NICE National Institute for Health and Care Excellence

NICE guideline

Borderline personality disorder: recognition and management

Clinical guideline

Published: 28 January 2009
nice.org.uk/guidance/cg78

Contents

Introduction

This guideline makes recommendations for the treatment and management of borderline personality disorder[1] in adults and young people (under the age of 18) who meet criteria for the diagnosis in primary, secondary and tertiary care.

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 and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide.

The extent of the emotional and behavioural problems experienced by people with borderline personality disorder varies considerably. Some people with borderline personality disorder are able to sustain some relationships and occupational activities. People with more severe forms experience very high levels of emotional distress. They have repeated crises, which can involve self-harm and impulsive aggression. They also have high levels of comorbidity, including other personality disorders, and are frequent users of psychiatric and acute hospital emergency services. While the general principles of management referred to in this guideline are intended for all people with borderline personality disorder, the treatment recommendations are directed primarily at those with more severe forms of the disorder.

Borderline personality disorder is present in just under 1% of the population, and is most common in early adulthood. Women present to services more often than men. Borderline personality disorder is often not formally diagnosed before the age of 18, but the features of the disorder can be identified earlier. Its course is variable and although many people recover over time, some people may continue to experience social and interpersonal difficulties.

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

People with borderline personality disorder have sometimes been excluded from any 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.

This guideline draws on the best available evidence. However, there are significant limitations to the evidence base, notably, few randomised controlled trials (RCTs) of interventions, which have few outcomes in common. Some of the limitations are addressed in the recommendations for further research (see section 4).

At the time of publication (January 2009), no drug has UK marketing authorisation for the treatment of borderline personality disorder, but this guideline contains recommendations about the use of drugs to manage crises, comorbid conditions and insomnia. The guideline assumes that prescribers will use a drug's summary of product characteristics to inform their decisions for each person.

NICE has developed a separate guideline on antisocial personality disorder (see section 6).

[1] The guideline also covers the treatment and management of people diagnosed with emotionally unstable personality disorder based on ICD-10 criteria.

Person-centred care

This guideline offers best practice advice on the care of adults and young people under the age of 18 with borderline personality disorder.

Treatment and care should take into account people's needs and preferences. People with borderline personality disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If someone does not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

If the patient is under 16, healthcare professionals should follow the guidelines in the Department of Health's 'Seeking consent: working with children'. If the person is 16 or 17 years old, full access should be provided to the treatment and care pathway described in this guideline, but within child and adolescent mental health services (CAMHS).

Good communication between healthcare professionals and people with borderline personality disorder is essential. It should be supported by written information tailored to the person's needs, addressing the evidence supporting this guideline. Treatment and care, and the information that people are given about it, should be culturally appropriate, and should refer to local provision of support and help within voluntary agencies, including those specifically for young people. The information should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the service user agrees, carers (who may include family and friends) should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in 'Transition: getting it right for young people'.

Key priorities for implementation

Access to services

- People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed.

Autonomy and choice

- Work in partnership with people with borderline personality disorder to develop their autonomy and promote choice by:
    - ensuring they remain actively involved in finding solutions to their problems, including during crises
    - encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make.

Developing an optimistic and trusting relationship

- When working with people with borderline personality disorder:
    - explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
    - build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable
    - bear in mind when providing services that many people will have experienced rejection, abuse and trauma, and encountered stigma often associated with self-harm and borderline personality disorder.

Managing endings and supporting transitions

- Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder. Ensure that:
    - such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased

- the care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis
- when referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.

Assessment

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

Care planning

- Teams working with people with borderline 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 professionals 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
  - develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are not enough
  - be shared with the GP and the service user.

The role of psychological treatment

- When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:
    - an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user
    - structured care in accordance with this guideline
    - provision for therapist supervision.

  Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, twice-weekly sessions may be considered.
- Do not use brief psychotherapeutic interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics outlined in 1.3.4.3.

The role of drug treatment

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

The role of specialist personality disorder services within trusts

- Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder and should:
    - provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
    - provide consultation and advice to primary and secondary care services
    - offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder
    - develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services

- be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia
- work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services
- ensure that clear lines of communication between primary and secondary care are established and maintained
- support, lead and participate in the local and national development of treatments for people with borderline personality disorder, including multicentre research
- oversee the implementation of this guideline
- develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline (see 1.5.1.2)
- monitor the provision of services for minority ethnic groups to ensure equality of service delivery.

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

1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and evidence used to develop the guidance.

1.1 General principles for working with people with borderline personality disorder

1.1.1 Access to services

1.1.1.1 People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed.

1.1.1.2 Young people with a diagnosis of borderline personality disorder, or symptoms and behaviour that suggest it, should have access to the full range of treatments and services recommended in this guideline, but within CAMHS.

1.1.1.3 Ensure that people with borderline personality disorder from black and minority ethnic groups have equal access to culturally appropriate services based on clinical need.

1.1.1.4 When language is a barrier to accessing or engaging with services for people with borderline personality disorder, provide them with:

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

1.1.2 Borderline personality disorder and learning disabilities

1.1.2.1 When a person with a mild learning disability presents with symptoms and behaviour that suggest borderline personality disorder, assessment and diagnosis should take place in consultation with a specialist in learning disabilities services.

1.1.2.2 When a person with a mild learning disability has a diagnosis of borderline personality disorder, they should have access to the same services as other people with borderline personality disorder.

1.1.2.3 When care planning for people with a mild learning disability and borderline personality disorder, follow the Care Programme Approach (CPA). Consider consulting a specialist in learning disabilities services when developing care plans and strategies for managing behaviour that challenges.

1.1.2.4 People with a moderate or severe learning disability should not normally be diagnosed with borderline personality disorder. If they show behaviour and symptoms that suggest borderline personality disorder, refer for assessment and treatment by a specialist in learning disabilities services.

1.1.3 Autonomy and choice

1.1.3.1 Work in partnership with people with borderline personality disorder to develop their autonomy and promote choice by:

- ensuring they remain actively involved in finding solutions to their problems, including during crises
- encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make.

1.1.4 Developing an optimistic and trusting relationship

1.1.4.1 When working with people with borderline personality disorder:

- explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
- build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable
- bear in mind when providing services that many people will have experienced rejection, abuse and trauma, and encountered stigma often associated with self-harm and borderline personality disorder.

1.1.5 Involving families or carers

1.1.5.1 Ask directly whether the person with borderline personality disorder wants their family or carers to be involved in their care, and, subject to the person's consent and rights to confidentiality:

- encourage family or carers to be involved
- ensure that the involvement of families or carers does not lead to withdrawal of, or lack of access to, services
- inform families or carers about local support groups for families or carers, if these exist.

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

- balance the developing autonomy and capacity of the young person with the responsibilities of parents or carers
- be familiar with the legal framework that applies to young people, including the Mental Capacity Act, the Children Acts and the Mental Health Act.

1.1.6 Principles for assessment

1.1.6.1 When assessing a person with borderline personality disorder:

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

1.1.7 Managing endings and supporting transitions

1.1.7.1 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder. Ensure that:

- such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased
- the care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis
- when referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.

1.1.7.2 CAMHS and adult healthcare professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services. They should:

- time the transfer to suit the young person, even if it takes place after they have reached the age of 18 years
- continue treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.

1.1.8 Managing self-harm and attempted suicide

1.1.8.1 Follow the recommendations in 'Self-harm' (NICE clinical guideline 16) to manage episodes of self-harm or attempted suicide.

1.1.9 Training, supervision and support

1.1.9.1 Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline. Training should also be provided for primary care healthcare professionals who have significant involvement in the assessment and early treatment of people with borderline personality disorder. Training should be provided by specialist personality disorder teams based in mental health trusts (see recommendation 1.5.1.1).

1.1.9.2 Mental health professionals working with people with borderline personality disorder should have routine access to supervision and staff support.

1.2 Recognition and management in primary care

1.2.1 Recognition of borderline personality disorder

1.2.1.1 If a person presents in primary care who has repeatedly self-harmed or shown persistent risk-taking behaviour or marked emotional instability, consider referring them to community mental health services for assessment for borderline personality disorder. If the person is younger than 18 years, refer them to CAMHS for assessment.

1.2.2 Crisis management in primary care

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

- assess the current level of risk to self or others
- 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 problems
- 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.

1.2.3 Referral to community mental health services

1.2.3.1 Consider referring a person with diagnosed or suspected borderline personality disorder who is in crisis to a community mental health service when:

- their levels of distress and/or the risk to self or others are increasing
- their levels of distress and/or the risk to self or others have not subsided despite attempts to reduce anxiety and improve coping skills
- they request further help from specialist services.

1.3 Assessment and management by community mental health services

1.3.1 Assessment

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

1.3.1.2 When assessing a person with possible borderline personality disorder in community mental health services, fully assess:

- psychosocial and occupational functioning, coping strategies, strengths and vulnerabilities
- comorbid mental disorders and social problems
- the need for psychological treatment, social care and support, and occupational rehabilitation or development
- the needs of any dependent children.[2]

1.3.2 Care planning

1.3.2.1 Teams working with people with borderline 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 professionals 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

- develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are not enough
- be shared with the GP and the service user.

1.3.2.2 Teams should use the CPA when people with borderline personality disorder are routinely or frequently in contact with more than one secondary care service. It is particularly important if there are communication difficulties between the service user and healthcare professionals, or between healthcare professionals.

1.3.3 Risk assessment and management

1.3.3.1 Risk assessment in people with borderline personality disorder should:

- take place as part of a full assessment of the person's needs
- differentiate between long-term and more immediate risks
- identify the risks posed to self and others, including the welfare of any dependent children.

1.3.3.2 Agree explicitly the risks being assessed with the person with borderline personality disorder and develop collaboratively risk management plans that:

- address both the long-term and more immediate risks
- relate to the overall long-term treatment strategy
- take account of changes in personal relationships, including the therapeutic relationship.

1.3.3.3 When managing the risks posed by people with borderline personality disorder in a community mental health service, risks should be managed by the whole multidisciplinary team with good supervision arrangements, especially for less experienced team members. Be particularly cautious when:

- evaluating risk if the person is not well known to the team
- there have been frequent suicidal crises.

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

1.3.4 Psychological treatment

1.3.4.1 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.

1.3.4.2 Before offering a psychological treatment for a person with borderline personality disorder or for a comorbid condition, provide the person with written material about the psychological treatment being considered. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for them to discuss not only this information but also the evidence for the effectiveness of different types of psychological treatment for borderline personality disorder and any comorbid conditions.

1.3.4.3 When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

- an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user
- structured care in accordance with this guideline
- provision for therapist supervision.

Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, twice-weekly sessions may be considered.

1.3.4.4 Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics outlined in 1.3.4.3.

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

1.3.4.6 When providing psychological treatment to people with borderline personality disorder as a specific intervention in their overall treatment and care, use the CPA to clarify the roles of different services, professionals providing psychological treatment and other healthcare professionals.

1.3.4.7 When providing psychological treatment to people with borderline personality disorder, monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms of borderline personality disorder.

1.3.5 The role of drug treatment

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

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

1.3.5.3 Drug treatment may be considered in the overall treatment of comorbid conditions (see section 1.3.6).

1.3.5.4 Short-term use of sedative medication may be considered cautiously as part of the overall treatment plan for people with borderline personality disorder in a crisis.[3] The duration of treatment should be agreed with them, but should be no longer than 1 week (see section 1.3.7).

1.3.5.5 When considering drug treatment for any reason for a person with borderline personality disorder, provide the person with written material about the drug being considered. This should include evidence for the drug's effectiveness in the treatment of borderline personality disorder and for any comorbid condition, and potential harm. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for the person to discuss the material.

1.3.5.6 Review the treatment of people with borderline personality disorder who do not have a diagnosed comorbid mental or physical illness and who are currently being prescribed drugs, with the aim of reducing and stopping unnecessary drug treatment.

1.3.6 The management of comorbidities

1.3.6.1 Before starting treatment for a comorbid condition in people with borderline personality disorder, review:

- the diagnosis of borderline personality disorder and that of the comorbid condition, especially if either diagnosis has been made during a crisis or emergency presentation
- the effectiveness and tolerability of previous and current treatments; discontinue ineffective treatments.

1.3.6.2 Treat comorbid depression, post-traumatic stress disorder or anxiety within a well-structured treatment programme for borderline personality disorder.

1.3.6.3 Refer people with borderline personality disorder who also have major psychosis, dependence on alcohol or Class A drugs, or a severe eating disorder to an appropriate service. The care coordinator should keep in contact with people being treated for the comorbid condition so that they can continue with treatment for borderline personality disorder when appropriate.

1.3.6.4 When treating a comorbid condition in people with borderline personality disorder, follow the NICE clinical guideline for the comorbid condition.

1.3.7 The management of crises

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

Principles and general management of crises

1.3.7.1 When a person with borderline personality disorder presents during a crisis, consult the crisis plan and:

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

Drug treatment during crises

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

1.3.7.2 Before starting short-term drug treatments for people with borderline personality disorder during a crisis (see recommendation 1.3.5.4):

- ensure that there is consensus among prescribers and other involved professionals about the drug used and that the primary prescriber is identified

- establish likely risks of prescribing, including alcohol and illicit drug use
- take account of the psychological role of prescribing (both for the individual and for the prescriber) and the impact that prescribing decisions may have on the therapeutic relationship and the overall care plan, including long-term treatment strategies
- ensure that a drug is not used in place of other more appropriate interventions
- use a single drug
- avoid polypharmacy whenever possible.

1.3.7.3 When prescribing short-term drug treatment for people with borderline personality disorder in a crisis:

- choose a drug (such as a sedative antihistamine[3]) that has a low side-effect profile, low addictive properties, minimum potential for misuse and relative safety in overdose
- use the minimum effective dose
- prescribe fewer tablets more frequently if there is a significant risk of overdose
- agree with the person the target symptoms, monitoring arrangements and anticipated duration of treatment
- agree with the person a plan for adherence
- discontinue a drug after a trial period if the target symptoms do not improve
- consider alternative treatments, including psychological treatments, if target symptoms do not improve or the level of risk does not diminish
- arrange an appointment to review the overall care plan, including pharmacological and other treatments, after the crisis has subsided.

Follow-up after a crisis

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

- a review of the crisis and its antecedents, taking into account environmental, personal and relationship factors
- a review of drug treatment, including benefits, side effects, any safety concerns and role in the overall treatment strategy
- a plan to stop drug treatment begun during a crisis, usually within 1 week
- a review of psychological treatments, including their role in the overall treatment strategy and their possible role in precipitating the crisis.

1.3.7.5 If drug treatment started during a crisis cannot be stopped within 1 week, there should be a regular review of the drug to monitor effectiveness, side effects, misuse and dependency. The frequency of the review should be agreed with the person and recorded in the overall care plan.

1.3.8 The management of insomnia

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

1.3.8.2 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 guidance 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.

1.3.9 Discharge to primary care

1.3.9.1 When discharging a person with borderline personality disorder from secondary care to primary care, discuss the process with them and, whenever possible, their family or carers beforehand. Agree a care plan that specifies the steps they can take to try to manage their distress, how to cope with future crises and how to re-engage with community mental health services if needed. Inform the GP.

1.4 Inpatient services

1.4.1.1 Before considering admission to an acute psychiatric inpatient unit for a person with borderline personality disorder, first refer them to a crisis resolution and home treatment team or other locally available alternative to admission.

1.4.1.2 Only consider people with borderline personality disorder for admission to an acute psychiatric inpatient unit for:

- the management of crises involving significant risk to self or others that cannot be managed within other services, or
- detention under the Mental Health Act (for any reason).

1.4.1.3 When considering inpatient care for a person with borderline personality disorder, actively involve them in the decision and:

- ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission
- agree the length and purpose of the admission in advance
- ensure that when, in extreme circumstances, compulsory treatment is used, management on a voluntary basis is resumed at the earliest opportunity.

1.4.1.4 Arrange a formal CPA review for people with borderline personality disorder who have been admitted twice or more in the previous 6 months.

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

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

1.5 Organisation and planning of services

1.5.1 The role of specialist personality disorder services within trusts

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

- provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
- provide consultation and advice to primary and secondary care services
- offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder
- develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services
- be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia
- work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services
- ensure that clear lines of communication between primary and secondary care are established and maintained
- support, lead and participate in the local and national development of treatments for people with borderline personality disorder, including multi-centre research
- oversee the implementation of this guideline
- develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline (see 1.5.1.2)
- monitor the provision of services for minority ethnic groups to ensure equality of service delivery.

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

1.5.1.2 Specialist teams should develop and provide training programmes that cover the diagnosis and management of borderline personality disorder and the implementation of this guideline for general mental health, social care, forensic and primary care providers and other professionals who have contact with people with borderline personality disorder. The programmes should also address problems around stigma and discrimination as these apply to people with borderline personality disorder.

1.5.1.3 Specialist personality disorder services should involve people with personality disorders and families or carers in planning service developments, and in developing information about services. With appropriate training and support, people with personality disorders may also provide services, such as training for professionals, education for service users and families or carers, and facilitating peer support groups.

[2] See the May 2008 Social Care Institute for Excellence research briefing 'Experiences of children and young people caring for a parent with a mental health problem'.

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

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available.

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

How this guideline was developed

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

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

The Healthcare Commission assesses how well NHS organisations meet core and developmental standards set by the Department of Health in 'Standards for better health'. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that NHS organisations should take into account national agreed guidance when planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website.

- Slides highlighting key messages for local discussion.
- Costing report to estimate the national savings and costs associated with implementation.
- Audit support for monitoring local practice.

4 Research recommendations

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

4.1 Development of an agreed set of outcomes measures

What are the best outcome measures to assess interventions for people with borderline personality disorder? This question should be addressed in a three-stage process using formal consensus methods involving people from a range of backgrounds, including service users, families or carers, clinicians and academics. The outcomes chosen should be valid and reliable for this patient group, and should include measures of quality of life, function and symptoms for both service users and carers.

The three-stage process should include: (1) identifying aspects of quality of life, functioning and symptoms that are important for service users and families/carers; (2) matching these to existing outcome measures and highlighting where measures are lacking; (3) generating a shortlist of relevant outcome measures to avoid multiple outcome measures being used in future. Where measures are lacking, further work should be done to develop appropriate outcomes.

Why this is important

Existing research examining the effects of psychological and pharmacological interventions for people with borderline personality disorder has used a wide range of outcomes measures. This makes it difficult to synthesise data from different studies and to compare interventions. Also, outcomes do not always adequately reflect patient experience. Agreeing outcome measures for future studies of interventions for people with borderline personality disorder will make it easier to develop evidence-based treatment guidelines in the future.

4.2 Psychological therapy programmes for people with borderline personality disorder

What is the relative efficacy of psychological therapy programmes (for example, mentalisation-based therapy, dialectical behaviour therapy or similar approach) delivered within well structured, high quality community-based services (for example, a day hospital setting, or a community mental health team) compared with high-quality community care delivered by general mental health services without the psychological intervention for people with borderline personality disorder?

This question should be answered using a randomised controlled design which reports medium-term outcomes (including cost effectiveness outcomes) of at least 18 months' duration. They should pay particular attention to the training and supervision of those providing interventions in order to ensure that systems for delivering them are both robust and generalisable.

Why this is important

Research suggests that psychological therapy programmes, such as dialectical behaviour therapy and mentalisation-based therapy as delivered in the studies reviewed for this guideline, may benefit people with borderline personality disorder. However, trials are relatively small, and research is generally at an early stage of development with studies tending to examine interventions delivered in centres of excellence. In addition, few trials have included large numbers of men. Pragmatic trials comparing psychological therapy programmes with high-quality outpatient follow-up by community mental health services would help to establish the effectiveness, costs and cost effectiveness of these interventions delivered in generalisable settings. The effect of these interventions among men and young people should also be examined.

4.3 Outpatient psychosocial interventions

What is the efficacy of outpatient psychosocial interventions (such as cognitive analytic therapy, cognitive behavioural therapy, schema-focused therapy, and transference focused therapy) for people with less severe (fewer comorbidities, higher level of social functioning, more able to depend on self-management methods) borderline personality disorder? This question should be answered using randomised controlled trials which report medium-term outcomes (for example, quality of life, psychosocial functioning, employment outcomes and borderline personality disorder symptomatology) of at least 18 months. They should pay particular attention to training and supervision of those delivering interventions.

Why this is important

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

4.4 Mood stabilisers

What is the effectiveness and cost-effectiveness of mood stabilisers on the symptoms of borderline personality disorder? This should be answered by a randomised placebo-controlled trial which should include the medium to long-term impact of such treatment. The study should be sufficiently powered to investigate both the effects and side effects of this treatment.

Why this is important

There is little evidence of the effectiveness of pharmacological treatments for people with personality disorder. However, there have been encouraging findings from small-scale studies of mood stabilisers such as topiramate and lamotrigine, which indicates the need for further research. Emotional instability is a key feature of borderline personality disorder and the effect of these treatments on mood and other key features of this disorder should be studied. The findings of such a study would support the development of future recommendations on the role of pharmacological interventions in the treatment of borderline personality disorder.

4.5 Developing a care pathway

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

Why this is important

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

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Borderline personality disorder: treatment and management' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from our website.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

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

6 Related NICE guidance

Antisocial personality disorder: treatment, management and prevention. NICE clinical guideline 77 (2009).

Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2007). [Replaced by NICE clinical guideline 113].

Depression (amended): the management of depression in primary and secondary care. NICE clinical guideline 23 (2007). [Replaced by NICE clinical guideline 90]

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).

Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. NICE clinical guideline 38 (2006).

Obsessive–compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).

Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005).

Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE clinical guideline 25 (2005).

Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004).

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004).

Zaleplon, zolpidem and zopiclone for the short-term management of insomnia. NICE technology appraisal guidance 77 (2004).

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002). [Replaced by NICE clinical guideline 82]

Alcohol dependence and harmful alcohol use: diagnosis and management in young people and adults. NICE clinical guideline 115 (2011).

7 Updating the guideline

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

Appendix A: The Guideline Development Group

Professor Peter Tyrer (Chair, Guideline Development Group)
Professor of Community Psychiatry, Imperial College London

Dr Tim Kendall (Facilitator, Guideline Development Group)
Joint Director, The National Collaborating Centre for Mental Health; Deputy Director, Royal College of Psychiatrists' Research and Training Unit; Consultant Psychiatrist and Medical Director, Sheffield Care Trust

Professor Anthony Bateman
Consultant Psychiatrist, Barnet, Enfield, and Haringey Mental Health NHS Trust and Visiting Professor, University College London

Ms Linda Bayliss (2008)
Research Assistant, The National Collaborating Centre for Mental Health

Professor Nick Bouras
Professor Emeritus of Psychiatry, Health Service and Population Research Department, Institute of Psychiatry, King's College London; Honorary Consultant Psychiatrist, South London and Maudsley NHS Trust

Ms Rachel Burbeck
Systematic Reviewer, The National Collaborating Centre for Mental Health

Ms Jenifer Clarke-Moore (2006–2007)
Consultant Nurse, Gwent Healthcare NHS Trust

Ms Elizabeth Costigan (2006–2007)
Project Manager, The National Collaborating Centre for Mental Health

Dr Mike Crawford
Reader in Mental Health Services Research, Imperial College London; Honorary Consultant Psychiatrist Central & North West London NHS Foundation Trust

Ms Victoria Green
Representing service user and family or carer interests

Dr Rex Haigh
Consultant Psychiatrist, Berkshire Healthcare NHS Foundation Trust

Ms Sarah Hopkins (2007–2008)
Project Manager, The National Collaborating Centre for Mental Health

Mrs Farheen Jeeva (2007–2008)
Health Economist, The National Collaborating Centre for Mental Health

Mr Dennis Lines
Representing service user and family or carer interests

Dr Ifigeneia Mavranezouli (2008)
Senior Health Economist, The National Collaborating Centre for Mental Health

Dr David Moore
General Practitioner, Nottinghamshire County Teaching Primary Care Trust

Dr Paul Moran
Clinical Senior Lecturer, Institute of Psychiatry, King's College London; Honorary Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Professor Glenys Parry
Professor of Applied Psychological Therapies, Centre for Psychological Services Research, University of Sheffield; Consultant Clinical Psychologist, Sheffield Care Trust

Mrs Carol Paton
Chief Pharmacist, Oxleas NHS Foundation Trust

Dr Mark Sampson
Clinical Psychologist, Manchester Mental Health and Social Care Trust

Ms Poonam Sood (2006–2007)
Research Assistant, The National Collaborating Centre for Mental Health

Ms Sarah Stockton
Senior Information Scientist, The National Collaborating Centre for Mental Health

Dr Michaela Swales
Consultant Clinical Psychologist, North Wales NHS Trust and Bangor University

Dr Clare Taylor
Editor, The National Collaborating Centre for Mental Health

Dr Angela Wolff
Representing service user and family/carer interests

Mr Loukas Xaplanteris (2006–2007)
Health Economist, The National Collaborating Centre for Mental Health

Appendix B: The Guideline Review Panel

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

Mr Peter Robb
Chair, Consultant ENT Surgeon, Epsom and St Helier University Hospitals

Mr Mike Baldwin
Project Development Manager, Cardiff Research Consortium

Dr Christine Hine
Consultant in Public Health (Acute Commissioning), Bristol and South Gloucestershire PCTs

Mr John Seddon
Lay member

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Changes after publication

January 2012: minor maintenance

January 2013: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Copyright

Contact NICE

National Institute for Health and Clinical Excellence
Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT

www.nice.org.uk
nice@nice.org.uk
0845 033 7780

Accreditation