GUIDELINES

Borderline and antisocial personality disorders: summary of NICE guidance

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This is one of a series of *BMJ* summaries of new guidelines, which are based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists. Further information about the guidance and the supporting evidence statements are in the full version on bmj.com.

Why read this summary?

Personality disorders are common, with an estimated prevalence in the community of 4.4%.[1] They can significantly impair personal and social functioning, with considerable cost to health services, society, the criminal justice system, and the individual. Of the 10 classified types of personality disorder, borderline and antisocial personality disorder are the most prominent in forensic and general psychiatric settings. People with borderline personality disorder tend to have volatile relationships, an unstable self image, labile affects, and impulsiveness; they also frequently self harm. People with antisocial personality disorder characteristically break rules routinely; engage in criminal behaviour; and have a strong tendency to be reckless, irresponsible, and deceitful. People with both disorders often report a history of serious family problems, domestic violence, abuse, and inconsistent and often violent punishment in childhood.

Separate guidelines were developed for these two disorders because of differences in diagnostic criteria and contact with services. People with borderline personality disorder tend to be "treatment seeking," whereas the antisocial group are "treatment resisting,"[2] and they are unlikely to come into contact with services except for the treatment of comorbid conditions or when legally mandated to attend treatment programmes.[3]

This article summarises the key recommendations from the National Institute for Health and Clinical Excellence (NICE) on the management of both borderline and antisocial personality disorder.[2 3] Because about 50% of children with conduct disorder develop antisocial personality disorder, the guideline for this disorder includes preventive strategies—namely, interventions for conduct disorder in childhood and adolescence.

Recommendations

NICE recommendations are based on systematic reviews of best available evidence. When minimal evidence is available, recommendations are based on the guideline development group's opinion of what constitutes good practice. Evidence levels for the recommendations are in the full version on bmj.com.

Recommendations for borderline personality disorder

The role of psychological treatment

- When providing psychological treatment, especially for people with multiple comorbidities or severe impairment (or both), include:
  - An explicit and integrated theoretical approach used by both the treatment team and the therapist, and shared with the service user
  - Structured care in accordance with this guideline
  - Provision for supervision by a therapist.
- Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, consider twice weekly sessions.
- Do not use brief psychological interventions (of less than three months' duration) specifically for borderline personality disorder or for its individual symptoms outside a service that has the characteristics outlined above.

The role of drug treatment

- Do not use drug treatment specifically for borderline personality disorder or for the individual symptoms or behaviour associated with it.

Access to services

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

Developing an optimistic and trusting relationship

- Explore treatment options in an atmosphere of hope and optimism.
- Build a trusting relationship; work in an open, engaging, and non-judgmental manner; and be consistent and reliable.

- Bear in mind that many people will have experienced rejection, abuse, and trauma and will have been stigmatised.

Autonomy and choice

- Work in partnership with people who have borderline personality disorder to develop their autonomy and promote choice by:
  - Ensuring they remain actively involved in finding solutions to their problems.
  - Encouraging them to consider different treatments and life choices, and to consider the consequences of the choices they make.

Managing endings and transitions

- Anticipate that withdrawal of treatments, coming to the end of treatments or services, and transition to other services may elicit strong emotions and reactions in service users.
- Discuss such changes with the person (and their family or carers if appropriate) beforehand, and ensure that the changes are structured and phased.
- Ensure the care plan supports effective collaboration with other care providers during endings and transitions, and that provision is made for access to services during a crisis.
- When referring a person for assessment by another service, ensure support during the referral period; agree arrangements for support in advance.

Assessment

- Community mental health services should be responsible for routine assessment, treatment, and management.

Planning care in community mental health teams

- Teams should develop comprehensive multidisciplinary care plans with service users (and their families or carers, where appropriate) and share these with service users and their general practitioners. Ensure that care plans:
  - Identify the roles and responsibilities of all healthcare and social care professionals
  - Specify short term treatment aims and the steps needed to achieve them
  - Identify long term goals
  - Include a crisis plan.

The role of specialist personality disorder services within trusts

- Mental health trusts should develop multidisciplinary specialist teams or services (or both) for people with personality disorders. Teams should have expertise in the diagnosis and management of borderline personality disorder and should:
  - Provide consultation and advice to primary and secondary care
  - Provide assessment and treatment services for people who have particularly complex needs or high levels of risk (or both)
  - Offer a diagnostic service when general psychiatric services are unclear about the diagnosis or management (or both)
  - Develop communication systems and protocols in different services, collaborate with all relevant local agencies, and ensure clear lines of communication between primary and secondary care
  - Work with child and adolescent mental health services to develop local protocols for transition to adult services
  - Oversee the implementation of this guideline
  - Develop and provide training programmes on diagnosis, management, and guideline implementation
  - Monitor the provision of services for minority ethnic groups.

Recommendations for antisocial personality disorder

Developing an optimistic and trusting relationship

- Recognise that a positive and rewarding approach is more likely than a punitive approach to engage people and retain them in treatment.
- Explore treatment options in an atmosphere of hope and optimism.
- Build a trusting relationship; work in an open, engaging, and non-judgmental manner; and be consistent and reliable.

Children with conduct problems

- Group based parent training programmes are recommended in the management of children with conduct disorders.
- For children 8 years or more with conduct problems, consider cognitive problem solving skills training to reduce the likelihood of developing antisocial personality disorder in adulthood if:
  - The family is unwilling or unable to engage with a parent training programme
  - Additional factors, such as callous and unemotional traits in the child, may reduce the effectiveness of a parent training programme.

Assessment by forensic or specialist personality disorder services

- As part of a structured clinical assessment, consider routinely using:
  - A standardised measure of severity (for example, psychopathy checklist–revised (PCL-R)[4] or psychopathy checklist–screening version (PCL-SV)[5]
  - A formal assessment tool such as the historical, clinical, risk management-20 (HCR-20)[6] to develop a risk management strategy.

Treatment of comorbid disorders

- Offer treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline. This should happen regardless of whether the person is receiving treatment for antisocial personality disorder, because such people are often excluded from routine care.

Psychological interventions

- For people with antisocial personality disorder with a history of offending behaviour who are in community or institutional care, consider group based cognitive and behavioural interventions focused on reducing offending and other antisocial behaviour.

Multiagency networking

- Service provision for people with antisocial personality disorder often involves a considerable amount of interagency working. To provide the most effective multiagency care, services should ensure that there are clear pathways that:
  - Specify the various interventions available at each point
  - Enable effective communication among clinicians and organisations.
- Establish clearly agreed local criteria to facilitate transfer between services and develop shared objective criteria on the comprehensive assessment of need and risk.
- Consider establishing antisocial personality disorder networks; wherever possible they should be linked to other personality disorder networks. These networks should be multiagency and should:
  - Actively involve service users
  - Have a central role in training staff
  - Provide specialist support and supervision for staff
  - Have a central role in developing standards for clinical pathways and coordinating such pathways
  - Monitor the effective operation of clinical pathways.

Overcoming barriers

In spite of their prevalence, these two personality disorders are often undiagnosed within the National Health Service and the criminal justice system. This is because mental health professionals often do not recognise the main characteristics of these disorders; clinical presentation often results from comorbidities, such as depression or substance misuse[7]; and people with a personality disorder may be considered responsible for their own condition, which is also often viewed as untreatable.[8 9] As a result, these guidelines and the Department of Health[10] recommend the development of specialist services for people with personality disorder in each mental health trust. With the development of these services we anticipate that these guidelines will gain support from mental health and social care professionals, with the hope that these two groups of often traumatised and mistreated people will get the help they need and be less stigmatised.

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