NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Centre for Clinical Practice – Surveillance Programme

Recommendation for Guidance Executive

Clinical guideline
CG78: Borderline personality disorder: Treatment and management

Publication date
January 2009

Previous review dates
November 2011

Surveillance report for GE
January 2015 (6 year surveillance review)

Surveillance recommendation
GE is asked to consider the following proposals:

- CG78: Borderline personality disorder should not be considered for an update at this time. GE is asked to note that this 'no to update' proposal will not be consulted on.
- The next surveillance review of the guideline should be scheduled to take account of the identified ongoing research.

Key findings

			Potential impact on guidance	
			Yes	**No**
Evidence identified from literature search				✓
Feedback from Guideline Development Group				✓
Anti-discrimination and equalities considerations				✓
No update	CGUT update	Standard update	Transfer to static list	**Change review cycle**
✓				✓

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Surveillance review of CG78: Borderline personality disorder: Treatment and management

Recommendation for Guidance Executive

Background information

Guideline issue date: January 2009
Last review: 2011 (no update)
NCC: Mental Health

Main conclusions from previous surveillance review

1. CG78 previously underwent a surveillance review in 2011 which recommended that the guideline should not be considered for an update. Although new evidence was identified relating to psychological interventions, pharmacological interventions and settings for delivery of treatments, it was determined that the evidence identified in these areas would not change the direction of current guideline recommendations.

Main findings of the current six year surveillance review

2. A literature search for systematic reviews was carried out between 1st June 2011 (the end of the search period for the previous surveillance review) and 28th October 2014 and relevant abstracts were assessed. Clinical feedback on the guideline was obtained from five members of the GDG through a questionnaire.

3. No new evidence that may impact on recommendations was identified relating to any of the clinical areas within the guideline.

4. Three of the GDG members that responded to the questionnaire felt that CG78: Borderline personality disorder requires an update because of potential new evidence, uncertainty over drug treatment, the cost effectiveness of psychological interventions, and because screening

for personality disorder was not covered in the original guideline. The new evidence provided by the GDG included some studies which were assessed at the last surveillance review point. However, a number of other studies are outside the criteria for the current surveillance review which included systematic reviews only, and will be considered at the next surveillance review of the guideline.

Ongoing research

5. The following ongoing research was identified by the GDG relating to treatment options for people with BPD:
   - HTA - 10/103/01: The clinical and cost effectiveness of lamotrigine for people with borderline personality disorder: Randomised controlled trial. Estimated publication date February 2017.
   - HTA - 08/53/06: Psychoeducation with problem solving (PEPS) therapy for adults with personality disorder: A pragmatic randomised controlled trial to determine the clinical effectiveness and cost-effectiveness of a manualised intervention to improve social functioning. Estimated publication date September 2015.
   - Two studies currently being prepared for publication on: Mentalisation-based treatment (MBT) v Structured Clinical Management; and 'The impact of major organizational changes on treatment outcome of day hospital Mentalization-Based Treatment (MBT)'.

Anti-discrimination and equalities considerations

6. None identified.

Implications for other NICE programmes

7. This guideline relates to a draft quality standard on Personality disorders (borderline and antisocial) (anticipated publication date May 2015).

8. The draft quality standard is unlikely to be affected by the decision not to update the guideline.

Conclusion

9. Through the 6 year surveillance review of CG78 no new evidence which may potentially change the direction of guideline recommendations was identified. The proposal is not to update the guideline at this time.

10. The next surveillance review of the guideline should be scheduled to take account of the publication of identified ongoing research in section 5, in particular HTA 10/103/01 which is due for publication around the time of the next scheduled review.

Mark Baker – Centre Director

Sarah Willett – Associate Director
Diana O'Rourke – Technical Analyst

Centre for Clinical Practice
January 2015

Appendix: Decision Matrix

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
Reliable identification and assessment of borderline personality disorder (BPD)			
78-01: What can help clinicians identify features of borderline personality disorder in young people?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-02a: Are there tools/assessments that could be used?			
No evidence identified.	No evidence identified.	Two GDG members stated that there is new evidence relating to screening and diagnosis of BPD which was not covered in the guideline and that brief, psychometrically-robust screens are now being increasingly used in clinical practice e.g. the Standardised Assessment of Personality-Abbreviated Scale which has been widely adopted among the UK Improving Access to Psychological Therapies (IAPT) population. The GDG also highlighted that diagnosis of BPD will change in the new ICD 11 diagnostic system. No evidence was identified through the literature search relating to this issue and ICD-11 is not due to be published until 2017.	During the development of the guideline the evidence relating to tools/assessments for BPD was discussed relating to the diagnosis of BPD in young people. The guideline also lists the main instruments available for assessing individuals with BPD, including the Standardised Assessment of Personality. However, no recommendations were made relating to this question. No new systematic reviews of evidence were identified through the literature search relating to this clinical question. This area will therefore be considered at the next surveillance review of the guideline.

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
78-02b: Are there tools/assessments that could be used in primary care?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
Treatment options for people with borderline personality disorder			
78-03: What interventions and care processes are effective in improving outcomes or altering the developmental course for people aged under 18 years with borderline symptoms or putative borderline personality disorder (that is, would meet diagnosis if over 18)?			
No evidence identified.	A systematic review (n=655) found that short-term psychodynamic psychotherapies had limited effectiveness as a treatment for children and young people with a broad range of mental health conditions, including BPD[1].	None identified through GDG questionnaire.	Due to the lack of evidence relating to treatments for young people with BPD, the guideline states that the recommendations for adults relating to treatment and management could be adopted for young people, with additional recommendations for structure of services and the presence of parents/carers. The new evidence relating to interventions for young people found that short-term psychodynamic psychotherapies had limited effectiveness. This is consistent with the current guideline recommendation which states: Do not use brief psychological interventions specifically for BPD or for the individual symptoms of the disorder.
78-04: For people with borderline personality disorder, which treatments are associated with improvement in mental state and quality of life, reduction in self-harm, service use, and risk-related behaviour, and/or improved social and personal functioning while minimising harms?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-04a: Which psychological therapy is most effective? (CBT, mentalisation, behaviour therapy, psychodynamic, CAT, group therapy, family therapy,			

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
schema-focused therapy, transference-focused and DBT, miscellaneous)			
Through a high-level RCT search, 11 RCTs were identified relevant to the clinical question[2-12]. Studies focused on different psychological interventions for BPD, including a modified version of interpersonal psychotherapy (IPT), dialectical behaviour therapy (DBT), cognitive therapy (CT), cognitive-behavioural therapy for personality disorders (CBT-PD), schema focused therapy (ST), Manual Assisted Cognitive Therapy (MACT), and motive-oriented therapeutic relationship (MOTR). Overall, the results of the studies suggested that the different types of therapy were effective in terms of managing symptoms such as self-harm, suicidal ideation, improved overall functioning, improved quality of life, and reduced anxiety, in patients with BPD. It was considered that the evidence identified was consistent the current guideline recommendations.	One systematic review found that there was variation between studies in the primary outcomes reported in published RCTs on specific psychotherapies for BPD, particularly, rates of suicide attempts and patient dropout and varied considerably[13]. An update of a Cochrane systematic review assessing the effects of psychological interventions for BPD was identified[14]. Meta-analysis of studies indicated a beneficial effect of dialectical behaviour therapy (DBT) over treatment as usual for the outcomes of anger, parasuicidality and mental health. The results of single studies also suggested that DBT, DBT for Post-traumatic stress disorder, mentalisation-based treatment (MBT) in a partial hospitalisation setting, outpatient MBT, transference-focused therapy and interpersonal therapy for BPD were more effective than controls in	The GDG highlighted that there was new evidence relating to the following psychological treatments: • Dialectical Behaviour Therapy (DBT) • Dialectical behaviour therapy for adolescents (DBT-A) • General psychiatric management • Mentalisation-based psychotherapy (MBT) • Long-term mentalisation-oriented outpatient group therapy • Mentalisation-based treatment for adolescents (MBT-A) • Transference-focused psychotherapy • Evidence that 'good well-organised psychological care' is as effective as many individual named treatments (e.g. CBT, MBT, STEPPS, TFP, SFT). The new evidence provided by	The guideline found no convincing evidence that the individual psychological therapies were efficacious in treating BPD and thus recommended when providing psychological treatment 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. It was considered that there was no new evidence identified at the 2 year surveillance review that would change the current guideline recommendations relating to psychological therapies. The new evidence identified at the 6 year surveillance review is also unlikely to alter the guideline recommendations in this area. One systematic review was identified suggesting that different psychological therapies were effective in managing symptoms of BPD. However, the evidence was limited by small numbers of participants in the trials

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
	terms of BPD core pathology and associated psychopathology. The results of another systematic review suggested that there was no difference between DBT and treatment as usual in terms of reducing symptoms of depression[15].	the GDG included some studies which were assessed at the last surveillance review point. However, a number of other studies are outside the criteria for the current surveillance review which included systematic reviews only. This evidence will be considered at the next surveillance review of the guideline. One GDG member identified that there is new evidence to suggest generally poor cost-effectiveness of psychological interventions. No further information was provided.	included in the systematic review, with typically around 30 participants per trial. Clinical feedback indicated that there was new evidence to support psychological therapies. The new evidence included some studies which were assessed at the last surveillance review point. A number of other studies are outside the criteria for the current surveillance review which included systematic reviews only. This evidence will be considered at the next surveillance review of the guideline.
78-04b: Which psychosocial therapy is most effective?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-04c: Which pharmacological therapies maximise benefits while minimising harms? (+ comorbidities)			
Through a high-level RCT search and a focused search, 12 studies (3 observational studies, 5 RCTs and 4 systematic reviews) relevant to the clinical question were identified. An observational study of quetiapine	A systematic review (n=4132) was identified which examined the risk of adverse events associated with ziprasidone[28]. The review found that the overall rate of adverse events was higher with ziprasidone than placebo, and that it was	The GDG highlighted that there was new evidence relating to antipsychotic medication and low and moderate dosages of extended-release quetiapine for the treatment of BPD. However, the new evidence is outside the	New evidence was identified at the 2 year review which supported the use of different pharmacological interventions which have beneficial effects in patients with BPD. However, the studies identified were only single trials with a small numbers of participants, therefore it was

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
reported reductions in symptoms, assessed by objective rating scales, in individuals with BPD[16]. The initial results of an observational study suggested that duloxetine is an effective and well-tolerated treatment for BPD, with positive effects on somatic symptoms[17]. Three RCTs were identified which examined the use of olanzapine for the treatment of BPD. One of the studies compared treatment with variably dosed olanzapine with placebo and found that both groups showed improvements in overall symptoms of BPD[18]. The results of a second study suggested that Olanzapine and Sertraline are both effective in alleviating symptoms of people with BPD[19]. Another study found no differences between olanzapine and haloperidol in the management of mental and behavioural symptoms of people with BPD[20]. Two studies evaluating the effectiveness of lamotrigine were identified. One observational study	specifically linked to increased rates of somnolence, extrapyramidal symptoms, headache, insomnia and respiratory disorders.	criteria for the current surveillance review which included systematic reviews only. This evidence will be considered at the next surveillance review of the guideline.	considered that the evidence was not sufficiently robust to change the current guideline recommendations. The evidence identified at the 6 year surveillance review suggests that ziprasidone leads to higher rates of adverse events, however, the study was not limited to a BPD population. The guideline does not recommend any specific pharmacotherapy for the management of patients with BPD, including ziprasidone. The new evidence is therefore unlikely to impact on the guideline recommendations at this time. Clinical feedback suggested that there was new evidence relating to pharmacological treatments for BPD, however, any evidence provided to support feedback was beyond the criteria of the current surveillance review which included systematic reviews only. In addition, no new systematic reviews of evidence were identified through the literature search. This area will therefore be considered at the next surveillance review of the guideline.

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
reported that lamotrigine appears to be an effective and relatively safe agent in the longer-term treatment of aggression in women with BPD[21]. The results of an RCT also suggested that lamotrigine is an effective treatment for affective instability and for the general impulsivity characteristic of BPD[22]. One RCT was identified which failed to show a significant effect of ziprasidone in people with BPD[23]. Four systematic reviews were identified which examined the effects of various pharmacological treatments, including second-generation antipsychotics, mood stabilisers, omega-3 dietary supplements, in people with BPD[24-27]. The results of the reviews were mixed with some evidence that drug treatments may be effective in improving symptoms of BPD although not overall severity of the disorder.			
78-04d: Combined therapy: psychological therapy + medication			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-04e: Therapeutic communities			

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-04f: Arts therapies			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-04g: Complementary therapies			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-05: Are treatment options altered in the presence of common comorbidities (depression, psychosis, anxiety disorders, bipolar disorder, substance use disorder, other axis II disorders)?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-05a: How should complex and severe borderline personality disorder be managed, including management strategies (over a period of time) and multiple comorbidities?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-06: How should the treatment of common comorbidities (depression, psychosis, anxiety disorders, bipolar disorder, substance use disorder, other axis II disorders) be altered in the presence of borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
Service configuration for people with borderline personality disorder			
78-07: What type of services maximise effectiveness and safety and minimise harm (taking into account long-term outcomes) for the delivery of specific treatments for people with borderline personality disorder? (for example, day hospitals, inpatient, therapeutic communities, use of enhanced care programming, team-based or individual-based care, partial hospitalisation)			
Through a high-level RCT search one RCT relevant to the clinical question was identified[29]. The study compared the effectiveness of a mentalisation based treatment (MBT) in an	No evidence identified.	None identified through GDG questionnaire.	It was considered that the evidence identified at the 2 year surveillance review would not invalidate the current guideline recommendations. No new evidence was identified at the 6 year surveillance review.

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
outpatient context against a structured clinical management (SCM) outpatient approach. The results suggested that both treatment approaches led to improved outcomes for individuals with BPD.			
78-07a: What is the role of inpatient (acute, forensic) care in the management of people with borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-07b: What is the role of specialist services (including community-based) in the medium and long-term management of people with borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-07c: Is long-term inpatient care in the treatment of borderline personality disorder effective?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-07d: Are particular therapies suited for particular service settings?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-07e: How should healthcare professionals from other healthcare settings care for people with borderline personality disorder? (primary care, A&E, crisis services, crisis houses, acute care)			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-08: How should NHS services interface with each other and with non-NHS services for people with borderline personality disorder? (including the transition from adolescent to adult services)			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-09: Which treatment pathways, care processes and clinical principles (case management, care coordination, CPA, and so on) maximise the effectiveness of care and reduce harm?			

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-10: How can healthcare professionals involved in the care of people with borderline personality disorder best be supported? (supervision, training, case loads and so on)			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
Family/carers of people with borderline personality disorder			
78-11: Do families (including children) and families/carers of people with borderline personality disorder have specific care needs?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-11a: If so, what specific interventions should be offered?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-12: Do family or carers, through their behaviour, styles of relating and relationships, influence clinical and social outcomes or well-being for people with borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-12a: If so, what interventions should be offered?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
Special groups with borderline personality disorder			
78-13: How should treatment and service configurations be adapted for people with borderline personality disorder who have learning disabilities? How should this take into account the severity of learning disability?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-14: How should treatment and service configurations be adapted for people with borderline personality disorder who are from an ethnic minority?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-15: How should treatment and service configurations be adapted for people with borderline personality disorder who are planning a pregnancy, pregnant			

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
or breastfeeding?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
Service user and family/carer experience			
78-16: What is the experience of people with borderline personality disorder of care in different settings?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
78-17: What is the experience of families/carers of people with borderline personality disorder of care in different settings?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
Research recommendations			
RR78-01: 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 [CMHT]) compared with high-quality community care delivered by general mental health services without the psychological intervention for people with borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
RR78-02: 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?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
RR78-03: What are the best outcome measures to assess interventions for people with borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
RR78-04: What is the effectiveness and cost effectiveness of mood stabilisers on the symptoms of borderline personality disorder?			
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.
RR78-05: What is the best care pathway for people with borderline personality disorder?			

Conclusion of the previous review (2011)	Is there any new evidence/intelligence identified during this 6-year surveillance review (2015)?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2015)
No evidence identified.	No evidence identified.	None identified through GDG questionnaire.	No relevant evidence identified.

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