clinical commissioning groups, NHS England) ensure that they commission services with staff who are trained and competent to carry out and document a structured assessment before diagnosing borderline or antisocial personality disorder.

What the quality statement means for patients, service users and carers

People with possible borderline or antisocial personality disorder have a documented and structured assessment before they are given a diagnosis. This means that the diagnosis is accurate and that their needs and any other health problems are identified from the outset.

Source guidance

- Antisocial personality disorder (2009) NICE guideline CG77, recommendation 1.3.1.1
- Borderline personality disorder (2009) NICE guideline CG78, recommendation 1.3.1.2

Definitions of terms used in this quality statement

Structured assessment

Structured assessment should be undertaken using a standardised and validated tool. Some of the main tools available for the assessment of personality disorders are:

- 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 Borderline personality disorder (2009) the full guideline CG78]

Quality statement 2: Psychological therapies

Quality statement

People with borderline or antisocial personality disorder are offered psychological therapies relevant to the disorder or individual symptoms of the disorder.

Rationale

Psychological therapies are recommended for managing and treating borderline personality disorder in the NICE guideline on borderline personality disorder and for managing and treating the symptoms and behaviours associated with antisocial personality disorder in the NICE guideline on antisocial personality 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. Not all psychological therapies are effective for people with personality disorder and some can be detrimental to a person's condition. Only therapies specifically developed for the disorder or for individual symptoms of the disorder should be offered.

Quality measures

Structure

Evidence of local arrangements to ensure that people with borderline or antisocial personality disorder have access to psychological therapies relevant to the disorder or individual symptoms of the disorder.

Data source: Local data collection.

Process

The proportion of people with borderline or antisocial personality disorder who received psychological therapies relevant to the disorder or for the individual symptoms of the disorder in the past 12 months.

Numerator – the number in the denominator who received psychological therapies relevant to the disorder or individual symptoms of the disorder.

Denominator – the number of people with borderline or antisocial borderline personality disorder who received psychological therapies in the past 12 months.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (mental health trusts) provide psychological therapies relevant to borderline and antisocial personality disorder and for individual symptoms of the disorder.

Health practitioners offer people with borderline or antisocial personality disorder psychological therapies relevant to the disorder or individual symptoms of the disorder.

Commissioners (clinical commissioning groups, NHS England) commission services that have sufficient resources to provide psychological therapies relevant to borderline and antisocial personality disorder. They also ensure that the services have staff trained and competent to provide psychological therapies relevant to the disorder or individual symptoms of the disorder.

What the quality statement means for patients, service users and carers

People with borderline or antisocial personality disorder can have psychological therapies (therapy) when they need them. The therapy they are offered is relevant to the disorder they have or to the symptoms of the disorder.

Source guidance

- Antisocial personality disorder (2009) NICE guideline CG77, adapted from recommendations 1.4.2.1, 1.4.2.2
- Borderline personality disorder (2009) NICE guideline CG78, adapted from recommendations 1.3.4.1, 1.3.4.3, 1.3.4.5

Definitions of terms used in this quality statement

Psychological therapies relevant to the disorder or individual symptoms of the disorder

For people with antisocial personality disorder:

- group-based cognitive and behavioural interventions to address problems such as impulsivity, interpersonal difficulties and antisocial behaviour
- group-based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour for people with a history of offending behaviour.

For people with borderline personality disorder:

- When considering a psychological treatment for a person with borderline personality disorder, take into account:
  - the choice and preference of the service user
  - the degree of impairment and severity of the disorder
  - 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
  - the availability of personal and professional support.
- Comprehensive dialectical behaviour therapy for women with borderline personality disorder for whom reducing recurrent self-harm is a priority.

Quality statement 3: Pharmacological interventions

Quality statement

People with borderline or antisocial personality disorders are not prescribed antipsychotic or sedative medication for medium or long term management unless there is a diagnosed psychotic disorder.

Rationale

No drugs are licensed for treating or managing borderline and antisocial personality disorder. Drugs should not be used to treat the symptoms of personality disorder and medication should only be used for short-term management of crisis or management of comorbid psychotic disorder.

Quality measures

Structure

Evidence of local arrangements to ensure that people with borderline or antisocial personality disorder are not prescribed antipsychotic or sedative medication for medium or long term management unless there is a diagnosed psychotic disorder.

Data source: Local data collection.

Process

Proportion of people with borderline or antisocial personality disorders and no diagnosis of psychotic disorder who were prescribed antipsychotic or sedative medication for medium or long term management.

Numerator – the number in the denominator who were prescribed antipsychotic or sedative medication for medium or long term management

Denominator – the number of people with borderline or antisocial personality disorders and no diagnosis of psychotic disorder

Data source: Local data collection.

Outcome measure

Antipsychotic and sedative drugs prescribing rates.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (GPs and mental health trusts) ensure that staff do not use antipsychotic or sedative medication for medium or long term management of borderline or antisocial personality disorder unless there is a diagnosed comorbid psychotic disorder.

Healthcare professionals do not use antipsychotic or sedative medication for medium or long term management of borderline or antisocial personality disorder unless there is a diagnosed comorbid psychotic disorder.

Commissioners (clinical commissioning groups, NHS England) commission services that do not use antipsychotic or sedative medication for medium or long term management of borderline or antisocial personality disorder unless there is a diagnosed comorbid psychotic disorder. What the quality statement means for patients, service users and carers

People with borderline or antisocial personality disorder are not prescribed medication to treat the symptoms of personality disorder and are only prescribed medication for a short time if they have a crisis.

Source guidance

- Antisocial personality disorder (2009) NICE guideline CG77, adapted from recommendations 1.4.3.1, 1.4.3.2
- Borderline personality disorder (2009) NICE guideline CG78, adapted from recommendations 1.3.5.1, 1.3.5.2, 1.3.5.3, 1.3.5.4

Definitions of terms used in this quality statement

Medium and long term management of borderline or antisocial personality disorder

Medium term is between 2- 4 weeks and 3-6 months, long term is over 6 months [Expert opinion]

Quality statement 4: Managing transitions

Quality statement

People with borderline or antisocial personality disorder have the risks associated with transitions and changes to services addressed in their care plan.

Rationale

Any changes to services provided to people with borderline or antisocial personality disorder may cause anxiety and be associated with an increased risk of self-harming behaviour and suicide attempts. If these changes are discussed with the service user beforehand, are structured and carefully phased, then this can give the service user a greater sense of control and reduce 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.

Quality measures

Structure

a) Evidence of local arrangements illustrating clear pathways and agreed local criteria to facilitate well-organised and smooth transfer between services for people with borderline or antisocial personality disorder.

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

a) Percentage of service users with a care plan that supports effective collaboration with other care providers during endings and transitions and specifies how to access services in times of crisis

Numerator – number in the denominator with a care plan that supports effective collaboration with other care providers during endings and transitions and specifies how to access services in times of crisis

Denominator – people with borderline or antisocial personality disorder with a care plan

Data source: Local data collection and audit support for the NICE guideline on borderline personality disorder audit criterion 4c.

b) Proportion of people with borderline or antisocial personality disorder with a documented discussion about changes to the services they receive before the changes take place.

Numerator – number in the denominator who had a documented discussion of changes to the services they receive before the changes took place.

Denominator – people with borderline or antisocial personality disorder with planned changes to their services.

Data source: Local data collection and audit support for the NICE guideline on borderline personality disorder audit criterion 4a.

Outcome

a) Service user experience of integrated care.

Data source: Health and Social Care Information Centre 2014 Adult Social Care Outcomes Framework

b) Frequency of crisis situations linked to transitions.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

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 have a care plan addressing the risks associated with transitions and changes to services. This should include access to services in crisis.

Health and social care practitioners ensure that people with borderline or antisocial personality disorder have care plans addressing the risks associated with transitions and changes to services. This should include specifying how to access services in crisis.

Commissioners (clinical commissioning groups, local authorities and NHS England area teams) commission services that give people with borderline or antisocial personality disorder a care plan addressing the risks associated with transitions and changes to services. The care plan should specify how to access services in crisis.

What the quality statement means for patients, service users and carers

People with borderline or antisocial personality disorder have a care plan which addresses the risks associated with transitions and changes to services. The care plan specifies details on how to access services in crisis.

Source guidance

- Antisocial personality disorder (2009) NICE guideline CG77, recommendation 1.6.1.1
- Borderline personality disorder (2009) NICE guideline CG78, 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 one service to another
- transfers from inpatient and detention settings to community settings
- 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 and responsible for each person with a personality disorder.

[Adapted from NICE guideline CG77 and NICE guideline CG78]

Quality statement 5: Social and occupational needs

Quality statement

People with borderline or antisocial personality disorder have their social care, social support and occupational needs identified in their care plan.

Rationale

The symptoms of borderline and antisocial personality disorders can often be improved with interventions yet people still find it difficult to make changes in their social and occupational activities. The initial assessment has to recognise that individual people have different needs and the care plan should specify what support is needed to help the person live well in the community. This may include support with social care, personal development, education and employment.

Quality measures

Structure

Evidence of local arrangements to ensure that people with borderline or antisocial personality disorder have their social care, social support and occupational needs identified in their care plan.

Data source: Local data collection.

Process

a) Proportion of people with borderline or antisocial personality disorder who have their social care needs identified in their care plan.

Numerator – number in the denominator who have their social care needs identified in their care plan.

Denominator – number of people with borderline or antisocial personality disorder who have a care plan.

Data source: Local data collection.

b) Proportion of people with borderline or antisocial personality disorder who have their social support needs identified in their care plan.

Numerator – number in the denominator who have their social support needs identified in their care plan.

Denominator – number of people with borderline or antisocial personality disorder who have a care plan.

Data source: Local data collection.

c) Proportion of people with borderline or antisocial personality disorder who have their occupational needs identified in their care plan

Numerator – number in the denominator who have their occupational needs identified in their care plan.

Denominator – number of people with borderline or antisocial personality disorder who have a care plan.

Data source: Local data collection.

d) Proportion of people with borderline or antisocial personality disorder with a care plan that specifies the roles and responsibilities of health and social care practitioners who need to be involved in supporting them with their social care, social support and occupational needs.

Numerator – number in the denominator whose plan specifies the roles and responsibilities of health and social care practitioners who need to be involved in supporting them with social care, social support and occupational needs.

Denominator – number of people with borderline or antisocial personality disorder who have a care plan.

Data source: Local data collection.

Outcome

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

b) Proportion of adults in contact with secondary mental health services living independently, with or without support.

c) Proportion of people using mental health services who report that they have as much social contact as they would like.

Data source: Health and Social Care Information Centre 2014 Adult Social Care Outcomes Framework

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (mental health trusts, social services, care homes and schools) ensure that systems are in place for people with borderline or antisocial personality disorder to have their social care, social support and occupational needs identified in their care plan.

Health and social care practitioners ensure that for people with borderline or antisocial personality disorder have their social care, social support and occupational needs identified in their care plan.

Commissioners (clinical commissioning groups, NHS England area teams and local authorities) commission services that work with people with borderline or antisocial personality disorder on a care plan that identifies their social care, social support and occupational needs.

What the quality statement means for patients, service users and carers

People with borderline or antisocial personality disorder have their social care, social support and occupational needs identified in the care plan.

Source guidance

- Antisocial personality disorder (2009) NICE guideline CG77, adapted from recommendation 1.3.1.1
- Borderline personality disorder (2009) NICE guideline CG78, adapted from recommendations 1.3.1.1, 1.3.2.1

Definitions of terms used in this quality statement

Needs identified in a care plan

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

- identify clearly the roles and responsibilities of all health and social care practitioners involved
- identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them
- identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims.

[Adapted from NICE guideline CG78]

Quality statement 6: Staff supervision

Quality statement

Mental health professional supporting people with borderline or antisocial personality disorder are routinely supervised.

Rationale

Sometimes it may be hard to engage with people with borderline or antisocial personality disorder. The traits of the borderline and antisocial personality disorders make it difficult to communicate and respect boundaries. Working with these people can be very demanding, stressful and can sometimes result in negative staff attitudes. As a result, there is an increased need for supervision and support for staff working with people with borderline or antisocial personality disorder. The support and supervision need to be part of the routine service, and should be properly resourced and monitored.

Quality measures

Structure

a) Evidence of local arrangements to ensure that staff supporting people with borderline or antisocial personality disorder are routinely supervised.

Data source: Local data collection.

b) Evidence of local arrangements illustrating that staff supervision is part of the routine service, and is properly resourced and monitored.

Data source: Local data collection.

Process

Proportion of mental health professionals supporting people with borderline or antisocial personality disorder who are routinely supervised.

Nominator – number in the denominator who are routinely supervised.

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

Data source: Local data collection.

Outcome

a) Service user experience of mental health services

b) Staff retention among mental health practitioners.

c) Job satisfaction among mental health practitioners.

Data source: Health and Social Care Information Centre (2014) NHS Outcomes framework and NHS Staff Survey

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (mental health trusts) ensure that mental health professionals working with people with borderline or antisocial personality disorder are routinely supervised.

Health and social care practitioners working with people with borderline or antisocial personality disorder are routinely supervised.

Commissioners (clinical commissioning groups and NHS England area teams) commission services for people with borderline or antisocial personality disorder that have staff supervision and support as part of the routine service. The services should be properly resourced and monitored.

What the quality statement means for patients, service users and carers

People with borderline or antisocial personality disorder are supported by mental health professionals who themselves have regular support and supervision.

Source guidance

- Antisocial personality disorder (2009) NICE guideline CG77, adapted from recommendation 1.6.3.4
- Borderline personality disorder (2009) NICE guideline CG78, adapted from recommendations 1.1.9.2

Definitions of terms used in this quality statement

Routine supervision

Routine 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

[Antisocial personality disorder (2009) NICE guideline CG77]

Status of this quality standard

This is the draft quality standard released for consultation from 21 November to 19 December 2014. It is not NICE's final quality standard on personality disorders (borderline and antisocial). The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 19 December 2014. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from May 2015.

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.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? 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 are available.

Good communication between health, public 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 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 (2009) NICE guideline CG77.
- Borderline personality disorder (2009) NICE guideline CG78.

Policy context

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

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

Definitions and data sources for the quality measures

- Health and Social Care Information Centre (2014) Adult Social Care Outcomes Framework
- Health and Social Care Information Centre (2014) NHS Outcomes framework
- Antisocial personality disorder (2009) NICE guideline CG77.
- Borderline personality disorder (2009) NICE guideline CG78.

Related NICE quality standards

Published

- Antisocial behaviour and conduct disorders in children and young people. NICE quality standard 59 (2014).
- Anxiety disorders NICE quality standard 53 (2014).

- Smoking cessation – supporting people to stop smoking NICE quality standard 43 (2013).
- Self-harm NICE quality standard 34 (2013).
- Drug use disorders. NICE quality standard 23 (2012).
- Service user experience in adult mental health NICE quality standard 14 (2011).
- Depression in adults NICE quality standard 8 (2011).
- Alcohol dependence and harmful alcohol use NICE quality standard 11 (2011).

In development

- Alcohol: preventing harmful alcohol use in the community Publication expected December 2014
- Psychosis and schizophrenia in adults Publication expected February 2015
- Bipolar disorder in adults Publication expected June 2015.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Eating disorders

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:

Dr Alastair Bradley
General Medical Practitioner, Tramways Medical Centre/Academic Unit of Primary Medical Care, University of Sheffield

Jan Dawson
Public Health Nutrition Lead and Registered Dietician, Manchester City Council

Dr Matthew Fay
GP, Westcliffe Medical Practice, Shipley, West Yorkshire

Dr Malcolm Fisk
Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

Ms Margaret Goose
Lay member

Mrs Geeta Kumar
Clinical Director, Women's Services (East) Betsi Cadwaladr University Health Board

Mrs Rhian Last
Clinical Lead, Education for Health

Dr Hugh McIntyre (Chair)
Consultant Physician, East Sussex Healthcare Trust

Mrs Mandy Nagra
Cancer Drug Fund and Individual Funding Request Manager, Specialised Commissioning, NHS England

Ms Ann Nevinson

Lay member

Dr Jane O'Grady

Director of Public Health, Buckinghamshire County Council

Mrs Jane Orr-Campbell

Director, Orr-Campbell Consultancy, Bedfordshire

Professor Gillian Parker

Professor of Social Policy Research and Director, Social Policy Research Unit, University of York

Mr David Pugh

Independent Consultant, Gloucestershire County Council

Dr Eve Scott

Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

Dr Jim Stephenson

Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Darryl Thompson

Psychosocial Interventions Development Lead, South West Yorkshire Partnership NHS Foundation Trust

Mrs Julia Thompson

Strategic Commissioning Manager, Sheffield City Council

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

Mrs Annette Duff

Nurse Consultant, Cognitive Behavioural Psychotherapist, Approved Clinician, Norfolk and Suffolk NHS Foundation Trust

Professor Peter Fonagy

Head of the Research Department of Clinical, Educational and Health Psychology, University College London

Ms Victoria Green

Representing Service User and Carer Interests

Professor James McGuire

Professor of Forensic Clinical Psychology, Institute of Psychology, Health and Society, Department of Psychological Sciences, University of Liverpool

Dr Paul Moran

Clinical Senior Lecturer | Consultant Psychiatrist, Institute of Psychiatry, King's College London

Miss Katherine Spivey

Service and Development Manager, Bridging the Gap PD Services Ltd, Doncaster

NICE project team

Mark Minchin

Associate Director

Craig Grime

Technical Adviser

Anna Wasielewska

Lead Technical Analyst

Rachel Neary-Jones

Programme Manager

Esther Clifford

Project Manager

Rita Parkinson

Co-ordinator

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.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on personality disorders.

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.

Copyright

© National Institute for Health and Care Excellence 2014. All rights reserved. NICE copyright material can be downloaded for private research and study, and may be reproduced for educational and not-for-profit purposes. No reproduction by or for commercial organisations, or for commercial purposes, is allowed without the written permission of NICE.

ISBN: