Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Understanding mental health, understanding adults

Managing Borderline Personality Disorder in General Practice

: useful rules of thumb

Complex Cases Service
June 2009

In partnership with the University of Cambridge

Dear GP

This leaflet, part of a series of leaflets on personality disorder, is produced by the Complex Cases Service.

The Complex Cases Service is the specialist, tertiary service, within the Cambridgeshire and Peterborough NHS Foundation Trust, providing assessment and treatment services for people with personality disorder who have particularly complex needs and/or high levels of risk. In addition, such specialist services have now been required by NICE to provide consultation and advice to primary and secondary care services, and to oversee the implementation of the guideline[1].

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The following leaflet arises out of a discussion we have had with the some of the psychiatric Gateway Workers, thinking with them about what information might help GP's more readily identify and manage patients with personality disorder in General Practice. It is also hoped that the leaflet will aid liaison between GPs and their gateway workers.

This leaflet is intended to be helpful; so if it isn't, or you could suggest improvements, do please let us know! If you would like to contact the authors of this leaflet, you can do so by e-mailing us on:

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[1] "Borderline personality disorder: treatment and management". NICE clinical guideline 78, January 2009. http://www.nice.org.uk/Guidance/CG78

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CONTENTS page

Identifying sufferers 1

Attitudes to sufferers 2

Treatment 3

The role of drug treatment 4

Referral to Mental Health Services 5

- When to refer
- What patients can expect if they are referred to mental health services 6
- The role of psychotherapy 7

Long-term management within primary care 7

Stepped-care referral and discharge pathways diagram back cover

Identifying sufferers

About 6% of your caseload will suffer from a personality disorder[2], but many may be un– or misdiagnosed; or, frequently, a co-morbid condition such as drug or alcohol abuse, or depression or anxiety may mask the presence of the personality disorder.

Use the acronym **CRISP** to remind you that this may be a patient's diagnosis.
Patients with this disorder are **not psychotic** but they may have a range of psychiatric symptoms - often changing with time - that have the following features:

Chronic
Looking back you will find a long psychiatric history but often a range of disorders presented.
Risky
Patients will be engaging in behaviours that put their lives or wellbeing – or the lives of others, including dependents - at risk. Self-harm (or harm to others) will be impulsive with striking evidence of poor planning and either failures of forethought or situations where emotion dramatically overruled common sense.
Instability
Interpersonal relationships, mood, and their sense of self will show marked instability.
Social slippage
In the course of life, the patient clearly underachieves and/or, often through successive crises, slowly becomes more socially disadvantaged.
Pervasive.
All areas of functioning and all ages of life other than early childhood are affected.

[2] Currently – and confusingly – there are diagnostic criteria for at least 10 different personality disorders. The recent NICE Guidance (which has inspired and shaped this leaflet) seems to address but one of these: Borderline PD. However, patients with Borderline PD in various degrees of severity, and in combination with various other personality disorders (and co-morbid conditions) represent the majority of people with personality disorder seeking help from mental health services.

Attitudes to sufferers

For too long patients with personality disorder have been viewed as a very troublesome, resource-hungry group (with a dubious diagnosis) who “won’t be helped” as much as “can’t be helped”. While this view is clearly pejorative and fails to appreciate the patients’ perspective and real (though fluctuating) distress, nonetheless it may often be the case that such strong and uncharitable feelings initially alert us to the possibility of a personality disorder. PD is undoubtedly a legitimate life-long mental illness, which devastates lives.

A particularly cruel aspect of the condition, however, is how readily patient’s ineffective interpersonal skills can alienate the care and support they seek … and, overtly or covertly, they have been unfairly excluded from services.

The following rule of thumb describes two common subgroups, which for the sake of identification (rather than understanding) we have characterised by the negative emotional impact they inadvertently cause.

Patients may be **treatment seeking**: treatment-seeking patients may present a considerable challenge to the resources of the surgery. They may telephone repeatedly and want frequent appointments while remaining dissatisfied with treatment. Their reasons for consulting may be multiple physical complaints, mood problems or difficulties and needs related to drug or alcohol dependence. (Your staff too may be stressed: the practice nurse who is troubled by dealing with repeated self-inflicted wounds; or the receptionist who is the frontline contact with the same frequently distressed or unreasonable patient.)

Overall these patients feel a **DRAIN**

Demanding – needing or asking for more resource than is available and in a hurry because of the extremity of their distress.
Recalcitrant – unwilling to comply with some or many treatment options.
Affect provoking – others (and you as well) show strong emotional responses both positive and negative to the patient.
Inconsistent and incomplete in their self-reporting and indifferent to the seriousness of their self-harming behaviour.
Needy for love, doing anything to avoid abandonment such as clinging to abusive relationships.

Other patients are **treatment resisting**: treatment-resisting patients raise issues of risk or require sudden accurate management, but in a context that make this task difficult. Such patients make you **FRET**:

Feckless – impulsivity, failure of forward planning and difficulties leading an ordinarily responsible life are prominent.
Risky – Often present a risk to self and others in a variety of ways.
Emergency presentation – turn up as an emergency or register as temporary rather than make a sustained relationship.
Toxic – stimulate strong negative responses and get thrown off lists, lose accommodation and get given up on or neglected.

Treatment

For patients who present in primary care – often in crisis - NICE now offers specific guidance, which is summarised and expanded below.

Immediate Worries – Risk.

Assess the current level of risk to self or others.
The special features of risk in this group are:

- Less secure links between stated intent and likelihood of future action.

- Wild fluctuations in level of risk and intent.
- Strong association of increased risk with drug and alcohol use.

If you decide to manage conservatively within primary care, then:

- ask about previous episodes and effective management strategies used in the past
- help to manage their anxiety by enhancing coping skills and helping them to focus on the current problem.
- encourage them to identify manageable changes that will enable them to deal with the current problems.
- offer a follow-up appointment at an agreed time.

The role of drug treatment

NICE is quite specific

Do not use:

- Drug treatment specifically for borderline personality disorder for the individual symptoms or behaviour associated with the disorder (e.g. repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms).
- Antipsychotic drugs for the medium- and long-term treatment of borderline PD.

- Consider drug treatment in the overall **treatment of co-morbid conditions**. Examples include:
  - Focused use of antidepressants in a depressive episode,
  - Brief (2 weeks or so) course of neuroleptics for agitation.

- Consider cautiously short-term use of sedative medication as part of the overall treatment plan for people with borderline PD **in a crisis**. Agree the duration of treatment with them, but it should be no longer than 1 week.[3]

- Review the treatment of those who do not have a diagnosed co-morbid mental or physical illness and who are currently being prescribed drugs. Aim to **reduce and stop unnecessary drug treatment**.

- In the **management of insomnia**, provide patients with general advice about sleep hygiene. For the further short-term management of insomnia follow the recommendations in "Guidance on the use of zaleplon, zolpidem, and zopiclone for the short-term management of insomnia" (NICE technology appraisal 77). However, be aware of the potential for misuse of many of the drugs used for insomnia and consider other drugs such as sedative antihistamines.

- A particular technical problem is the management of patients with personality disorders who are already being prescribed considerable amounts of medication on a long-term basis. In light of the new guidance such individuals now need review and should probably be discussed with the tertiary service.

Referral to mental health Gateway Worker

When to refer

Most patients can be conservatively managed in primary care with support and encouragement during crises. NICE advises that you should consider referral when:

- Levels of distress or risk to self/others are increasing.

  It is worth remembering that fatal events are often preceded by a run of non-fatal events.

[3] Anithistamines are not licensed for this indication and informed consent should be obtained and documented.

- Levels of distress and risk remain high despite attempts to reduce anxiety and improve coping
- They request help from specialist services

What patients can expect if they are referred to mental health services

Diagnosis

If a patient meets the criteria, then they should expect to be given their diagnosis.
The label of "personality disorder" is still misunderstood and stigmatising. However, there are advantages in being given a diagnosis: (i) many patients have known all along that there was "something wrong" and are relieved to be told they share with many others a real, recognised condition (ii) with the right label patients are able to access further information, peer support networks etc on, for example, the internet.

Stepped-care

Depending upon the level of risk and of psychosocial impairment, and the patient's willingness to engage with mental health services, he or she may best be supported:

i. solely by the GP in primary care
ii. in the PC Psychological Health Service (PCPHS) with a short psycho-educational course, which introduces the patient to the meaning and implications of their diagnosis, and encourages them to live constructively with the condition
iii. in secondary care (i.e. the Intake and Treatment, or Rehabilitation and Recovery teams)
iv. or, where the patient's problems are complex and high risk, in tertiary care by the Complex Cases Service.

General principles of support

Engagement, psycho-education, risk assessment and management, and help to meet psychosocial needs, are the backbone of support: to stabilise the patients, help them better manage their recurrent crises, improve the quality of their lives and establish independent social networks.

The role of psychotherapy

There *is* evidence that some forms of psychotherapy can be of benefit to people with personality disorder.
However, with this group of patients there are also inherent dangers in embarking upon a formal talking therapy. While many patients with personality disorder have experienced adverse and abusive early histories, and they may even want psychotherapy, there are real risks that (i) it may not be successful, and they will again experience abandonment, rejection and failure (ii) the therapy will only serve to make the patient more ill and more risky. So, in line with NICE, a formal talking therapy will only be offered with caution.

In particular, as NICE stipulates that psychotherapy of less than 3 months duration should NOT be given specifically for a personality disorder (or for any of its individual symptoms), a referral to the PCPHS courses of brief psychological therapies would not normally be appropriate

Long-term management within primary care

Some of your patients will already be well known to secondary and tertiary care and have longstanding chronic psychiatric difficulties. This group of patients will need primary care throughout their lives. The keys to long-term management are

- **Keeping a relationship with the patient**
  This involves tolerating the patient's abnormal relationship style and setting careful limits on what you expect/require of the patient so as not to set them up to fail. It involves explaining the limits of primary care to the patient so as not to set <u>you</u> up to fail.

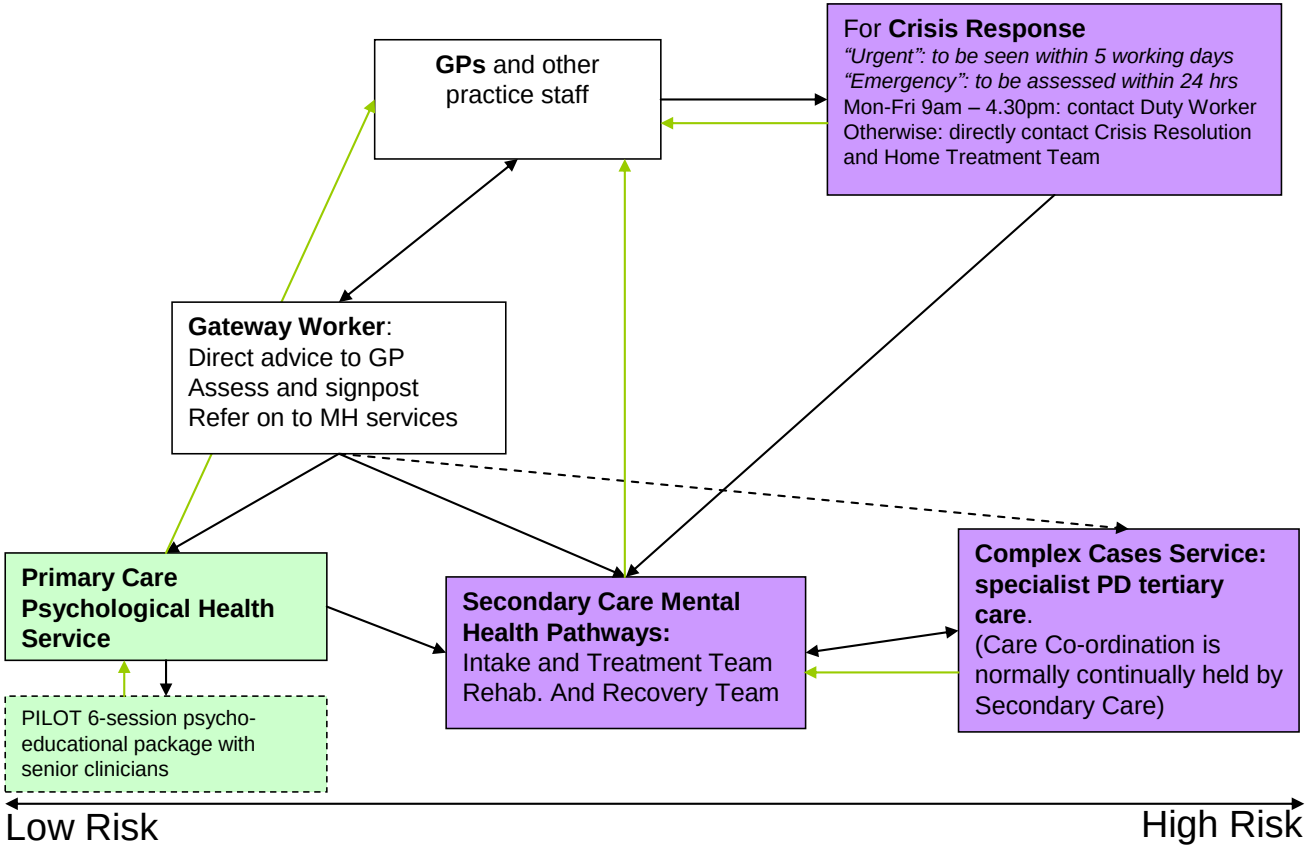
- **Maintaining professional boundaries**.
  This involves remaining sensitive to the tendency of these patients to provoke either undue levels of care and involvement with temptations to breach professional boundaries or to provoke hostility and even poor or deficient professional standards in treatment as a result.

- **Good information sharing**
  These patients' chaotic lives make gathering information about them taxing. They may present to multiple agencies. Many serious-incident enquiries, such as those that follow death or homicide, highlight deficiencies in the awareness of different agencies about risks posed by the patient to themselves or others and recent events. Making sure that you receive and transmit information from all parties about the patient, and balancing this with your duty of confidentiality, can be time consuming, but repays effort.

- **Optimistic realism**.
  It is easy to give up hope or expectation of change in this group of patients. Maintaining an atmosphere of hope is important and regular review of therapeutic initiatives can be beneficial. Even though formal talking therapies and medication may be contra-indicated, simple measures such as problem solving, support groups or lifestyle advice can be very efficacious. However, a realistic appreciation of the limits of therapeutic efforts is important to avoid subjecting the patient to over-heroic interventions and cycles of hope and disappointed expectations. By the same token, patients need regular review in relation to risk, which may fluctuate in severity. But some chronic risks cannot be reduced further and when this is the case tolerating the risk is important.

- **Sharing the burden**
  This group of patients should be managed in partnership with other agencies. Regular contact with these agencies, and developing good links with secondary and tertiary care, helps to share the burden of managing them and provides checks and oversight in relation to complex management decisions.

Stepped-care Referral and Discharge Pathways for Adult patients suspected or identified[1] has having a Personality Disorder



[1] If you wish to re- refer a patient who has had a previous episode of care in Secondary mental health pathways, then this should normally be made again through the Gateway Worker unless otherwise advised by Secondary Care

Primary Care Psychological Health Service Secondary Care Mental Health Pathways 21.05.2009 CW