Appendix A: Summary of evidence from surveillance

2018 surveillance of Borderline personality disorder: recognition and management (2009) NICE guideline CG78

Summary of evidence from surveillance

Studies identified in searches are summarised from the information presented in their abstracts.

Feedback from topic experts who advised us on the approach to this surveillance review, and from stakeholders if public consultation was conducted, was considered alongside the evidence to reach a final decision on the need to update each section of the guideline.

1.1 General principles for working with people with borderline personality disorder

Recommendations in this section of the guideline

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.

Surveillance decision

This section of the guideline should not be updated.

Editorial amendments are needed:

- The person-centred care section of the short version will be replaced with the following box as per newer NICE guidelines:

> People have the right to be involved in discussions and make informed decisions about their care, as described in your care.
>
> Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

- From recommendation 1.1.2.4 'People with a moderate or severe learning disability should not normally be diagnosed with borderline personality disorder…', a link will be added to NG54 Mental health problems in people with learning disabilities: prevention, assessment and management
- From recommendation 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…', a link will be added to the NICE topic overview page for Service transition
- The wording of recommendation 1.1.8.1 'Follow the recommendations in 'Self-harm' (NICE clinical guideline 16) to manage episodes of self-harm or attempted suicide' will be changed to 'Follow the recommendations in NICE's guidelines on self-harm in over 8s: short-term management and prevention of recurrence and self-harm in over 8s: long-term management to manage episodes of self-harm or attempted suicide.'

Patient experience

Previous surveillance summary

In previous surveillance of this guideline, no studies relevant to this section were identified.

2018 surveillance summary

A systematic review and meta-synthesis (1) examined 14 qualitative studies exploring clients' experiences of treatment and recovery in borderline personality disorder. The meta-synthesis identified 10 themes, grouped into 3 domains. Domain 1 'Areas of change' – clients make changes in 4 main areas: developing self-acceptance and self-confidence; controlling difficult thoughts and emotions; practising new ways of relating to others; and implementing practical changes and developing hope. Domain 2 'Helpful and unhelpful treatment characteristics' – treatment elements that either supported recovery (safety and containment; being cared for and respected; and focusing on change) or hindered recovery (not being an equal partner in treatment). Domain 3 'The nature of change' – clients' experience of change as an open-ended journey and a series of achievements and setbacks.

Intelligence gathering

In 2018, experts noted guidelines may be interpreted as formal instructions rather than factors to be included in clinical decisions – and had concerns about restriction of service flexibility through commissioning decisions, especially for those with more severe presentations of borderline personality disorder who often fail to be suitably engaged in the recommended treatments.

They also had concerns that uptake of guidance appears sporadic across the country.

Experts also noted that many of those with diagnosable borderline personality disorder receive help, support and sometimes treatment

in non-health settings, where there is little or no awareness of relevant NICE guidelines, and NICE-recommended treatments are not equitably accessible.

Impact statement

Most of the themes and domains highlighted by the evidence are already accounted for in guideline recommendations. For example:
1.1.3.1 'develop their autonomy and promote choice [...] finding solutions to their problems [...] consider the different treatment options and life choices available to them, and the consequences of the choices';
1.1.4.1 'explore treatment options in an atmosphere of hope and optimism [...] build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable';
1.1.7.1 'withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions [...] changes are discussed carefully beforehand [...] care plan supports effective collaboration with other care providers during endings and transitions.' The new evidence identified through surveillance is therefore unlikely to impact the guideline.

Although experts had concerns about interpretation and implementation of the guideline by healthcare professionals, the recommendations make clear that treatment should be collaborative with the patient. This is reinforced by the 'Your care' section of the guideline which states '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 '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.' Implementation is outside the scope of surveillance reviews and no impact is expected.

Experts also had concerns about people with severe borderline personality disorder, and people receiving help, support and treatment in non-health settings. However no new evidence was identified to address these issues.

New evidence is unlikely to change guideline recommendations.

1.2 Recognition and management in primary care

Recommendations in this section of the guideline

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.

Surveillance decision

This section of the guideline should not be updated.

Recognition of borderline personality disorder – emotional awareness

Previous surveillance summary

In previous surveillance of this guideline, no studies relevant to this section of the guideline were identified.

2018 surveillance summary

A systematic review and meta-analysis (2) of 39 studies examined the association between emotional awareness and borderline personality pathology. An overall moderate positive association between borderline personality pathology and low emotional awareness was significant but had high heterogeneity. Studies comparing borderline personality disorder to healthy controls yielded a strong significant association. No significant difference was found between studies using instruments for emotional awareness and those using alexithymia (lack of emotional awareness) instruments. The strongest associations with regard to aspects of alexithymia were found for difficulties in identifying and describing emotions rather than externally oriented thinking.

Intelligence gathering

No topic expert feedback or additional information was relevant to this section.

Impact statement

The new evidence suggests a moderate relationship between low emotional awareness and borderline personality pathology, but there was high heterogeneity, and the authors of the evidence noted that the mono-method self-report used in almost all studies is problematic and precludes drawing definite conclusions. The guideline currently recommends referring people presenting in primary care with marked emotional instability to community mental health services for assessment for borderline personality disorder. The new evidence broadly agrees with this and no impact is expected.

New evidence is unlikely to change guideline recommendations.

1.3 Assessment and management by community mental health services

Recommendations in this section of the guideline

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.

[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.

Surveillance decision

This section of the guideline should not be updated.

Editorial amendments are needed:

- In footnote 2 to recommendation 1.3.1.2, the hyperlink to the SCIE Research briefing 'Experiences of children and young people caring for a parent with a mental health problem' is broken and will be fixed. Correct link here.
- From recommendation 1.3.7.1 'When a person with borderline personality disorder presents during a crisis…', a link will be added to NG10 Violence and aggression: short-term management in mental health, health and community settings
- The wording of recommendation 1.3.6.4 will be changed from:
  'When treating a comorbid condition in people with borderline personality disorder, follow the NICE clinical guideline for the comorbid condition'
  to: 'When treating a comorbid condition in people with borderline personality disorder, follow the NICE clinical guideline for the comorbid condition (see the NICE mental health and behavioural conditions topic page, or search the NICE find guidance page)'
- The hyperlink in recommendation 1.3.8.2 to NICE technology appraisal 77 is broken and will be fixed. Correct link here.

Screening instruments / diagnostic manuals

Previous surveillance summary

Topic experts highlighted evidence on screening instruments – the study (3) was excluded from the 2015 surveillance review which looked only at systematic reviews, but has been assessed as part of the 2018 surveillance summary.

2018 surveillance summary

An overview (3) of 3 studies examined 8 different screening instruments to predict personality disorders. The instruments were assessed in 3 prospective, observational, test-development studies (n=195, n=79 and

n=102 respectively) in 3 random samples of Dutch psychiatric outpatients, using the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) as the gold standard. The 8 instruments examined were: 3 short questionnaires (a self-report form of the Standardized Assessment of Personality-Abbreviated Scale [SAPAS-SR], the self-report Iowa Personality Disorder Screen [IPDS], and a short self-report version of the SCID-II [S-SCID-II]); 2 longer questionnaires (the self-report SCID-II Personality Questionnaire [SCID-II-PQ] and the NEO Five-Factor Inventory [NEO-FFI]); 1 short semistructured interview (the Quick Personality Assessment Schedule [PAS-Q]); and 2 informant-based interviews (the Standardized Assessment of Personality [SAP] and the Standardized Assessment of Personality-Abbreviated Scale for Informants [SAPAS-INF]). The SCID-II rate of identification of personality disorders in the 3 studies was between 48% and 64%. The SAPAS-SR, the IPDS, and the PAS-Q had the best sensitivity (83%, 77%, and 80%, respectively) and specificity (80%, 85%, and 82%, respectively). Moreover, these 3 instruments correctly classified the largest number of patients. Using the SAPAS-SR, the IPDS, or the PAS-Q raised the odds from 50% to between 80% and 84% that a patient in a psychiatric outpatient population will receive a personality disorder diagnosis.

Intelligence gathering

Topic experts in 2015 noted that the SAPAS has been widely adopted among the UK Improving Access to Psychological Therapies (IAPT) population. Experts in 2018 had mixed feelings about the need for recommendations on screening tools, with some noting the risk of false positives, and potential for increased numbers of personality disorder diagnoses – when services may not be fully meeting the demands of existing patients with these diagnoses.

Experts in both 2015 and 2018 noted that a new Diagnostic and Statistical Manual of Mental Disorders (DSM) version 5 is now available and that a new International Classification of Diseases (ICD) version 11 will soon be available (note: now released as an advance preview).

During development of DSM-5, significant changes to the section on personality disorders were proposed but these changes were not implemented in the final version and the DSM-4 approach was retained. However, the rejected proposals were captured as an alternative hybrid dimensional-categorical model for inclusion in a separate section of DSM-5 to encourage further research to guide future editions of the DSM.

The new ICD-11 abolishes all type-specific categories of personality disorder apart from the main one, the presence of personality disorder itself – within which the severity of personality disturbance (mild, moderate, severe) is identified. The severity can then be qualified by a description of domain traits (anankastia, detachment, disinhibition, dissociality, negative affectivity, borderline pattern) to show which facets of personality are most prominent. Topic experts indicated that if adopted, ICD-11 would likely have an impact on NICE's guidelines on antisocial and borderline personality disorders. They further noted it would therefore be appropriate to wait until ICD-11 has published and the community has had chance to react to it before proposing any changes to the guidelines.

Experts in 2018 also noted that much personality disorder goes undiagnosed in primary care and is over-represented in subpopulations e.g. prisoner or homeless populations. If the guidelines were to be updated then this is a key area that needs to be addressed i.e. how to provide initial assessment and diagnosis services to scale in primary care services that provide the bulk of healthcare to such subpopulations.

Impact statement

The full guideline lists the main screening instruments available at the time for assessing individuals with borderline personality

disorder, including the Standardised Assessment of Personality. However, no recommendations were made relating to instruments.

The new evidence indicates the potential usefulness of the SAPAS-SR, IPDS, and PAS-Q instruments. The authors of the evidence stated that because the PAS-Q takes a longer time and requires qualified personnel to administer it, they recommend the SAPAS-SR or the self-report version of the IPDS. Topic experts noted that SAPAS has been adopted by the community, and that much personality disorder goes undiagnosed in primary care. However the evidence for screening instruments is from a single study, and expert opinion on the need for recommendations on screening instruments was mixed. No impact on the guideline, which does not currently recommend named instruments, is expected at this time.

Additionally, topic experts noted the publication of DSM-5 and the release of ICD-11. DSM-5 has retained the approach to personality disorders from DSM-4 and is currently unlikely to affect the guideline.

The pending change in approach to personality disorder classification in the advance preview of the new version of ICD-11, if adopted, may impact on the assessment of personality disorder by healthcare professionals which could impact the guideline. However it is proposed not to update the guideline at this time, but conduct a further surveillance review once reaction of the community to ICD-11 has been gauged. Any further evidence on screening instruments will also be re-examined at that time.

New evidence is unlikely to change guideline recommendations.

Borderline personality disorder in young people

Previous surveillance summary

A systematic review (4) (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 borderline personality disorder.

2018 surveillance summary

A systematic review and meta-analysis (5) of 61 studies examined the aetiological and psychopathological validity of borderline personality disorder in young people (the extent to which borderline personality disorder in adults and young people share common risk factors and psychopathology). Significant pooled associations with borderline personality disorder in young people (aged 19 years and under) were observed for sexual abuse, physical abuse, maternal hostility/verbal abuse, and neglect. Several psychopathological features were also significantly associated with borderline personality disorder in young people, including comorbid mood, anxiety disorders, substance use disorders, self-harm, suicide ideation, and suicide attempt.

Intelligence gathering

Topic experts noted that since the guideline was published, studies have showed success of treatments in adolescents that were originally developed in adults.

Impact statement

The evidence that short-term psychodynamic psychotherapies has limited effectiveness in children and young people is consistent with recommendation 1.3.4.4 ‘Do not use brief psychological interventions’.

The systematic review demonstrates that adults and young people share common aetiological and psychopathological correlates,

which is consistent with the statement in the full guideline that 'Given the limited evidence base, there is no reason why the recommendations developed for adults should not be adopted for the treatment and management of young people with borderline personality disorder'. This is supported by topic expert feedback. No impact on the guideline is expected.

New evidence is unlikely to change guideline recommendations.

Psychological treatment

Previous surveillance summary

Ten RCTs (6–15) were identified on different psychological interventions, including a modified version of interpersonal psychotherapy (IPT), dialectical behaviour therapy (DBT), cognitive therapy (CT), cognitive behavioural therapy for personality disorders (CBT), schema focused therapy (ST), Manual Assisted Cognitive Therapy (MACT), motive-oriented therapeutic relationship (MOTR), and mentalisation-based treatment. Overall, the results of the studies suggested that all of 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 borderline personality disorder.

A meta-analysis (16) examining dialectical behaviour therapy found a moderate global effect and a moderate effect size for suicidal and self-injurious behaviours.

A systematic review (17) found borderline personality disorder was not associated with particularly high rates of dropout from treatment.

A systematic review (18) found variation between studies in the primary outcomes reported in published RCTs on specific psychotherapies for borderline personality disorder, particularly, rates of suicide attempts and patient dropout and varied considerably.

A Cochrane review (19) assessed psychological interventions for borderline personality disorder, and indicated a benefit of dialectical behaviour therapy (DBT) over treatment as usual. Single studies also suggested that DBT, DBT for posttraumatic stress disorder, mentalisation-based treatment (MBT) in a partial hospitalisation setting, outpatient MBT, transference-focused therapy and interpersonal therapy were more effective than controls.

Another systematic review (20) suggested that there was a net benefit in favour of DBT when combining effect measures for suicide and parasuicidal behaviour (5 studies), but revealed no difference between DBT and treatment as usual in terms of reducing symptoms of depression.

Topic experts in 2015 also highlighted other evidence relating to psychological treatments (the studies were excluded from the 2015 surveillance review which looked only at systematic reviews – but any that met inclusion criteria have been assessed as part of the 2018 surveillance summary).

2018 surveillance summary

General psychotherapies

A systematic review and meta-analysis (21) of 33 RCTs (n=2256) examined efficacy of psychotherapies for borderline personality disorder in adults. Outcomes were analysed for both post-test and follow-up data, and also according to study design: i) stand-alone design (an independent psychotherapy versus a control intervention); or ii) add-on design (psychotherapy added to usual treatment versus usual treatment alone). At post-test, a

composite endpoint of outcomes relevant to borderline personality disorder (borderline symptoms, self-harm, and suicide) was significantly more improved with psychotherapy than control in both stand-alone and add-on study designs. Significant benefits of psychotherapy remained when outcomes were examined individually, including self-harm, suicide, health service use, and general psychopathology. There were no significant differences in treatment retention between psychotherapy and control for either stand-alone or add-on designs. In a subgroup analysis of specific psychotherapy types, dialectical behaviour therapy and psychodynamic approaches were the only psychotherapies significantly more effective than control.

A systematic review and cost analysis (22) of 30 economic evaluations (n=134,136) examined the value of psychological treatment for borderline personality disorder. Almost all included studies fulfilled ≥50% of the quality criteria. In a cost offset analysis of psychotherapy (calculated by subtracting the total costs after the intervention is provided, from the total costs before the start of the intervention), the mean cost saving for treating borderline personality disorder with evidence-based psychotherapy across studies was USD $2,988 per patient per year. In a cost offset analysis of psychotherapy versus treatment as usual (the difference in total costs after the intervention is provided, compared to cost related to the provision of treatment as usual), a further mean weighted reduction of USD $1,551 per patient per year (range $83 - $29,392) was found compared to treatment as usual. Evidence-based psychological treatment was both less expensive as well as more effective, despite considerable differences in health cost arrangements between individual studies and countries. Where it was able to be calculated, a significant difference in cost-savings between different types of evidence-based psychotherapies was found.

Dialectical behaviour therapy

A single-centre, observer blind RCT (23) (n=108) examined 16 weeks dialectical behaviour therapy (DBT) versus 16 weeks collaborative assessment and management of suicidality treatment for reduction of self-harm in adults with borderline personality disorder and a recent suicide attempt (within a month). At 28 weeks, the number of participants with a composite primary outcome of new self-harm (nonsuicidal self-injury [NSSI] or suicide attempt) did not differ significantly between groups. Nor did the individual components of the primary outcome.

An assessor-blinded RCT (24) (n=99 women with borderline personality disorder) examined DBT for high suicide risk (at least 2 suicide attempts and/or NSSI acts in the last 5 years, an NSSI act or suicide attempt in the 8 weeks before screening, and a suicide attempt in the past year). The study specifically evaluated the importance of the skills training component of DBT by comparing skills training plus case management (DBT-S), DBT individual therapy plus activities group (DBT-I), and standard DBT which includes skills training and individual therapy. The study involved 1 year of treatment and 1 year of follow-up. Treatment was delivered in a university-affiliated clinic and community settings by therapists or case managers. All 3 varieties of DBT resulted in similar improvements in the frequency and severity of suicide attempts, suicide ideation, use of crisis services due to suicidality, and reasons for living. Compared with DBT-I, interventions that included skills training (i.e. standard DBT and DBT-S) resulted in significantly greater improvements in the frequency of NSSI acts and depression during the treatment year. In addition, anxiety significantly improved during the treatment year with standard DBT and DBT-S, but not DBT-I. Compared with DBT-I, standard DBT had significantly lower dropout rates, and patients were significantly less likely to use crisis services in follow-up (emergency

department visits and psychiatric hospitalisations).

An RCT (25) (n=84) examined 20 weeks of brief DBT skills training versus waitlist in suicidal outpatients with borderline personality disorder. Significantly greater reductions in the primary outcome of suicidal and non-suicidal self-injurious behaviours were seen with DBT than waitlist between baseline and 32 weeks. DBT participants showed greater improvements than controls on measures of anger, distress tolerance and emotion regulation at 32 weeks (significance not reported in abstract).

An RCT (26) (n=64) compared 10 weeks training in either mindfulness [note: mindfulness is a core element of DBT] or interpersonal effectiveness skills for borderline personality disorder. A significantly greater reduction in borderline personality disorder symptoms, and increase in decentreing capacity, was seen with mindfulness versus control. Treatment response rates (in reference to borderline personality disorder symptoms) were higher for the mindfulness group (significance not reported in abstract). Interpersonal effectiveness alone did not result in improvements on any outcome measures.

Psychoeducation

A health technology assessment comprising a multi-site, assessor blind RCT (27) (n=306 community-dwelling adults with any personality disorder) examined clinical and cost-effectiveness of psychoeducation with problem-solving (PEPS) therapy plus usual treatment versus usual treatment alone. The study was set in community mental health services in 3 NHS trusts in England and Wales. PEPS comprised up to 4 individual sessions of psychoeducation, a collaborative dialogue about personality disorder, followed by 12 group sessions of problem-solving therapy for interpersonal problems. More adverse events in the PEPS arm halted recruitment after 306 people were randomised (90% of planned sample size). At 72-week follow-up, PEPS therapy plus usual treatment was no more effective than usual treatment alone for the primary outcome of the Social Functioning Questionnaire (SFQ), nor for any of the secondary outcomes (service use, mood, client-specified problems), or social problem-solving. Over the follow-up, PEPS cost £182 less than usual treatment (after adjusting for baseline costs), and resulted in more quality-adjusted life-years (QALY; after adjusting for baseline utility score), but neither difference was significant. At NICE thresholds, PEPS had a 64% likelihood of being more cost-effective (though the authors noted that QALY gains were very similar in the 2 groups, but with a very slight advantage in favour of PEPS after controlling for baseline differences, therefore technically, PEPS was 'dominant' in that it resulted in lower average costs and greater QALY gains, however there was uncertainty around both estimates). More adverse events, mainly self-harm, occurred with PEPS arm, but the difference was not significant.

An RCT (28) (n=80) examined web-based psychoeducation versus web-based control (no psychoeducation) in women with borderline personality disorder. Patients participated in 15 assessment periods divided into an acute phase (weeks 1–12) and a maintenance phase (months 6, 9, and 12). Main outcomes were assessed using the Zanarini Rating Scale for Borderline Personality Disorder. In the acute phase, psychoeducation led to a significant improvement in scores on all 10 outcomes studied, whereas only 7 of these outcomes significantly improved with control. Psychoeducation led to a significantly greater decline in impulsivity and a significantly greater increase in psychosocial functioning than control. In the maintenance phase, psychoeducation led to a significant improvement in scores on 9 of the 10 outcomes studied, whereas only 3 of these outcomes significantly improved with control. Psychoeducation led to a significantly greater decline in all 5 studied areas of borderline psychopathology: affective symptoms, cognitive symptoms, impulsivity, interpersonal

difficulties, and overall borderline personality disorder symptoms.

Transference-focused psychotherapy

An RCT (29) (n=104) examined transference-focused psychotherapy versus treatment by experienced community therapists for borderline personality disorder. Mentalisation was assessed by means of the Reflective Functioning Scale. Significant improvements were seen in reflective function in the transference-focused psychotherapy group within 1 year of treatment. The between-group effect was of medium size. Improvements in reflective function were significantly correlated with improvements in personality organisation.

Mentalisation

A multi-site RCT (30) (n=95) examined day hospital mentalisation-based treatment versus specialist treatment as usual in borderline personality disorder. The primary outcome was total score on the Borderline Personality Disorder Severity Index. Secondary outcomes included symptom severity, quality of life, and interpersonal functioning. Data were collected at baseline and every 6 months until 18-month follow-up. Both treatments were associated with significant improvements in all outcomes. Mentalisation was not superior to control on any outcome, but was associated with higher acceptability leading to significantly higher early drop-out rates with control.

A feasibility RCT (31) (n=46 patients with concurrent borderline personality and substance use disorders) examined mentalisation-based treatment plus substance use treatment versus substance use treatment alone. After 18 months there was no significant difference between groups on any outcome variable, including suicide attempts.

Motive-oriented therapeutic relationship

An RCT (32) (n=85 patients with borderline personality disorder) examined motive-oriented therapeutic relationship added to a 10-session general psychiatric treatment, versus general psychiatric treatment alone. Motive-oriented therapeutic relationship led to a significant additional reduction of general problems (symptoms, interpersonal and social problems) but did not yield an additional reduction of specific borderline symptoms. A significantly stronger therapeutic alliance, as assessed by the therapist, developed in motive-oriented therapeutic relationship treatments compared to general psychiatric treatment alone.

A process-outcome mediation analysis (33) based on the above RCT (32) examined early change in frequency of coping strategies (in particular the decrease in behavioural forms of coping) as a potential mechanism of change in responsive treatments for borderline personality disorder. Patients were randomly assigned to 10 sessions of psychiatric treatment with or without motive-oriented therapeutic relationship. The 1st, 5th, and 9th session of each therapy were analysed using the Coping Action Pattern Rating Scale (171 sessions analysed in total), a validated observer-rated method for assessing coping strategies. Psychological distress was assessed using the OQ-45 (a self-report measure of client functioning) at intake, and after sessions 5 and 10. There was a responsiveness effect associated with the motive-oriented therapeutic relationship and a significant decrease in frequency of behavioural forms of coping, which was not different between the 2 conditions. In addition, the early decrease in behavioural forms of coping between sessions 1 and 5 partially mediated the link between the group assignment and the change in psychological distress between sessions 5 and 10.

Intelligence gathering

In 2015, 1 expert indicated that there was new evidence to suggest generally poor cost-effectiveness of psychological interventions, but no further information was provided.

In 2018, experts noted:

- More guidance is required for the role of the Community Mental Health Teams when managing patients where there is an absence of psychological therapy due to waiting lists.
- Importance of non-specific therapeutic factors, especially the therapeutic environment: general statements in NICE guideline CG78 are seen as helpful but could usefully be developed further.

Impact statement

At the time of development, the full version of the guideline noted 'There is as yet no convincing evidence that the individual psychological therapies are efficacious'.

Instead, recommendation 1.3.4.3 therefore states '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.'

Evidence for psychotherapies was identified by the surveillance review and its impact is described below:

General psychotherapies

Previous surveillance found 2 systematic reviews concluding that overall efficacy of -psychotherapies is promising but more research is needed, and that borderline personality disorder was not associated with particularly high rates of dropout from treatment.

Among the new evidence, a systematic review found that psychotherapies, particularly dialectical behaviour therapy and psychodynamic approaches, appear to be effective. However, the review authors noted that effects are small, inflated by risk of bias and publication bias, and particularly unstable at follow-up. A further systematic review found psychotherapy to be cost-effective. These findings are consistent with the guideline recommendation to provide psychological treatment without specifying a type.

New evidence is unlikely to change guideline recommendations.

Dialectical behaviour therapy

Among the new evidence examining DBT for patients at risk of self-harm and suicide, 2 of 3 RCTs suggest that it is effective, and that the skills training component may be particularly effective (although 1 RCT found that DBT was not superior to collaborative assessment and management of suicidality). One of the 2 RCTs showing an effect was performed in women, which is consistent with recommendation 1.3.4.5 that states 'For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme.' However the other RCT with a positive result was not specifically in women and may suggest DBT could be effective in mixed sex populations.

A further RCT found that mindfulness (which is a core idea of DBT) reduced borderline personality disorder symptoms, and increased decentreing capacity, versus interpersonal effectiveness skills.

The new evidence does not add substantially to evidence on DBT found by previous surveillance reviews (individual RCTs, a Cochrane review, and a further systematic review), and does not therefore change the conclusion of previous surveillance that there is no impact on the guideline.

New evidence is unlikely to change guideline recommendations.

Psychoeducation

The authors of the health technology assessment concluded they had found no evidence to support the use of psychoeducation with problem solving therapy alongside standard care for improving social functioning of adults with personality disorder living in the community. The evidence is unlikely to affect the guideline which does not specifically recommend PEPS therapy.

Other new evidence suggests that web-based psychoeducation can reduce the symptom severity of borderline personality disorder. However as a single trial it is unlikely to impact the guideline which does not currently recommend this therapy.

New evidence is unlikely to change guideline recommendations.

Transference-focused psychotherapy

New evidence suggests potential benefits of transference-focused psychotherapy, however this was from a single trial and is unlikely to impact the guideline which does not currently recommend this therapy.

New evidence is unlikely to change guideline recommendations.

Mentalisation

An RCT of mentalisation from previous surveillance was not deemed to impact the guideline.

The findings of the new evidence that mentalisation-based treatment was not superior to treatment as usual in borderline personality disorder, nor superior to substance-use treatment alone in patients with concurrent substance use disorders, is unlikely to impact the guideline which does not currently recommend this therapy.

New evidence is unlikely to change guideline recommendations.

Motive-oriented therapeutic relationship

The new evidence suggests that adding motive-oriented therapeutic relationship to general psychiatric treatment may have promise for reducing general problems but not specific borderline symptoms. Although the evidence builds on a pilot trial identified by previous surveillance, as a single study it remains unlikely to impact the guideline which does not currently recommend this therapy.

New evidence is unlikely to change guideline recommendations.

Interpersonal psychotherapy, cognitive therapy, cognitive behavioural therapy, and schema focused therapy

Previous surveillance concluded there was no impact on the guideline and no new evidence was found to change this conclusion.

New evidence is unlikely to change guideline recommendations.

Drug treatment

Previous surveillance summary

Thirteen studies (3 observational studies, 5 RCTs and 5 systematic reviews) were identified.

An observational study of quetiapine reported reductions in symptoms, assessed by objective rating scales, in individuals with borderline personality disorder (34). The initial results of an observational study suggested that duloxetine is an effective and well-tolerated treatment for borderline personality disorder, with positive effects on somatic symptoms (35). Three RCTs were identified which examined the use of olanzapine for the treatment of borderline personality disorder. One of the studies compared treatment with variably dosed olanzapine with placebo and found that both olanzapine and placebo groups showed improvements in overall symptoms of borderline personality disorder but did not differ significantly at end-point (36). The results of a second study suggested that olanzapine and sertraline are both effective in alleviating symptoms of people with borderline personality disorder (37). Another study found no differences between olanzapine and haloperidol in the management of mental and behavioural symptoms of people with borderline personality disorder (38). Two studies evaluating the effectiveness of lamotrigine were identified. One observational study reported that lamotrigine appears to be an effective and relatively safe agent in the longer-term treatment of aggression in women with borderline personality disorder (39). The results of an RCT also suggested that lamotrigine is an effective treatment for affective instability and for the general impulsivity characteristic of borderline personality disorder (40). One RCT was identified which failed to show a significant effect of ziprasidone in people with borderline personality disorder (41). Four systematic reviews were identified which examined the effects of various pharmacological treatments, including second-generation antipsychotics, mood stabilisers, and omega-3 dietary supplements, in people with borderline personality disorder (42–45). The results of the reviews were mixed with some evidence that drug treatments may be effective in improving symptoms of borderline personality disorder although not overall severity of the disorder. A fifth systematic review (n=4132) was identified which examined the risk of adverse events associated with ziprasidone (46). The review found that the overall rate of adverse events was higher with ziprasidone than placebo, and that it was specifically linked to increased rates of somnolence, extrapyramidal symptoms, headache, insomnia and respiratory disorders.

2018 surveillance summary

Quetiapine

A double-blind RCT (47) (n=95) examined efficacy and tolerability of low (150 mg/day) and moderate (300 mg/day) dosages of extended-release quetiapine versus placebo in adults with borderline personality disorder. The low-dosage group had significant improvement on the clinician-rated Zanarini Rating Scale for Borderline Personality Disorder compared with placebo. Time to response (50% or more reduction on Zanarini scale total score) was significantly shorter with both low and moderate-dosage than placebo. Among participants who completed the study, 82% in the low-dosage group were rated as 'responders' (undefined in abstract) compared with 74% in the moderate-dosage group and 48% in the placebo group (significance not reported in abstract). Treatment-emergent adverse events included sedation, change in appetite, and dry mouth. The overall completion rate for the 8-week double-blind treatment phase was 67% (67% for the low-dosage group, 58% for the moderate-dosage group, and 79% for the placebo group). Participants who experienced sedation were more likely to drop out.

Asenapine versus olanzapine

An open-label RCT (48) (n=51 outpatients aged 18–50 years) examined efficacy and tolerability of 12 weeks of asenapine (5–10 mg/day) versus olanzapine (5–10 mg/day) in borderline personality disorder. Participants were assessed at baseline and 12 weeks with the following instruments: the Clinical Global Impression Scale, Severity item (CGI-S), Hamilton Depression Rating Scale (HAM-D), Hamilton Anxiety Rating Scale (HAM-A), Social Occupational Functioning Assessment Scale (SOFAS), Borderline Personality Disorder Severity Index (BPDSI), Barratt Impulsiveness Scale, version 11 (BIS-11), Modified Overt Aggression Scale (MOAS), Self-Harm Inventory (SHI), and Dosage Record and Treatment Emergent Symptom Scale (DOTES). A significant within-subject effect (trial duration) was seen for all rating scales, except the HAM-D, the MOAS, and 2 items of the BPDSI, namely, 'identity disturbance' and 'parasuicidal behaviours'. A significant effect between subjects was found for the 2 items of the BPDSI 'affective instability' and 'dissociation/paranoid ideation'. Asenapine was significantly superior to olanzapine in reducing the affective instability score, whereas olanzapine was significantly superior to asenapine in reducing dissociation/paranoid ideation. The study was found to be underpowered to detect a difference between the drugs on the dissociation/paranoid ideation item of the BPDSI. Both medications were well tolerated, with asenapine associated with a higher frequency of oral hypoesthesia and akathisia, and olanzapine prone to induce weight gain.

Olanzapine-fluoxetine

A systematic review and meta-analysis (49) of 9 double-blind RCTs (n=2827) examined fixed dose-combination products in psychiatry. All except 2 studies tested only 1 combination drug (e.g. olanzapine and fluoxetine). In a subgroup analysis, the olanzapine-fluoxetine combination was not significantly superior to a single therapeutic agent for borderline personality disorder.

Olanzapine versus aripiprazole

An open-label RCT (50) (n=24 women) examined olanzapine (mean modal dose 6.4 mg/day) and aripiprazole (mean modal dose 7.0 mg/day) for borderline personality disorder. Participants were selected from outpatients at 2 psychiatric clinics, and inpatients from female wards of a psychiatric hospital. Patients with prominent comorbid mental disorders were excluded. At 8 weeks, both olanzapine and aripiprazole showed a significant improvement in the primary outcome of the Brief Psychiatric Rating Scale (BPRS). Significant improvement in secondary outcomes of anger and hostility (Buss-Durkee Hostility Inventory), and overall illness severity (Clinical Global Impressions-Severity Scale), were seen with olanzapine but not aripiprazole. The analysis of specific BPRS subscales in both groups revealed similar, significantly lower scores in anxiety, tension, depressive mood and hostility. Olanzapine showed better results on uncooperativeness and excitement, and aripiprazole was superior for suspiciousness and unusual thought content.

Lamotrigine

A health technology assessment comprising a double-blind RCT (51) set in secondary care NHS mental health services in 6 centres in England (n=276 participants randomised aged at least 18 years, excluding coexisting psychosis or bipolar affective disorder, and those on mood stabilisers) examined the clinical and cost-effectiveness of lamotrigine (up to 200 mg/day; women on oral contraceptives up to 400 mg/day) versus placebo for borderline personality disorder. Participants were stratified by study centre, severity of personality disorder and extent of hypomanic symptoms. Of the 195 participants followed up 52 weeks later, 49 (36%) who were prescribed lamotrigine and 58 (42%) prescribed placebo were taking it. For the primary outcome, mean total score on the

Zanarini Rating Scale for Borderline Personality Disorder score did not differ significantly between participants on lamotrigine and placebo. No significant differences in secondary outcomes (depressive symptoms, deliberate self-harm, social functioning, health-related quality of life, resource use and costs, side effects of treatment and adverse events) were seen at any time. Adjusted costs of direct care for those prescribed lamotrigine were similar to those prescribed placebo. The authors noted that levels of adherence were low, but greater adherence was not associated with better mental health.

Intelligence gathering

It was noted that recommendation 1.3.7.3 mentions sedative antihistamine, and there has been a Medicines and Healthcare products Regulatory Agency (MHRA) Drug Safety Update April 2015 on hydroxyzine and risk of QT interval prolongation and Torsade de Pointes. This is covered by the British National Formulary.

It was further noted that recommendation 1.3.8.2 links to NICE technology appraisal guidance 77 on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia, and there has been a May 2014 MHRA Drug safety update on about the risk of drowsiness and reduced driving ability with zolpidem. This is covered by the British National Formulary.

It was also noted that it continues to be the case that no drug has UK marketing authorisation for the treatment of borderline personality disorder.

Impact statement

Duloxetine

Previous surveillance found an observational study suggesting that duloxetine is effective but no new evidence was found reinforcing these effects and no impact on the guideline is expected.

New evidence is unlikely to change guideline recommendations.

Ziprasidone

Evidence from previous surveillance failed to show a significant effect of ziprasidone, and found that rate of adverse events was higher with ziprasidone than placebo. No new evidence was found on this drug, and no impact on the guideline is expected.

New evidence is unlikely to change guideline recommendations.

Quetiapine

New evidence suggests that quetiapine 150 mg/day reduced the severity of borderline personality disorder symptoms versus placebo. The evidence was from a single trial, and although it reinforces evidence from previous surveillance (a single small observational review) the evidence base remains limited and is unlikely to impact the guideline which does not recommend specific drugs.

New evidence is unlikely to change guideline recommendations.

Asenapine versus olanzapine

Previous surveillance found no specific benefit of olanzapine over placebo or other drugs.

The authors of the new evidence stated that asenapine and olanzapine had a similar efficacy. While asenapine was more effective for affective instability, olanzapine was superior for paranoid ideation and dissociation. The authors noted that the open-label study design, lack of a placebo group, and small sample size were major limitations and findings need to be replicated in further studies. The guideline does not recommend specific drugs and the evidence is unlikely to change the conclusion of the previous surveillance that there is no impact on the recommendations.

New evidence is unlikely to change guideline recommendations.

Olanzapine-fluoxetine

Previous surveillance found no specific benefit of olanzapine over placebo or other drugs.

The new evidence suggests that an olanzapine-fluoxetine combination was not superior to a single therapeutic agent for borderline personality disorder. The guideline does not recommend specific drugs and the evidence is unlikely to change the conclusion of the previous surveillance that there is no impact on the recommendations.

New evidence is unlikely to change guideline recommendations.

Olanzapine versus aripiprazole

Previous surveillance found no specific benefit of olanzapine over placebo or other drugs.

Both olanzapine and aripiprazole had benefits for general symptoms of borderline personality disorder. However this was a single trial with a small number of participants. The guideline does not recommend specific drugs and the evidence is unlikely to change the conclusion of the previous surveillance that there is no impact on the recommendations.

New evidence is unlikely to change guideline recommendations.

Lamotrigine

Previous surveillance identified 2 small studies suggestive of benefit of lamotrigine.

The authors of the new health technology assessment concluded the addition of lamotrigine to usual care of people with borderline personality disorder was not found to be clinically effective or provide a cost-effective use of resources. Neither lamotrigine nor treatment with specific drugs are recommended by the guideline, and the evidence is unlikely to change the conclusion of the previous surveillance that there is no impact on the recommendations.

New evidence is unlikely to change guideline recommendations.

1.4 Inpatient services

Recommendations in this section of the guideline

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.

Surveillance decision

No new information was identified at any surveillance review.

1.5 Organisation and planning of services

Recommendations in this section of the guideline

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.

Surveillance decision

This section of the guideline should not be updated.

An editorial amendment is needed:

- From recommendation 1.5.1.1
  '…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'
  - a link will be added to NG66 Mental health of adults in contact with the criminal justice system

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Links with the criminal justice system

Previous surveillance summary

In previous surveillance of this guideline, no studies relevant to this section were identified.

2018 surveillance summary

No relevant evidence was identified.

Intelligence gathering

Topic experts highlighted concerns around pressures in the prison service e.g. overcrowding and rising levels of self-harm, and that the guideline may need reviewing against this context.

Impact statement

The guideline recommendation 1.5.1.1 states '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.'

In addition NICE guideline NG66 Mental health of adults in contact with the criminal justice system specifically addresses this population.

No impact for NICE guideline CG78 is expected, but a cross-referral to NG66 will be added to CG78 from recommendation 1.5.1.1.

New evidence is unlikely to change guideline recommendations.

Research recommendations

Research recommendations considered in surveillance

RR - 01 What are the best outcome measures to assess interventions for people with borderline personality disorder?

Summary of findings

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR - 02 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?

Summary of findings

New evidence was found for a variety of psychological therapy programmes. Systematic reviews found that psychotherapy in general was clinically and cost-effective. RCTs examining individual therapies had mixed results and evidence either did not support them, or was insufficient to suggest adding them to the recommendations at this time.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR - 03 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?

Summary of findings

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR - 04 What is the effectiveness and cost-effectiveness of mood stabilisers on the symptoms of borderline personality disorder?

Summary of findings

New evidence was found for the mood stabilisers lamotrigine and asenapine. There was no evidence to support the use of lamotrigine for borderline personality disorder. There was evidence that asenapine and olanzapine had a similar efficacy, but study limitations prohibited firm conclusions.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR - 05 What is the best care pathway for people with borderline personality disorder?

Summary of findings

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

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