NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Personality disorders (borderline and antisocial)

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for personality disorders (antisocial and borderline). It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

- Antisocial personality disorder: Treatment, management and prevention. NICE clinical guideline 77 (2009).
- Borderline personality disorder: Treatment and management. NICE clinical guideline 78 (2009).

2 Overview

2.1 Focus of quality standard

This quality standard will cover treating and managing borderline and antisocial personality disorders. For borderline personality disorder this quality standard will apply to adults and young people under 18. For antisocial personality disorder this quality standard will apply to adults over 18 only. NICE quality standard 59 covers antisocial behaviour and conduct disorder in children and young people.

2.2 Definition

Clinical guidelines on antisocial personality disorder and borderline personality disorder use the diagnostic system DSM-IV to define the characteristics of the personality disorders. The DSM-IV which was also used to carry out the Adult Psychiatric Morbidity Survey (2007) defines a personality disorder as ‘an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in

adolescence or early adulthood, is stable over time, and leads to distress or impairment'.

The current classification (DSM-IV) identifies ten types of personality disorder grouped into three clusters:

- Cluster A includes the 'odd or eccentric' types
- Cluster B disorders are the 'dramatic, emotional or erratic' types
- Cluster C is the anxious-fearful group

There are issues with all the available screening tools, and no 'gold standard' has emerged. One common disadvantage is the large number of questions required to assess the full range of disordered personality types. ASPD and BPD are both cluster B disorders.

Antisocial personality disorder (ASPD)

People with ASPD exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifested in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others.

DSM-IV characterises ASPD as a pervasive pattern of disregard for and violation of the rights of others that has persisted in the individual since the age of 15 or earlier, as indicated by three (or more) of seven criteria:

- a failure to conform to social norms
- irresponsibility
- deceitfulness
- indifference to the welfare of others
- recklessness
- a failure to plan ahead
- irritability and aggressiveness

A feature of ASPD in the DSM-IV is that it requires the individual to meet diagnostic criteria in childhood (presence of conduct disorder before age 15) as well as

adulthood. Because particular behaviours must have persisted beyond the age of 18, people younger than this cannot be given the diagnosis.

The condition is associated with a wide range of interpersonal and social disturbance. Criminal behaviour is central to the definition of antisocial personality disorder, although it is often the culmination of previous and long standing difficulties, such as socioeconomic, educational and family problems.

Borderline personality disorder (BPD)

BPD is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present.

According to the DSM-IV diagnostic criteria, BPD is indicated by five (or more) of the following criteria:

- frantic efforts to avoid real or imagined abandonment
- pattern of unstable and intense personal relationships
- unstable self-image
- impulsivity in more than one way that is self-damaging (e.g. spending, sex, substance, abuse, binge eating, reckless driving)
- suicidal or self-harming behaviour
- affective instability
- chronic feelings of emptiness
- anger
- paranoid thoughts or severe dissociative symptoms (quasi-psychotic).

Unlike ASPD, a DSM-IV diagnosis of BPD is possible before the age of 18.

BPD is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are at particular risk of suicide.

2.3 Incidence and prevalence

Antisocial personality disorder

People with antisocial personality disorder have often grown up in fractured families in which parental conflict is typical and parenting is harsh and inconsistent. As a result of parental inadequacies and/or the child's difficult behaviour, the child's care is often interrupted and transferred to agencies outside the family. This in turn often leads to truancy, having delinquent associates and substance misuse, which frequently result in increased rates of unemployment, poor and unstable housing situations, and inconsistency in relationships in adulthood. Many people with antisocial personality disorder have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour.

The prevalence of antisocial personality disorder in the general population is 3% in men and 1% in women. While the incidence of antisocial personality disorder in women may be lower and the threshold for entry to services such as forensic services or the criminal justice system higher, there is some evidence to suggest that women with antisocial personality disorder have greater severity of problems characterised by more complex comorbidities and corresponding poor outcomes.

The prevalence of antisocial personality disorder among prisoners is around 47%. A history of aggression, unemployment and promiscuity is more common than serious crimes among people with antisocial personality.

The course of antisocial personality disorder is variable and although recovery is attainable over time, some people may continue to experience social and interpersonal difficulties. Antisocial personality disorder is often comorbid with depression, anxiety, alcohol and drug misuse.

Borderline personality disorder

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

Borderline personality disorder is often comorbid with depression, anxiety, eating disorders, post-traumatic stress disorder, alcohol and drug misuse, and bipolar disorder (the symptoms of which are often confused with borderline personality disorder).

The extent of the emotional and behavioural problems experienced by people with borderline personality disorder varies considerably. Some people are able to sustain

some relationships and occupational activities but people with more severe forms experience very high levels of emotional distress. They have repeated crises, which can involve self-harm and impulsive aggression. They also have high levels of comorbidity, including other personality disorders, and are frequent users of psychiatric and acute hospital emergency services.

2.4 Management

Antisocial personality disorder

Managing the condition focuses on dealing with specific issues related to the disorder:

- interventions targeted specifically at antisocial personality disorder
- the treatment and management of the symptoms and behaviours associated with antisocial personality disorder, such as impulsivity and aggression
- the treatment of comorbid disorders such as depression and drug misuse
- the management of offending behaviour.

Whilst a range of psychological interventions is recommended for people with antisocial personality disorders, pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity.

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

Borderline personality disorder

People with borderline personality disorder have sometimes been excluded from health or social care services because of their diagnosis. This may be because staff lack the confidence and skills to work with this group of people.

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

The course of borderline personality disorder is very variable. Most people show symptoms in late adolescence or early adult life, although some may not come to the attention of psychiatric services until much later. The outcome in those who have received treatment or formal psychiatric assessment is that at least 50% of people improve sufficiently to not meet the criteria for borderline personality disorder 5 to 10

years after first diagnosis. It is not known to what extent this is a consequence of treatment – evidence suggests that a significant proportion of improvement is spontaneous and accompanied by greater maturity and self-reflection.

2.5 National Outcome Frameworks

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

Table 1 The Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* ***Outcome measures*** **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life.** 1D Carer-reported quality of life **People are able to find employment when they want, maintain a family and social life and contribute to community life and avoid loneliness or isolation.** 1F Proportion of adults in contact with secondary mental health services in paid employment** 1H Proportion of adults in contact with secondary mental health services living independently, with or without support* 1I Proportion of people who use services and their carers who reported that they had as much social contact as they would like*
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with the experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support. 3B Overall satisfaction of carers with social services 3E Improving people's experience of integrated care** ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process.** 3C The proportion of carers who report that they have been included or consulted in discussion about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.** 3D Proportion of people who use services and carers who find it easy to find information about services **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.**

4 Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm	***Overarching measure*** 4A. The proportion of people who use services who feel safe** ***Outcome measures*** **Everyone enjoys physical safety and feels secure.** **People are free from physical and emotional abuse, harassment, neglect and self-harm.** **People are protected as far as possible from avoidable harm, disease and injuries.** **People are supported to plan ahead and have the freedom to manage risks the way they wish.** 4B Proportion of people who use services who say that those services have made them feel safe and secure
Aligning across the health and care system * Indicator complementary ** Indicator shared *** Indicator complementary with the Public Health Outcomes Framework and the NHS Outcomes Framework	

Table 2 NHS Outcomes Framework 2014–15

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

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

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

3 Summary of suggestions

3.1 Responses

In total 10 stakeholders responded to the 2-week engagement exercise 24/07/2014 – 7/08/2014

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 1 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Assessment and diagnosis • critical approach to diagnostic methodology • assessment and diagnosis • nutritional assessment	SCM, RCP, HQT
Appropriate treatment • psychological interventions • pharmacological interventions • specialist services – young people • approved/responsible clinician	RCN, SCM, ACAT, RCP
Managing endings and supporting transitions	RCN, SCM
Person centred care • social and occupational activities • therapeutic relationships and environments	SCM, EE
Supervision and support	RCN, EE, SCM
Partnership work • multi agency and multidisciplinary work • personality disorders network	SCM, RCP, EE, CMHP
Additional areas • emergency departments • reference to previous DH work • children and young people guideline for BPD • areas for further debate	SCM, EE, RCP

Suggested area for improvement	Stakeholders
ACAT, Association for Cognitive Analytic Therapy CMHP, College of Mental Health Pharmacy EE, Enabling Environments HQT Diagnostics RCN, Royal College of Nursing RCP, Royal College of Psychiatrists SCM, Specialist Committee Member	

4 Suggested improvement areas

4.1 Assessment and diagnosis

4.1.1 Summary of suggestions

Critical approach to diagnostic methodology

Stakeholders highlighted the complexity of defining and as a result diagnosing personality disorders, borderline personality disorder in particular. They pointed out the variety of symptoms that people may manifest and the potential for people with the condition to be very different from one another. The comments highlighted the lack of consensus around diagnostic models and questioned using DSM-IV highlighted by the guidelines as the main diagnostic tool in light of potentially better i.e. dimensional approaches to diagnosis. These comments aimed to highlight the need for staff working with this client group to be aware of the uncertainties and questions around the diagnostic tools and methods and adopt a critical approach to the standard diagnostic models.

Assessment and diagnosis

Stakeholders stressed the importance of adhering to the principles of the assessment and diagnosis. They highlighted that it's vital to first establish whether or not the person meets the general or basic criteria for personality disorders and then assess specific criteria for one or more types of disorders.

Stakeholders highlighted the risk of over diagnosing the occurrence of personality disorder and pointed out the need to consider the consequences and stigma still attached to the diagnosis despite the work done to change attitudes.

Stakeholders suggested that personality status needs to be routinely assessed at an early stage in the initial assessment of all new referrals to secondary care.

Nutritional assessment

Stakeholders suggested that the GPs should test people for fatty acids and Vitamin D imbalance before referring them for a formal assessment for behavioural therapies. They suggested that for patients with the imbalance, dietary advice and nutritional intervention should be given for at least 3 months before any further referrals are made.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Critical approach to diagnostic methodology	No recommendations identified
Assessment and diagnosis	**Assessment** NICE CG77 Recommendations: 1.3.1.1, 1.3.1.2, 1.3.1.3 NICE CG78 Recommendations: 1.3.1.1, 1.3.1.2
Nutritional assessment	No recommendations identified

Assessment and diagnosis

NICE CG77 – Recommendation 1.3.1.1

When assessing a person with possible antisocial personality disorder, healthcare professionals in secondary and forensic mental health services should conduct a full assessment of:

- antisocial behaviours
- personality functioning, coping strategies, strengths and vulnerabilities
- comorbid mental disorders (including depression and anxiety, drug or alcohol misuse, post-traumatic stress disorder and other personality disorders)
- the need for psychological treatment, social care and support, and occupational rehabilitation or development
- domestic violence and abuse.

NICE CG77 – Recommendation 1.3.1.2

Staff involved in the assessment of antisocial personality disorder in secondary and specialist services should use structured assessment methods whenever possible to increase the validity of the assessment. For forensic services, the use of measures such as PCL-R or PCL-SV to assess the severity of antisocial personality disorder should be part of the routine assessment process.

NICE CG77 – Recommendation 1.3.1.3

Staff working in primary and secondary care services (for example, drug and alcohol services) and community services (for example, the probation service) that include a high proportion of people with antisocial personality disorder should be alert to the possibility of antisocial personality disorder in service users. Where antisocial personality disorder is suspected and the person is seeking help, consider offering a referral to an appropriate forensic mental health service depending on the nature of the presenting complaint. For example, for depression and anxiety this may be to general mental health services; for problems directly relating to the personality disorder it may be to a specialist personality disorder or forensic service.

NICE CG78 – Recommendation 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.

NICE CG78 – Recommendation 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.

4.1.3 Current UK practice

Assessment and diagnosis

No published studies on current practice were highlighted for this suggested area for quality improvement. This area is based on stakeholder's knowledge and experience.

4.2 Appropriate treatment

4.2.1 Summary of suggestions

Psychological interventions

Stakeholders highlighted the need to improve availability of services and the way the treatment is delivered in different trusts. Specifically they highlighted the need for:

- a wide range of psychological therapies that would suit personal needs and facilitate engagement with complex clients
- consistent approach taken by all stakeholders involved in treatment
- more secondary mental health settings willing to take patients with ASPD
- the forensic settings to be better equipped to provide long-term treatment.
- resources to be put into developing protocols for engaging patients with ASPD
- expanding the remit of IAPT to include management of PD

Pharmacological interventions

Stakeholders highlighted that even though NICE guidelines 77 and 78 state that drug treatments should not be used to treat the symptoms of personality disorder and that medication is only recommended for short term crisis management, national audits show that majority of patients receive drugs in the mid – to long term. Stakeholders suggested that all patients should have medication reviewed regularly (3 – 6 monthly), with clear treatment plans that include medication available in their notes.

Stakeholders suggested that multi-disciplinary teams working with people with personality disorders should include a specialist pharmacist role to ensure safe and effective use of medicines.

Specialist BPD services for young people

Stakeholders suggested that specialist BPD services are needed for young people. Stakeholders highlighted that these services are needed both in the community and in particular specialist units for the more severe cases which cannot be managed on generic adolescent units or discharged to the community.

Approved/Responsible Clinician (AC/RC)

Stakeholders highlighted that access to a non-medical approved clinician or responsible clinician was enshrined in law within the amended Mental Health Act but

in reality very few non-medical AC/RC's are available to people with personality disorders.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Psychological interventions	**The role of psychological interventions** NICE CG77 Recommendations: 1.4.2.1, 1.4.2.2, 1.4.2.4 **Psychological treatment** NICE CG78 Recommendations: 1.3.4.1, 1.3.4.3, 1.3.4.4,
Pharmacological interventions	**The role of pharmacological interventions** NICE CG77 Recommendations: 1.4.3.1, 1.4.3.2 **The role of drug treatment** NICE CG78 Recommendations: 1.3.5.1, 1.3.5.2, 1.3.5.3, 1.3.5.4, 1.3.5.6 **The management of crises** NICE CG78 Recommendation: 1.3.7.5
Specialist BPD services for young people	No recommendations
Approved/Responsible Clinician	No recommendations

Psychological interventions

NICE CG77 – Recommendation 1.4.2.1

For people with antisocial personality disorder, including those with substance misuse problems, in community and mental health services, consider offering group-based cognitive and behavioural interventions, in order to address problems such as impulsivity, interpersonal difficulties and antisocial behaviour.

NICE CG77 – Recommendation 1.4.2.2

For people with antisocial personality disorder with a history of offending behaviour who are in community and institutional care, consider offering group based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour.

NICE CG77 – Recommendation 1.4.2.4

When providing cognitive and behavioural interventions:

- assess the level of risk and adjust the duration and intensity of the programme accordingly (participants at all levels of risk may benefit from these interventions)
- provide support and encouragement to help participants to attend and complete programmes, including people who are legally mandated to do so.

NICE CG78 - Recommendation 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.

NICE CG78 - Recommendation 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.

NICE CG78 - Recommendation 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.

Pharmacological interventions

NICE CG77 – Recommendation 1.4.3.1

Pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity.

NICE CG77 – Recommendation 1.4.3.2

Pharmacological interventions for comorbid mental disorders, in particular depression and anxiety, should be in line with recommendations in the relevant NICE clinical guideline (see section 6). When starting and reviewing medication for comorbid mental disorders, pay particular attention to issues of adherence and the risks of misuse or overdose.

NICE CG78 – Recommendation 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).

NICE CG78 – Recommendation 1.3.5.2

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

NICE CG78 – Recommendation 1.3.5.3

Drug treatment may be considered in the overall treatment of comorbid conditions.

NICE CG78 – Recommendation 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.

NICE CG78 – Recommendation 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.

NICE CG78 – Recommendation 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.

4.2.3 Current UK practice

Researchers from the University of Nottingham identified specialist personality disorder services across the Nottinghamshire, Derbyshire and Lincolnshire region and explored their capacity in relation to estimated need in each area. They also investigated the therapeutic approaches used in each area. The study (2011) found that:

- services were available but patchy for community non-forensic service users across the region but only a minority of people with personality disorder seemed able to access their treatment
- services were more readily available in high, medium and low secure forensic settings for both men and women with personality disorder in the NHS and independent sector
- there was a limited level of specialist forensic services within community-based settings
- there was some adherence to Government policy standards for the treatment of personality disorder across services in the region, but there was a wide disparity in the service models adopted in both forensic and non-forensic settings.

Psychological interventions

Community Mental Health Survey (2013) asked people who use community mental health services about their experiences in accessing talking therapies, as defined in the questionnaire (i.e. included counselling, cognitive behavioural therapy (CBT), and anxiety management). Only 39% of respondents said that they had received talking therapy from NHS mental health services in the last 12 months.

Horton, A. et al (2012) analysed case notes of 47 patients with a diagnosis of BPD, discharged from four acute inpatient wards in Sheffield over 12 months. Of 68 discharges involving 47 patients, 78% were prescribed drug treatment specifically for BPD. Of the 47 patients, only 17% received a structured psychological intervention.

Between 2012 and 2013 'We need to talk' coalition (a group of mental health charities, professional organisations, Royal College and service providers) carried out research with people who have either used or tried to access psychological therapies on the NHS in England within the last two years. The research included:

- two focus groups with 10 people
- carrying out a survey of more than 1600 people with mental health problems who have used psychological therapies

- carrying out surveys with local MINDs, the British Psychoanalytic Council, UK Council for Psychotherapy and NHS psychological therapists

The survey results showed wide variation in people's experiences of psychological service provision, availability, access and quality. While many people are now getting access to their choice of psychological therapy within weeks, some still wait years for services that are not right for them; Key findings:

- one in 10 people have been waiting over a year to receive treatment
- over half have been waiting over three months to receive treatment
- around 13% of people are still waiting for their first assessment for psychological therapy
- 58% weren't offered choice in the type of therapies they received
- three quarters were not given a choice in where they received their treatment
- half felt the number of sessions weren't enough
- 11% said they had to pay for treatment because the therapy they wanted was not available on the NHS
- 40% had to request psychological therapies rather than being offered them
- one in ten, after being assessed, were not offered psychological therapies
- one in ten felt their cultural needs were taken into account by the service they were offered, though most others said this didn't matter to them

Pharmacological interventions

In 2012 Prescribing Observatory for Mental Health (POMH) conducted a national baseline audit on prescribing for people with borderline personality disorder. The audit included over 2,500 patients. Audit standards and treatment targets were largely derived from recommendations in the NICE guideline on borderline personality disorder (2009). Key findings:

- Around 4 out of 5 patients were prescribed at least one medication from four drug groups: antipsychotics, antidepressants, mood stabilisers and sedatives;
- Just over half of patients with PD alone (i.e. without any co-morbid mental illness) were prescribed at least one antipsychotic and the vast majority of these prescriptions were of at least 6-month duration.

- Benzodiazepines were prescribed in a third of those patients without comorbid psychotic illness, while Z-hypnotics were prescribed in a fifth.
- Two-thirds of patients had a written crisis plan which was accessible in the clinical records.
- Only two-fifths of these crisis plans mentioned medication and in just over a quarter there was no evidence that the patient had been involved in its development.

4.3 Managing endings and supporting transitions

4.3.1 Summary of suggestions

Stakeholders suggested that if the ending is collaborative, and people with personality disorders feel they have a sense of control over it as well as flexibility around re-accessing, it helps to reduce anxiety and to enable continued development. The stakeholders highlighted that recovery is not a linear process, and that setbacks could occur. If gains are not maintained people with personality disorder end up returning to mental health services and if access is problematic then often a crisis is reached before they receive support.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Managing endings and supporting transitions	**Access and assessment** CG77 Recommendation: 1.1.1.2 **Multi agency care** CG77 Recommendation: 1.6.1.1, **Transition from child and adolescent services to adult services** CG77 Recommendation: 1.2.9 **Managing endings and supporting transitions** CG78 Recommendations: 1.1.7.1, 1.1.7.2 **Care planning** CG78 Recommendation: 1.3.2.2

Managing endings and supporting transitions

CG77 - Recommendation 1.1.1.2

Seek to minimise any disruption to therapeutic interventions for people with antisocial personality disorder by:

- ensuring that in the initial planning and delivery of treatment, transfers from institutional to community settings take into account the need to continue treatment

- avoiding unnecessary transfer of care between institutions whenever possible during an intervention, to prevent disruption to the agreed treatment plan. This should be considered at initial planning of treatment.

CG77 – Recommendation 1.6.1.1

Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Therefore, services should ensure that there are clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided. These pathways should:

- specify the various interventions that are available at each point

- enable effective communication among clinicians and organisations at all points and provide the means to resolve differences and disagreements.

Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk.

CG 77 – Recommendation 1.2.9

Health and social care services should consider referring vulnerable young people with a history of conduct disorder or contact with youth offending schemes, or those who have been receiving interventions for conduct and related disorders, to appropriate adult services for continuing assessment and/ or treatment.

CG78 – Recommendation 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.

CG78 – 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. 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.

CG78 – Recommendation 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.

4.3.3 Current UK practice

Gintalaite-Bieliauskiene, K. et al (2013) carried out an audit which measured compliance to guidelines on Borderline Personality Disorder in the female psychiatric intensive care unit at Elizabeth Casson House, Bristol. Findings from the retrospective review of the records of 46 patients admitted between 2007 and 2010 showed that 76% of patients were provided with the copy of the multi-disciplinary care plan at the time of admission and that in 80% of admissions discharge planning was discussed with the patient and documented.

NHS Bolton Foundation Trust and Greater Manchester West NHS Foundation Trust carried out an audit using an adapted tool included with the NICE clinical guideline 78 Borderline Personality Disorder. It was applied to 30 patients diagnosed with BPD after January 2009 and under follow up in July 2011. The results showed that transition of care was discussed in advance with only 36% of the patients. What is more, none of the changes occurred in a structured and phased way and there was no evidence of any of the patients being supported during referrals and arrangements being agreed beforehand. The audit also showed that 67% of the crisis plans included the opportunity to access services and 44% of these established how to access them.

4.4 Person centred care

4.4.1 Summary of suggestions

Social and occupational activities

Stakeholders highlighted the pervasive impact of personality disorder on all aspects of a person's functioning. They suggested that developing flexible treatment protocols which would recognise the variable needs of people with personality disorders are needed and that interventions need to be moved from their location in health care to locations where these patients experience problems.

Stakeholders suggested that even though people with personality disorder can improve symptoms through therapy, they often continue to struggle to make the same improvements in social and occupational activities (including education/employment). Stakeholders further highlighted that if attention is not paid to the whole person's life and only to their symptoms, then the progress is likely to be limited.

Importance of therapeutic relationships and environments

Stakeholders highlighted that research shows that non-specific therapeutic factors are more important for outcomes than specific therapeutic techniques. They suggested that the results are closely related to the 'culture' and 'ethos' of treatment services.

Stakeholders highlighted that people with personality disorder struggle to trust and engage with others, even though they want help. The establishment of a therapeutic relationship is important if someone is to make progress. Caring, 'human' therapeutic relationship, combined with consistency in this relationship (both towards the person with personality disorder and in terms of length of therapy and after-care) is extremely important.

Stakeholders suggested that while a need for improvement in this area has long been recognised, and there have been efforts to improve it, people with personality disorder still encounter negative and stigmatising responses from professionals including mental health clinicians.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Social and occupational activities	**Assessment** CG78 Recommendation: 1.3.1.1 **Care planning** CG78 Recommendation: 1.3.2.1 **Psychological treatment** CG78 Recommendation: 1.3.4.7
Importance of therapeutic relationships and environments	**Developing an optimistic and trusting relationship** CG77 and CG78 Recommendation: 1.1.4

Social and occupational activities

CG78 - Recommendation 1.3.1.1

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.

CG78 – Recommendation 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.

CG78 – Recommendation 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.

Importance of therapeutic relationships and environments

CG77 - Recommendation 1.1.4

Staff working with people with antisocial personality disorder should recognise that a positive and rewarding approach is more likely to be successful than a punitive approach in engaging and retaining people in treatment. Staff should:

- 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.

CG78 - Recommendation 1.1.4

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.

4.4.3 Current UK practice

Social and occupational activities

Community Mental Health Survey (2013)

The survey results suggest that some respondents would like more support in getting help with aspects of day to day living. Of those respondents who needed support:

- Over a third of respondents with physical health needs said that they did not receive support from someone in NHS mental health services in getting help with this but they would have liked it (37%).
- Almost two fifths said that they did not receive support from someone in NHS mental health services in getting help with care responsibilities but they would have liked it (39%).
- Almost a third (32%) of respondents on CPA and over half of those not on CPA (52%) said they did not receive support from someone in NHS mental health services in getting help with finding or keeping work but would have liked it.
- Over a quarter (28%) of respondents on CPA, and over half of respondents not on CPA (53%, up from 50% in 2012) said that they did not receive support from someone in NHS mental health services in getting help with finding and / or keeping their accommodation but would have liked it.
- Over a quarter (27%) of respondents on CPA and almost half of those not on CPA (48%) said that they did not receive support from someone in NHS mental health services in getting help with financial advice or benefits but would have liked it
- Currently, fewer than one person in ten using mental health services is in work. Many more would like to try out work yet are discouraged from seeking employment. Some are told by health professionals ‘you’ll never work again’ or warned to postpone their job search because they are ‘not ready’. 43% of those who have wanted help with employment never received it.

Centre for Mental Health promotes Individual Placement and Support (IPS) as the most well-established method of 'place then train' in mental health. IPS has been shown to be more effective the more closely it follows these eight principles:

- It aims to get people into competitive employment
- It is open to all those who want to work
- It tries to find jobs consistent with people's preferences

- It works quickly
- It brings employment specialists into clinical teams
- Employment specialists develop relationships with employers based upon a person's work preferences
- It provides time unlimited, individualised support for the person and their employer
- Benefits counselling is included.

Implementation of the Individual Placement and Support (IPS) approach in the UK has been patchy and few places have achieved high fidelity to the model.

13 sites have been selected to be new Centres of Excellence in supporting people who use mental health services into employment. The sites that have committed to being partners in the programme are in Central and North West London, Coventry, Devon, Essex, Manchester, North Staffordshire, Nottingham, Shropshire, Somerset, Stafford, Sussex, Walsall and Worcestershire. They will act as exemplars of how can be implemented in localities across England. These areas will demonstrate how to base employment services for people with mental health problems on the evidence of what works best. In each site, the local mental health trust will work with partners in employment services, local authorities and other agencies to offer people effective support to get into paid work. The learning from these sites will be shared with other areas of England

Importance of therapeutic relationships and environments

Community Mental Health Survey (2013)

The majority of service users responded positively to questions about the health or social care worker that they had seen most recently and said that they ‘definitely’:

- Were listened to carefully (78%)
- Had their taken views into account (72%)
- Had trust and confidence in the person that they had seen (70%)
- Were treated with respect and dignity (86%)
- Were given enough time to discuss their condition and treatment (70%)

However the survey shows that some respondents do not know who their care coordinator or lead professional is:

- For respondents on Care Programme Approach (CPA), 11% did not know and 5% were unsure

- For respondents not on CPA, 33% did not know and 10% were unsure.

Though the majority of respondents who know who their care coordinator is were generally positive about them:

- 72% said that they could ‘always’ contact their care coordinator (or lead processional) if they had a problem

- 60% said that that their care coordinator (or lead professional) organised the care and services they need ‘very well’.

A small qualitative study carried out by Bridget McGrath and Maura Dowling (2012) with registered psychiatric nurses found that the nurses perceive service users with BPD in a negative manner. The service users are “challenging and difficult” to deliver care to and made the nurses feel used and devalued in their experiences. People with BPD were also perceived as manipulative, attention seeking, superficial and calculated. Feelings of anger, frustration and fear were commonly mentioned by the nurses. Nurses admitted feeling tempted to abandon positive expectations for care outcomes as well as providing minimal care and ignoring or avoiding services users with BPD.

4.5 Supervision and support

4.5.1 Summary of suggestions

Staff supervision and support

Stakeholders highlighted the importance of therapeutic relationships and suggested that 'quality of relationships' and non-specific therapeutic factors are often more important for outcomes than specific therapeutic techniques.

Stakeholders highlighted that increased supervision and support for staff teams working with service users with a personality disorder is required in order to sustain them in the heavy interpersonal connections that they are required to make and maintain.

Stakeholders suggested that whilst staff supervision (group and individual) has improved in quality and quantity in many areas and services, practical wellbeing initiatives reducing staff distress and increasing productive self-management are in paucity.

Stakeholders also suggested that cases of self-harm and suicide could be used as treatment opportunities within the emergency departments.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Staff supervision and support	**Intensive staff support** CG77 Recommendation: 1.5.2 **Multi-agency care** CG77 Recommendation: 1.6.1.2 **Staff training, supervision, support** CG77 Recommendations: 1.6.3.3, 1.6.3.4, 1.6.3.5 CG78 Recommendation: 1.1.9.2

Staff supervision and support

CG77 – Recommendation 1.5.2

Staff providing interventions for people who meet criteria for psychopathy or DSPD should receive high levels of support and close supervision, due to increased risk of harm. This may be provided by staff outside the unit.

CG77 – Recommendation 1.6.1.2

Services should consider establishing antisocial personality disorder networks, where possible linked to other personality disorder networks. (They may be organised at the level of primary care trusts, local authorities, strategic health authorities or government offices.) These networks should be multi-agency, should actively involve people with antisocial personality disorder and should:

- take a significant role in training staff, including those in primary care, general, secondary and forensic mental health services, and in the criminal justice system

- have resources to provide specialist support and supervision for staff

- take a central role in the development of standards for and the coordination of clinical pathways

- monitor the effective operation of clinical pathways.

CG77 – Recommendation 1.6.3.3

Services should ensure that all staff providing psychosocial or pharmacological interventions for the treatment or prevention of antisocial personality disorder are competent and properly qualified and supervised, and that they adhere closely to the structure and duration of the interventions as set out in the relevant treatment manuals. This should be achieved through:

- use of competence frameworks based on relevant treatment manuals
- routine use of sessional outcome measures
- routine direct monitoring and evaluation of staff adherence, for example through the use of video and audio tapes and external audit and scrutiny where appropriate.

CG77 – Recommendation 1.6.3.4

Services should ensure that staff supervision is built into the routine working of the service, is properly resourced within local systems and is monitored. Supervision, which may be provided by staff external to the service, should:

- make use of direct observation (for example, recordings of sessions) and routine outcome measures
- support adherence to the specific intervention
- promote general therapeutic consistency and reliability
- counter negative attitudes among staff.

CG77 – Recommendation 1.6.3.5

Forensic services should ensure that systems for all staff working with people with antisocial personality disorder are in place that provide:

- comprehensive induction programmes in which the purpose of the service is made clear
- a supportive and open environment that encourages reflective practice and honesty about individual difficulties such as the potential for therapeutic boundary violations (such as inappropriate relations with service users)
- continuing staff support to review and explore the ethical and clinical challenges involved in working in high-intensity environments, thereby building staff capacity and resilience.

CG78 – Recommendation 1.1.9.2

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

4.5.3 Current UK practice

Staff supervision and support

No published studies on current practice were highlighted for this suggested area for quality improvement.

4.6 Partnership work

4.6.1 Summary of suggestions

Multi agency and multidisciplinary work

Stakeholders highlighted that community management of people with personality disorders requires close collaboration between carers, CAMHS and other services such as social care and education. They suggested that multi agency working should be more explicit and made more clear for all stakeholders involved.

Stakeholders highlighted that ASPD is one of the most expensive conditions and the lack of integration between health care and justice services, particularly for young people, is very detrimental to the likely outcome of their disorder.

Stakeholders highlighted that where medicines are prescribed in personality disorder, the patients should be provided with written information and an opportunity to discuss therapy, as well as ongoing review of the treatment regimen (as per CG77 and CG78). They suggested that this support and review should be offered by a multi-disciplinary team which should include a specialist pharmacist.

Personality disorder network

Stakeholders suggested development of new PD-specific quality network. They highlighted that such networks exist for most other areas of UK psychiatric practice and that the network can be very effective in raising standards of care.

4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Multi-agency and multidisciplinary work	**Multi-agency care** CG77 – Recommendation: 1.6.1.1 **The role of specialist personality disorder services within trusts** CG78 – Recommendations: 1.5.1.1,
Personality disorder specific network	**Multi-agency care** CG77 – Recommendation: 1.6.1.2

Multi-agency and multidisciplinary work

CG77 – Recommendation 1.6.1.1

Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Therefore, services should ensure that there are clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided. These pathways should:

- specify the various interventions that are available at each point
- enable effective communication among clinicians and organisations at all points and provide the means to resolve differences and disagreements.

Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk.

CG78 – Recommendation 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.

Personality disorder specific network

CG77 – Recommendation 1.6.1.2

Services should consider establishing antisocial personality disorder networks, where possible linked to other personality disorder networks. (They may be organised at the level of primary care trusts, local authorities, strategic health authorities or government offices.) These networks should be multi-agency, should actively involve people with antisocial personality disorder and should:

- take a significant role in training staff, including those in primary care, general, secondary and forensic mental health services, and in the criminal justice system
- have resources to provide specialist support and supervision for staff
- take a central role in the development of standards for and the coordination of clinical pathways
- monitor the effective operation of clinical pathways.

4.6.3 Current UK practice

Multi-agency and multidisciplinary work

NHS Bolton Foundation Trust and Greater Manchester West NHS Foundation Trust carried out an audit using an adapted tool included with the NICE clinical guideline 78 Borderline Personality Disorder. It was applied to 30 patients diagnosed with BPD after January 2009 and under follow up in July 2011. The results showed that 60% of patients had a multidisciplinary care plan (89% of these were developed with the patient). Whilst 100% of the care plans identified roles of all professionals involved and short-term treatment aims and steps to achieve them, only 17% of the care

plans identified long-term goals that the person would like to achieve and none of the care plans documented the need for collaboration with other care providers during changes. What is more, there was no information that any of the care plans were shared with the GPs.

Personality disorder specific network

No published studies on current practice were highlighted for this suggested area for quality improvement.

4.7 Additional areas

4.7.1 Summary of suggestions

Emergency departments

Stakeholders suggested better protocols for ED departments while dealing with self-harm. This area of quality improvement is not within the remit of this topic and is better addressed by quality standard for self-harm (QS34).

Reference to previous DH work

Stakeholders suggested that it should be recognised that official DH publications include a lot of information about commissioning high quality PD services. This is a suggestion from a stakeholder for the quality standard development process rather than an area for quality improvement.

Guideline for young people

Stakeholders suggested the need for a separate guideline for young people. This is a suggestions rather than area for quality improvement hence outside the scope of this quality standard. However a guideline Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management (CG158) already exists and is supported by a quality standard on Antisocial behaviour and conduct disorders in children and young people (QS59).

Areas for further debate

Stakeholders suggested that more discussions are needed on:

- the pros and cons of admission in adolescence
- assessing and diagnosing BPD in adolescents

These are area for further debate rather than areas for quality improvement that can be addressed within this quality standard.

Appendix 1: Key priorities for implementation (CG77)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Developing an optimistic and trusting relationship

- Staff working with people with antisocial personality disorder should recognise that a positive and rewarding approach is more likely to be successful than a punitive approach in engaging and retaining people in treatment. Staff should:
    - 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.[recommendation 1.1.4]

Assessment in forensic/specialist personality disorder services

- Healthcare professionals in forensic or specialist personality disorder services should consider, as part of a structured clinical assessment, routinely using:
    - a standardised measure of the severity of antisocial personality disorder such as Psychopathy Checklist–Revised (PCL-R) or Psychopathy Checklist–Screening Version (PCL-SV)
    - a formal assessment tool such as Historical, Clinical, Risk Management-20 (HCR-20) to develop a risk management strategy. [recommendation 1.3.2.7]

Treatment of comorbid disorders

- People with antisocial personality disorder should be offered treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline, where available (see section 6). This should happen regardless of whether the person is receiving treatment for antisocial personality disorder.

The role of psychological interventions

- For people with antisocial personality disorder with a history of offending behaviour who are in community and institutional care, consider offering group-based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour. [recommendation 1.4.2]

Multi-agency care

- Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Therefore, services should ensure that there are

clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided. These pathways should:

  - specify the various interventions that are available at each point

  - enable effective communication among clinicians and organisations at all points and provide the means to resolve differences and disagreements.

Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk.

- Services should consider establishing antisocial personality disorder networks, where possible linked to other personality disorder networks. (They may be organised at the level of primary care trusts, local authorities, strategic health authorities or government offices.) These networks should be multi-agency, should actively involve people with antisocial personality disorder and should:

  - take a significant role in training staff, including those in primary care, general, secondary and forensic mental health services, and in the criminal justice system

  - have resources to provide specialist support and supervision for staff take a central role in the development of standards for and the coordination of clinical pathways

  - monitor the effective operation of clinical pathways. [recommendation 1.6.1]

Appendix 2: Key priorities for implementation (CG78)

Access to services

- People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed. [recommendation 1.1.1]

Autonomy and choice

- Work in partnership with people with borderline personality disorder to develop their autonomy and promote choice by:
    - ensuring they remain actively involved in finding solutions to their problems, including during crises
    - encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make. [recommendation 1.1.3]

Developing an optimistic and trusting relationship

- When working with people with borderline personality disorder:
    - explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
    - build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable
    - bear in mind when providing services that many people will have experienced rejection, abuse and trauma, and encountered stigma often associated with self-harm and borderline personality disorder. [recommendation 1.1.4]

Managing endings and supporting transitions

- Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder. Ensure that:
    - such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased
    - the care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis

- when referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them. [recommendation 1.1.7]

Assessment

- Community mental health services (community mental health teams, related community based services, and tier 2/3 services in child and adolescent mental health services – CAMHS) should be responsible for the routine assessment, treatment and management of people with borderline personality disorder. [recommendation 1.3.1]

Care planning

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

  - identify clearly the roles and responsibilities of all health and social care professionals involved

  - identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them

  - identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims

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

  - be shared with the GP and the service user. [recommendation 1.3.2]

The role of psychological treatment

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

  - an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user

- structured care in accordance with this guideline
- provision for therapist supervision.

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

- Do not use brief psychotherapeutic interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics outlined in 1.3.4.3. [recommendation 1.3.4]

The role of drug treatment

- Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms). [recommendation 1.3.5]

The role of specialist personality disorder services within trusts

- Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder and should:
  - provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
  - provide consultation and advice to primary and secondary care services
  - offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder
  - develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services
  - be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia
  - work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services

- ensure that clear lines of communication between primary and secondary care are established and maintained

- support, lead and participate in the local and national development of treatments for people with borderline personality disorder, including multicentre research

- oversee the implementation of this guideline

- develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline (see 1.5.1.2)

- monitor the provision of services for minority ethnic groups to ensure equality of service delivery.

The size and time commitment of these teams will depend on local circumstances (for example, the size of trust, the population covered and the estimated referral rate for people with borderline personality disorder). [recommendation 1.5.1]

Appendix 3: Suggestions from stakeholder engagement exercise

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	4.1	Rufus Greenbaum	HQT Diagnostics	The GP should test for Fatty Acids before referring patients for formal Assessment for behavioural therapies.	A person with personality disorder will usually have an imbalance in their Fatty Acids. This usually shows up as: **Omega-3 Index** – usually too low (Target >8%) **Omega-6/3 Ratio** – usually too high (Target <3:1) **Trans fats** – usually too high (Target < 0.5%) *We suggest that a fatty acid test is done to measure these values and dietary advice is given (www.hqt-diagnostics.com)* Options are: Increase consumption of fish high in Omega-3 Suggest a suitable course of Omega-3 Fish Oil with >2g Omega-3 per day Suggest reduce consumption of foods with	There is evidence that Fatty Acid imbalance is related and implicated to ADHD, Depression, Autism, Borderline Personality, Substance Abuse & Psychotic Disorders ***This should be corrected by dietary advice and with at least 3 months of Omega-3 Fish Oil before referring patients for formal Assessment for behavioural therapies***	http://www.expertomega3.com/omega-3-study.asp?id=38 www.expertomega3.com www.hqt-diagnostics.com

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Omega-6 Suggest reduce consumption of Trans fats		
002	4.1	Rufus Greenbaum	HQT Diagnostics	The GP should test for Vitamin D 25(OH)D Levels should be supplemented to between 80-100 nmol/L for at least 3 months before referring patients for formal Assessment for behavioural therapies.	A person with personality disorder will usually be deficient In Vitamin D	Several studies suggest an association between hypovitaminosis D and basic & executive cognitive functions, depression, bipolar disorder, and schizophrenia. ***Vitamin D 25(OH)D levels should be supplemented to between 80-100 nmol/L for at least 3 months before referring patients for formal Assessment for behavioural therapies.***	http://www.vitamindwiki.com/Vitamin+D+associated+with+personality+types+of+Extrovert+and+open+%E2%80%93+Jan+2011 http://www.vitamindwiki.com/Hypothesis%3A+Some+Mental+Illness+could+be+treated+or+prevented+with+vitamin+D www.vitamindwiki.com Search separately for: • Antisocial (1 significant review) • Depression (2,520 results) • Bipolar (64 results) • Schizophrenia (2,070 results) • Cognitive (2,280 results) • Personality (18 results)

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
003	4.1	Professor James McGuire	SCM	Key area for quality improvement 1: Basic concepts of personality disorder and the process of diagnosis	It is essential not to “over diagnose” the occurrence of personality disorder, as despite publications and pronouncements designed to change attitudes towards those classed in this way, underlying expectations and stereotypes are difficult to influence.	First, in some services there is a tendency to assess individuals in terms of the specific criteria for one or more types of personality disorder (PD) without first establishing whether or not they meet the general or basic criteria for such disorders. To be diagnosed with PD, there should be evidence of the persistence and enduring nature of problems, i.e. of stability over time; of their pervasiveness, i.e. they emerge consistently across several areas of an individual’s functioning; and of lack of flexibility in how he/she responds in different environments. In addition, the individual’s problems should not be better explained by other mental disorders that may be present. It may be worth emphasizing in guidelines the importance of adhering to these principles when undertaking assessment and diagnosis.	I base this on my experience in preparing reports concerning individuals detained under the Mental Health Act and reading reports prepared by clinicians working in secure forensic mental health services.

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						Second, this has implications for many mental health clinicians' understanding of personality development and the view, unfortunately reinforced by NICE guidelines, that features of PD can be identified in individuals before adulthood. There are dangers in extending downwards in terms of age the diagnostic criteria that are applied to adults that lead them to be described as having personality disorders. The most highly regarded assessments such as the International Personality Disorder Examination (IPDE) require that a feature or trait be present for a period of five years prior to the point of examination, and actively present during the preceding 12 months. As adolescence is a time of sometimes fairly rapid fluctuation in personality and behaviour,	

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						and stable patterns may not be identifiable until early adulthood at the earliest, we should apply considerable caution to the view that features of PD can be recognised in individuals prior to their early twenties.	
004	4.1	Professor James McGuire	SCM	Key area for quality improvement 2: Concepts of diagnosis in BPD	There is a fundamental need to base clinical services and decisions made within them on sound scientific evidence. It is likely that the conceptual model or approach to understanding mental health problems which clinical staff bring to their work with individuals will influence their interactions with them and their expectations of them. The approach which staff adopt to individuals with these problems, and the ways they think about them when assessing them, are likely to have a profound	It is highly questionable whether the term Borderline Personality Disorder (BPD) refers to an actual syndrome and how useful the term is as a means of identifying, classifying and providing treatment or other services for individuals. For diagnosis of BPD, an individual has to meet five out of nine criteria. This means that there are in theory, potentially 256 different combinations of symptoms/criteria: that is, 256 different ways to manifest BPD. In a study of 930 psychotherapeutic day-hospital patients in Norway, Johansen et al. (2004) found	These points are not based on experience of service delivery but on background research with implications for how we conceptualise the problems in this area. See the following study: Johansen, M., Karterud, S., Pedersen, G., Gude, T. & Falkum, E. (2004). An investigation of the prototype validity of the borderline DSM-IV construct. *Acta Psychiatrica Scandanavica*, 109, 289-298.

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					and far reaching influence on how they understand their problems and therefore on how they provide services to them.	252 who met criteria for a diagnosis of BPD. Within that group, researchers identified 136 different permutations of the criteria. The largest number of patients with exactly the same combination of criteria was just six. This demonstrates the extent to which people described as having BPD can be very dissimilar in their symptom presentations. Indeed they may have very little in common with each other. Alongside this we should note (as the NICE guideline does) the high level of comorbidity with other diagnosable disorders manifested by those with BPD. A question surely arises as to how well founded is the core assumption of this approach. It is not clear that it makes sense to talk of people as having BPD, given it is not clear what it is they have. There are grounds for suggesting that those who	

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						work with this client group (i.e. people described as having BPD) should at the very least be aware of these uncertainties and questions.	
005	4.1	Professor James McGuire	SCM	Key area for quality improvement 3: Concepts of diagnosis in ASPD: categories versus dimensions	The perception of individuals as belonging to a group, or being in a defined category, is likely to influence how they are otherwise perceived. Such perceptions are likely to be translated into, amongst other things, an expectation that if certain features are present, others will be too as they "fit together" in a presumptive but not soundly based model.	It would be very valuable to move towards a *dimensional* rather than *categorical* approach to the understanding of what is defined as Antisocial Personality Disorder (ASPD), as the former corresponds more closely to what can be established concerning such problems using sound scientific methods. Prior to the publication of DSM-5 there were extensive debates on the question of whether personality disorders represent discrete clinical categories or "taxons". Nevertheless what might be described as the "status quo" that existed in DSM-IV was carried over into DSM-5. A "hybrid model" incorporating a combination of categorical	Like the issue above, these points are not based on experience of service delivery but on background research with implications for how we conceptualise the problems in this area. See the following studies: Edens, J. F., Marcus, D. K., Lilienfeld, S. O. & Poythress, N. G. (2006). Psychopathic, not psychopath: taxometric evidence for the dimensional structure of psychopathy. *Journal of Abnormal Psychology*, 115, 131-144. Doi: 10.1037/0021-843X.115.1.131 Marcus, D. K., John, S. L. & Edens, J. F. (2004). A taxometric analysis of

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						and dimensional concepts is described in the DSM-5 as an alternative possibility requiring further research. Many clinical researchers find the retention of the DSM-IV model as the core approach highly questionable, and again as for BPD it is important that clinical staff be provided with an understanding of these issues and adopt an appropriately sceptical approach to the standard diagnostic models, as their scientific base is somewhat tenuous. With particular reference to what is regarded as the more severe form of ASPD, labelled as “psychopathy”, research studies using the statistical method of *taxometric analysis* have demonstrated that the principal features of it are dimensional rather than categorical in nature. That is, there is no naturally occurring	psychopathic personality. *Journal of Abnormal Psychology*, 113, 626-635. Doi: 10.1037/0021-843X.113.4.626

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
						separate group of people who can validly be called “psychopaths” who are somehow fundamentally different from other people.	
006	4.1	Dr Bernadka Dubicka	The Royal College of Psychiatrists	Key area for quality improvement 2	Diagnosis – this is a major issue in adolescence but very little is discussed with regards to this in the current guidance. Guidance regarding when the diagnosis may be helpful would be useful and similarly when making a formal diagnosis may not be indicated. Diagnosis is associated with significant stigma and the development of BPD is not necessarily inevitable in YP with symptoms. However, diagnosis may be important and necessary in order to access the appropriate care pathway – further discussion of the pros/cons	Diagnosis in adolescence is controversial and clinicians would benefit from further guidance from NICE.	

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					would be helpful.		
007	4.1	Paul Moran	SCM		I have one major recommendation for improvement in quality standards: personality status needs to be routinely assessed at an early stage in the initial assessment of all new referrals to secondary care. I need to double check the guidelines on BPD and ASPD, but from recollection, this does not appear as a recommendation in either guideline (so I'm therefore not 100% sure if you can therefore take this forward). However, the absence of routine assessment of PD status and associated needs creates major problems downstream in care pathways. When patients find themselves directed to the wrong part of a service and a diagnosis of PD is only considered after a protracted period of		

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					treatment failure for spurious diagnoses of depression or anxiety. This is certainly the case in IAPT services (although they are rectifying this with the introduction of routine PD screening for all newly referred clients).		
008	4.2	Dr Jason Hepple	Association for Cognitive Analytic Therapy (ACAT)	The opportunity for people with personality disorder and histories of abuse and trauma to access psychological therapies that give weight to the witnessing and exploration of these earlier life events.	With the increase in adult survivors of historic childhood abuse coming forward, user choice demands a range of psychological therapies available – some may be symptom focussed or concerned with self-management while others (EG: CAT) offer a chance to look in depth at the narrative of the past and explore ways that the past is affecting current mental health and relationships.	There is an increase in demand for more in-depth approaches with the current identification of buried historic abuse on a large scale. There is a tendency for hard-pressed services to offer briefer and more solution focussed / case management approaches which do not fully cater to user need or acceptability.	CAT is recognised in IAPT–SMI competencies as a specialist intervention for personality disorder. UCL CORE
009	4.2	Dr Jason Hepple	Association for Cognitive Analytic Therapy (ACAT)	For people with personality disorder and complex	Many clients do not engage with treatment when offered approaches that are not able to work in this way.	Failure to engage or improve is a significant problem in IAPT pilot data and in secondary care. These clients need access to	CAT is an effective an acceptable intervention for clients with complex needs and ‘mixed’ diagnoses.

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				relational problems to receive psychological therapies that can understand and work with the enactment of the relational problems in the therapy relationship.		second line approaches, like CAT, that are designed to engage with complex clients.	Kellett S, Bennett D, Ryle A, Thake A (2013) Cognitive analytic therapy for borderline persoanlity disorder: Therapist competence and therapeutic effectiveness in routine practice. Clinical Psychology and Psychotherapy 20: 216-225. Clarke S, Thomas P, James K (2013) Cognitive analytic therapy for personality disorder: randomized controlled trial. British Journal of Psychiatry 203: 129-134. Ryle A, Kellett S, Hepple J and Calvert R (2014) Cognitive Analytic Therapy (CAT) at Thirty. Advances in Psychiatric Treatment 20, 258-268.
010	4.2	Dr Jason Hepple	Association for Cognitive Analytic Therapy (ACAT)	There is a paucity of psychological therapy approaches	This population of clients has complex needs and higher risk. They should have access to the range of psychological therapy	It is important to offer clients in forensic settings a choice of psychological therapy approach and a chance to explore their life stories and	For example: Pollock, P., Stowell-Smith, M. and Göpfert, M. (2006) Cognitive Analytic Therapy

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				recommended for those with antisocial personality disorder or for those in forensic settings.	approaches that are recommended in IAPT-SMI personality disorder guidance.	work through trauma. CAT has shown itself effective at engaging with complex cases, and with 'mixed' personality disorder and there is a lot of clinical experience of using CAT and combining CAT with other approaches in forensic settings.	for Offenders: A New Approach to Forensic Psychotherapy, Routledge. *Compton Dickson S (2006) Beyond body, beyond words: Cognitive analytic music therapy in forensic psychiatry. Music Therapy Today 7, 839-875.*
011	4.2	Ian Hulatt, Annette Duff	Royal College of Nursing	Ensuring a driven/grounded robust dynamic formulatory approach is used to care for service users with personality disorders.	Treatment evidence for Personality Disorder is psychological and evidence suggests that for complex case assessments and treatments, outcomes are improved when care is driven by formulatory understanding of the individual which promotes a collective understanding and consistency of approach.	The delivery of psychological interventions for complex case personality disordered service users has improved outcomes when all stakeholders are consistent in approach; formulation driven care for personality disordered service users is at best patchy and in some services nonexistent. It is particularly important for 'shop floor' staff within in-patient settings to have their care driven/guided by a formulatory understanding of the service user so that they	New Ways of working document, Improving access to psychological treatment, DOH 2009 recognising complexity, DOH 2014 Meeting the challenge making the difference.

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						are consistent in their approach, understand the purpose of the service users behaviour and respond appropriately. This is also a protective factor for staff in managing their own wellbeing.	
012	4.2	Ian Hulatt, Annette Duff	Royal College of Nursing	Ensuring access to an AC/RC that is needs appropriate	Non medical AC/RC's can bring a different approach to the psychological delivery of care of the personality disordered service user.	This was enshrined in law within the amended Mental Health Act but in reality very few non medical AC/RC's are available to personality disordered service users despite all treatment evidence being psychological.	Amended Mental Health Act
013	4.2	Victoria Green	SCM	Access to recommended service and treatment, as recommended by previous NICE guidance	There is a disparity between trusts regarding the availability of current treatment and the way it is delivered. In some areas there is no suitable provision for treating people with personality disorder and people with personality disorder are either being offered no service or limited or partial service. Research showed that brief treatment was ineffective for people	With the current economic climate in services, some services are returning to an 'illness' definition of referral criteria, and by doing so excluding people with a personality disorder from services. Many people with personality disorder are struggling to access appropriate treatment, and end up in the wrong type of service, with limited treatment and inadequate follow up.	Feedback from service users via Emergence CIC. NICE (2009) Guidance on the treatment and management of Borderline Personality Disorder. Turner, Neffgen & Gillard (2011) Understanding personality disorders and recovery. Emergence Katsakou et al (2012).

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					with BPD and that treatments should be offered in a structured and coherent way.	This contributes to the maintenance and deterioration of their symptoms.	Recovery in Borderline Personality Disorder (BPD): A qualitative study of service user perspectives. Plos one. Green (2014) The experience of recovery for people with Borderline Personality Disorder. Unpublished thesis. http://www.pn.counselling.co.uk/recognising_complexity_june_09.pdf
014	4.2	Delia Bishara	College of Mental Health Pharmacy	Key area for quality improvement 2	Regular review of medication	As above, drug treatments should not be used to treat the symptoms of PD (NICE CG78) but they usually are (POMH-UK). Where medicines are prescribed, they should be used for short term crisis management (NICE CG78) but in fact the majority of patients receive them in the mid – to long term (POMH-UK). All patients should have medication reviewed regularly (3 – 6 monthly), with	NICE CG78 POMH-UK audit results for personality disorder

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						clear treatment plans that include medication available in their notes.	
015	4.2	Delia Bishara	College of Mental Health Pharmacy	Key area for quality improvement 3	Review of benzodiazepine and z-hypnotic prescribing	As above, drug treatments should not be used to treat the symptoms of PD (NICE CG78), but a third of patients with PD are prescribed a benzodiazepine, and a fifth a z-hypnotic (POMH-UK). Z-hypnotics should not be prescribed first line for insomnia, and where they are required, they should be used short term (NICE technology appraisal TA77). Polypharmacy associated with benzodiazepine use results in increased mortality in other psychiatric populations (Polypharmacy with Antipsychotics, Antidepressants or Benzodiazepines and Mortality in Schizophrenia, Tiihonen et al 2012, Archives of General Psychiatry), and an increased risk of dementia (Billioti de Gage et al,	NICE CG78 POMH-UK audit results NICE technology appraisal TA77 Tiihonen et al 2012, Archives of General Psychiatry Billioti de Gage et al, Benzodiazepine use and risk of dementia, BMJ 2012

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						Benzodiazepine use and risk of dementia, BMJ 2012). Benzodiazepine and z-hypnotic prescriptions should therefore be reviewed at least 3 monthly in patients with personality disorder.	
016	4.2	Peter Fonagy	SCM	Key area for quality improvement 1 Availability of Evidence Based Interventions for BPD	In many settings evidence based interventions are not yet available From specialist centres we know that non-specialist Tier 4 deliver frequently inadequate care	It is expensive to offer sub-optimal treatment to patients with personality disorder because of knock on effects for other services as well as NHS	
017	4.2	Peter Fonagy	SCM	Key area for quality improvement 4 IAPT services should be expanded to include management of PD	Currently IAPT services only manage anxiety and depression using brief treatment protocols. Many patients with PD particularly with trauma histories present to IAPT where the constraints of treatment do not permit adequate management. Patients are referred on to secondary services with very mixed outcomes. It would be far more sensible to provide	Patients repeatedly present to IAPT in what is becoming a revolving door in many settings. The greater needs of patients with this significant PD are not addressed resulting in inefficient use of health care resources.	

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					adequate treatment within the context of IAPT including longer term interventions from appropriately trained staff.		
018	4.2	Peter Fonagy	SCM	Key area for quality improvement 5 There are too few secondary mental health settings willing to take patients with ASPD and forensic settings are often not well equipped to provide relative long-term treatment	ASPD is a major health care problem, not just for those suffering from the condition, but the communities in which individuals with this diagnosis reside. There is substantial difficulty in engaging these patients in treatment and few secondary or tertiary centres are well equipped to work with these patients to engage in a treatment programme.	Resources should be put into developing protocols for engaging patients with ASPD	
019	4.2	Dr Bernadka Dubicka	The Royal College of Psychiatrists	Key area for quality improvement 5	Specialist BPD services – these are lacking for young people, both in the community and in particular specialist units for the more severe cases which cannot be managed on generic	As stated	Tier 4 review documents the lack of specialist provision.

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					adolescent units or discharged to the community.		
020	4.3	Victoria Green	SCM	Managing endings and moving on from mental health services	Gains made in therapy can be lost if endings are not managed well and appropriate follow-on/up is not in place, and re-accessing support is problematic.	If gains are not maintained people with personality disorder end up returning to mental health services, and if access is problematic then often a crisis is reached before they can access support. Plenty of research shows that recovery is not a linear process, and that setbacks can occur. Personal experiences and feedback from other service users suggests that if the ending is collaborative, and they feel they have a sense of control over an ending, if there is flexibility around re-accessing, even if only knowing they can access if they need, helps to reduce anxiety and to enable continued development.	
021	4.4	Victoria Green	SCM	Paying attention to the	The type of therapeutic environment is helpful in reducing anxiety and	People with personality disorders report better engagement, trust and hope	Crawford et al (2007) see reference above.

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				therapeutic environment	building trust. This is noticed in the actual physical environment and the culture that is transmitted by a team. People with personality disorders have said that specialist personality disorders have a different 'feel' to them than mainstream services and helps facilitate engagement, positivity and hope, and trust.	when in specialist services due to the ethos of such services, and a 'felt' sense of understanding transmitted through this. The same sense is not reported as frequently in mainstream services, which can have a detrimental impact on progress.	Turner, Neffgen, & Gillard, 2011. See reference above. Haigh (2002) (See NICE 2009 for reference). Green (2014) reference as above. Personal experience Feedback from Emergence CIC
022	4.4	Victoria Green	SCM	Facilitating access to activities for development	Due to the pervasive impact of personality disorder on all aspects of a person's functioning. People with personality disorder can improve symptoms through therapy but can struggle to make the same improvements in social and occupational activities (including education/employment). Research has showed that improvements in this area are not as quick as improvements in other areas.	If attention is not paid to the whole person's life and only their symptoms, then progress can be limited. Most current therapies neglect wider functioning, such as supporting people to develop social networks and so on. Symptomatic improvement does not necessarily improve quality of life.	Personal experience Feedback from Emergence CIC Turner et al (2011) See above Green (2014) See above Katsakou et al (2012) See above Zanarini, Frankenberg, & Garrett Fitzmaurice (2012) Attainment and stability of sustained symptomatic remission and recovery

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							among patients with borderline personality disorder and Axis II comparison subjects: A 16-year follow-up study. The American Journal of Psychiatry, 163, 827-832 Zanarini (2012) Diagnostic specificity and long-term prospective course of borderline psychopathology. Psychiatric Annals, 42, 53-58. Bateman (2012) Treating borderline personality disorder in clinical practice. American Journal of Psychiatry, 169, 560-563. Research highlighting benefits of Therapeutic Communities – e.g Rex Haigh's work.
023	4.4	Peter Fonagy	SCM	Additional developmental areas of emergent practice	Flexible treatment protocols need to be developed which recognise the variable needs of these patients. The treatments need to be moved from their location in	These patients are hard to reach and many will not come forward for treatment unless special efforts are made to enlist their collaboration	

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					health care to locations where these patients experience problems e.g. employment context, probation and other community settings.		
024	4.4	Rex Haigh	Enabling Environments	Implementation of suitable therapeutic environments	Research shows that non-specific therapeutic factors are more important for outcomes than specific therapeutic techniques, and these are closely related to the 'culture' or 'ethos' of treatment services	RCPsych Centre for Quality Improvement has developed a suitable tool for this, which is applicable across all PD settings	www.enablingenvironments.com www.personalitydisorder.org.uk/news/wp-content/uploads/Innovation-in-Action.pdf
025	4.5	Ian Hulatt, Annette Duff	Royal College of Nursing	Evidence based Staff Wellbeing focus	It is well evidenced that increased supervision and support for staff teams that are working with service users with a diagnosis of personality disorder is required in order to sustain them in the heavy interpersonal connections that they are required to make and maintain.	Whilst staff supervision (group and individual) has improved in quality and quantity in many areas/services, practical wellbeing initiatives that are well evidenced in reducing staff distress and increasing productive self management/soothing e.g. mindfulness, are in paucity	DOH 2009 Recognising complexity MOJ/DOH 2011 working with Personality disordered offenders
026	4.5	Rex Haigh	Enabling Environments	Training on 'quality of relationships'	Research shows that non-specific therapeutic factors are more important for outcomes than specific therapeutic techniques.	KUF awareness training (which is in this area) has demonstrated positive outcomes	www.personalitydisorderkuf.org.uk Davies, Julie, Mark Sampson, Frank Beesley, Debra Smith, and Victoria

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							Baldwin. "An evaluation of Knowledge and Understanding Framework personality disorder awareness training: Can a co-production model be effective in a local NHS mental health Trust?." *Personality and mental health* 8, no. 2 (2014): 161-168. http://onlinelibrary.wiley.com/doi/10.1002/pmh.1257/abstract;jsessionid=2DF05EC68BFA8F5D2F1BC46D09B3BBDD.f04t03?deniedAccessCustomisedMessage=&userIsAuthenticated=false Lamph, Gary, Cameron Latham, Debra Smith, Andrew Brown, Joanne Doyle, and Mark Sampson. "Evaluating the impact of a nationally recognised training programme that aims to raise the awareness and challenge attitudes of personality disorder in multi-agency partners." *Journal of*

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
							Mental Health Training, Education and Practice, The 9, no. 2 (2014): 89-100. www.emeraldinsight.com/journals.htm?articleid=17108926&show=abstract
027	4.6	Delia Bishara	College of Mental Health Pharmacy	Key area for quality improvement 1	Access to a specialist pharmacist	Drug treatments should not be used to treat the symptoms of personality disorder (NICE guideline CG78) but national audits show that they frequently are (POMH-UK audit 2012 showed 4 in 5 patients were prescribed at least one drug, I don't have access to the full results). Where medications are used, regimens are often complex, usually involve the use of medicines outside of their product license, and are often prescribed in the context of an acute crisis (NICE guideline CG78). Access to a specialist pharmacist has been recognised as contributing to the safe and effective use of medicines in psychiatric conditions (Schizophrenia Commission	NICE guideline CG78 POMH-UK audit 2012 Schizophrenia Commission Report

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						Report). NICE guideline CG78 recommends that where medicines are prescribed in personality disorder, the patient should be provided with written information and an opportunity to discuss therapy, as well as ongoing review of the treatment regimen. This support and review should be offered by a multi-disciplinary team which should include a pharmacist.	
028	4.6	Peter Fonagy	SCM	Key area for quality improvement 2 Improved links between BD services and Ministry of Justice Provision for ASPD	Individuals with ASPD are often managed in the community by probation services or in prison. In both settings without access to adequate health service provision.	ASPD is one of the most expensive conditions and the lack of integration between health care and justice services, particularly for young people, is very detrimental to the likely outcome of their disorder.	
029	4.6	Dr Bernadka Dubicka	The Royal College of Psychiatrists	Key area for quality improvement 3	Community management – this usually requires close collaboration between carers, CAMHS and other	Services for young people are often fractured and more explicit recommendations may help support the	

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					services such as social care and education. Although this is alluded to in the current guidance, multi agency working should be made more explicit, including the role of paediatric admissions in those who frequently self-harm.	development of appropriate multidisciplinary community services.	
030	4.6	Rex Haigh	Enabling Environments	Use of well-established existing quality networks	Quality network methodology is inclusive, democratic and experienced as mush less persecutory than 'compliance monitoring'	Can be very effective in raising, and continuing to raise, standards which are agreed by all stakeholders.	www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation.aspx Haigh, Rex, and Sarah Tucker. "Democratic development of standards: the community of communities—a quality network of therapeutic communities."*Psychiatric Quarterly* 75, no. 3 (2004): 263-277.
031	4.6	Rex Haigh	Enabling Environments	Development of new PD-specific quality network	Such networks exist for most other areas of UK psychiatric practice	These methods can be very effective in raising, and continuing to raise, standards which are agreed by all stakeholders.	www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation.aspx

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
032	4.7	Peter Fonagy	SCM	Key area for quality improvement 3 Better mental health training for Emergency Department services to support patients with PD	Self-harming patients with PD often present to EDs where staff are primarily concerned about breaches rather than ensuring adequate treatment. This is part of an overarching aim to improve mental health literacy around PD.	Self-harm and suicide could be seen as treatment opportunities rather than emergencies which need urgent addressing. Better protocols and training in these would be helpful in the long-term management of PD patients. Past initiatives to educate health care staff have been successful but need to be renewed/refreshed.	
033	4.7	Dr Bernadka Dubicka	The Royal College of Psychiatrists	Key area for quality improvement 1	Assessment – developmental issues and context of symptoms need further consideration in young people. Transient BPD type symptoms may present in adolescence in response to environmental triggers, e.g. family issues, trauma, which will need to inform management. Stage of development needs to be considered as developmentally immature adolescents may require a different management	Vital to informing management of symptoms and risk in young people.	

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					approach, e.g. how able are they to build a collaborative therapeutic relationship and maintain boundaries (1.3.4.1). Risk assessment in adolescents also needs further consideration as this will also involve the ability of carers/to manage risk which impacts on community treatment, and possible safeguarding concerns which may be impacting on presentation.		
034	4.7	Dr Bernadka Dubicka	The Royal College of Psychiatrists	Key area for quality improvement 4	Tier 4 – more discussion is needed on the pros and cons of admission in adolescence; often behaviours can become worse in units, due to imitation of other behaviours witnessed, and young people can become overly dependent, and escalate behaviours when discharge is imminent.	Explicit guidance would be helpful to reduce the number of inappropriate prolonged admissions.	Recent Tier 4 document by NHS England discusses the need to assess potential risks of admission.

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					Admissions often occur when the home situation has broken down and young people are unable to return home - admissions then become prolonged whilst looking for alternative placements and trying to involve social care. The current pressure on community services significantly impacts on the ability of community services to manage these cases and results in increased pressure to admit and prolonged stays.		
035	4.7	Dr Bernadka Dubicka	The Royal College of Psychiatrists	Additional developmental areas of emergent practice	Overall a separate guidance for young people should be considered. The adult guidance does not sufficiently consider the needs of adolescents in a number of areas which need significant elaboration for young people.		
036	4.7	Rex Haigh	Enabling Environments	Reference to relevant	Official DH publication in the area deserves	Much information about commissioning high quality	http://www.pn.counselling.co.uk/recognising_complexit

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				previous DH work	recognition	PD services	y_june_09.pdf
037	4.4 & 4.5	Victoria Green	SCM	Promoting the emphasis of the importance of the therapeutic relationship through training	People with personality disorder struggles to trust and engage with others, even though they want help. The establishment of a therapeutic relationship is important if someone is to make progress. Challenging difficult behaviours of strategies for coping is better accepted within the context of a caring, 'human' therapeutic relationship. This combined with consistency in a therapeutic relationship (both towards the person with personality disorder and in terms of length of therapy and after-care) is important in establishing this.	While a need for improvement in this area has long been recognised, and there have been efforts to improve it. People with personality disorder still encounter negative and stigmatising responses from professionals. Some good training initiatives have improved this in some areas (e.g. KUF training) but like access to personality disorder services, this varies considerably across trusts. Outside of specialist services people still report difficult encounters with mental health clinicians.	Feedback from service users & Emergence Personal experience Turner et al (2011) Understanding personality disorder and recovery. Emergence. Green (2014) The experience of recovery for people with borderline personality disorder. Unpublished thesis Crawford et al (2007). Learning the lessons: multisite evaluation (see NICE guidelines 2009 on BPD for full reference). www.personalitydisorderkuf.org.uk Davies et al (2014) An evaluation of knowledge and understanding framework personality

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							disorder awareness training. Personality and mental health, 8, 161-168. Lamph et al (2014). Evaluating the impact of a nationally recognised training programme that aims to raise the awareness and challenge attitudes of personality disorder in multi-agency partners. Journal of mental health training, education and practice, 9, 89-100.