Good Practice Guidance

*Prescribing Medication and the Personality Disorder Pathway*

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Executive Summary

- Psychotropic medication continues to be used in the long-term management of personality disorder, as shown in surveys and audits.
- This is despite widespread guidance and research evidence that this is ineffective or harmful.
- Clinicians often use clinically plausible reasons for their prescribing when clients present with multiple problems, even when no comorbid condition has been diagnosed.
- With a well-developed PD Pathway in CNTW, prescribing should be integrated into the overall care plan for each client and be guided by the multidisciplinary team.
- There are risks of iatrogenic harm of continuing to prescribe off-license for personality disorder, at great cost to clients, society and CNTW.
- Clinical guidance is offered for clinicians to follow, based on the best available evidence and recommendations to support best practice.

Introduction

There is a longstanding dilemma in the care and management of clients diagnosed with personality disorder (PD). This is that psychotropic medication continues to be used in the long-term management of the condition or its symptoms, despite widespread guidance and research evidence that this is ineffective or harmful (Silk, 2015; Paris, 2015; Ingenhoven, 2015; Paton et al, 2015; Chanen & Thompson, 2016; NICE, 2009; Bateman & Krawitz, 2013; Krawitz & Batcheler, 2006). The Prescribing Observatory for Mental Health (POMH, 2014) UK Quality Improvement Project on prescribing for personality disorder found that out of a baseline national cohort of 2500 patients just over half were prescribed at least one antipsychotic (without co-morbid mental illness). There is a clear discrepancy between clinical practice and how the evidence supports us to practise.

NICE guidance (NICE, 2009) and expert consensus (Bateman & Krawitz, 2013; Paris, 2015) recommends strongly that psychological treatments should be the first line treatments of choice in personality disorder, and that pharmacological interventions play a modest adjunctive role. These psychological treatments include Structured Clinical Management, Dialectical Behaviour Therapy (DBT), Mentalisation-Based Therapy (MBT), Cognitive Analytic Therapy (CAT) and Cognitive-behavioural Therapy for Personality Disorder (CBT-pd). CNTW has developed a clearly worked out care pathway for clients diagnosed with personality disorder and associated conditions, which includes all these models. There is also clinical guidance to go with the pathway and a therapist manual for implementing SCM (Mitchell, 2015; Mitchell, 2016).

There are many reasons for the continuance of prescribing for personality Disorder in the absence of good evidence. Some of these factors will be briefly reviewed in this
guidance in order to raise awareness and influence best practice. This guidance has been developed as a tool to aid clinical decision making when considering prescribing in the overall management of clients with personality disorder.

The guidance will outline the key features of the CNTW PD Pathway; provide fundamental guiding principles and good practice guidance in relation to the management of PD, co-morbid conditions and crises. The guidance will also review some of the clinical reasons for prescribing and the risks of doing so inappropriately. Some clinical vignettes outlining different clinical presentations will be given, suggesting ways of responding to the client. Finally, some medication specific research evidence will be summarised, as shown in the Appendix. We hope to prompt some thinking about the nature of prescribing in PD in the hope that we can come to make more balanced judgements about pharmacological treatment in this client group.

It is recommended that this guidance is used in conjunction with the PD Pathway Clinical Guidance and the cluster 8 EUPD e-pathway currently under pilot in Sunderland.

1.1 The PD Pathway

SCM is the cornerstone of effective evidence based practice for clients with PD, and should underpin most if not all generic mental health services. The SCM clinician strives to provide structure, coordination and integration of a wide range of services involved with the client. These are the core principles of SCM. For this reason, and the fact that most clients will be likely to receive generic rather than specialist treatment and management, we have developed in our trust, a care pathway for PD where SCM is a first-line treatment option (Mitchell, 2015). We have articulated the various components of the pathway from initial assessment through to discharge and transition into other services or recovery. We have integrated the role of the care coordination within the SCM programme, so that the tasks of care coordination may be undertaken, whilst the strategic tasks and process of SCM are also followed and implemented according to the model.

As part of the SCM approach, 3-4 monthly medical reviews are recommended where pharmacotherapy is a feature of the care package (see section 2.2. below). Where medication is being requested by the client and/or carers as being potentially useful to them, the care coordinator or SCM clinician will carefully review their reasons and expectations about treatment (section 2.1 below) and only if it is not possible to reach an agreement, would there be a need to meet with the locality psychiatrist to examine any request or indication which could be supported by the principles contained in this guidance.

We have based our PD pathway on the generic framework developed by Livesley (2003). Livesley bases his model on the following four principles:
1. Knowledge of the structure/origins of PD and evidence about what interventions work (treatment efficacy).
2. The assumptions that the main features of PD form a hierarchy of stability and change and treatment progresses through a series of phases.
3. Those features most susceptible to change should be targeted first.
4. Those features that are most stable and difficult to change should be targeted later (i.e. core self-identity and entrenched relational problems)

Based on these principles, Livesley had outlined five phases of change through which a client’s journey may move, when will be targeted by interventions appropriate to that phase. The five phases are shown in table below.

**Table 1.** Livesley’s Phases of Change (Livesley, 2003)

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<td>3. Control and regulation</td>
<td>3. Intense distress, self-harming behaviour and other symptoms, impulsivity</td>
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<td>5. Synthesis</td>
<td>5. Identity problems, fragmented sense of self</td>
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Against these five phases, we have mapped the various treatment models, according to when the treatment model is most effective at which point within the client’s care pathway, as shown in Figure 1 below.

**Figure 1.** Personality Disorder Pathway
Within phases 1-3, we recommend the use of SCM, DBT and MBT since these evidence based approaches are most suited to clients who present with high levels of instability, chaos and emotional dysregulation. It is only when sufficient stability and emotion regulation has been achieved that we recommend more specialist therapies, such as CBT, EMDR, CAT and TFP. We have found over many years that clients entering individual therapies, such as psychodynamic psychotherapy, or structured therapies such as CBT, are unable to make good use of them as they do not yet have the reflective ability or emotional stability to do so. In fact, we have seen many clients deteriorate in some therapies as they do not yet have emotion regulation or mentalising skills and capacities, similar to the concerns expressed by Fonagy and colleagues (Bateman & Fonagy, 2004).

The various psychological treatments offered with the pathway are delivered by clinicians who are specialist, partly specialist, or generic and based within community settings. These clinicians work closely with clients, often jointly, in allocating clients to the most appropriate treatment model based on clinical need as much as possible, and resource availability. Prescribing for any reason for clients on the pathway should be done in relation to the overall pathway of care rather than in isolation, and be guided by the MDT, with the care coordinator or SCM clinician present. This prescribing may be supported with scaffolding from community pharmacists and prescribing clinicians and the PD hub where appropriate. We see prescribing as to linked to phases 1 and 2 of the Livesley framework described above.

1.2 The Primary Care Interface
It is recognized that clients experiencing personality difficulties or disorder may often present to primary care in the first instance and on a regular basis. The reasons for this may include emotional instability, suicidal states of mind and behaviour, anxiety, depressed mood, insomnia and pain.

Where there is a request from the primary care clinician and/or a difficulty with the client’s relationship with the primary care clinician, the following guidance is recommended:

- Discuss with the primary care clinician over the telephone or face to face their concerns and validate these.
- Provide information about the evidence base for medication in the treatment and management of the personality and other problems, as applicable.
- Provide information about NICE guidance on the management of PD in primary care, as applicable (see page 10 of the quick reference guide Borderline Personality Disorder: Treatment and Management; NICE, 2009).
- Provide scaffolding to the primary care clinician on how to manage the therapeutic relationship, as appropriate.
- Provide information to the primary care clinician on the CNTW PD Pathway, and the role of prescribing within this.
- Provide the primary care clinician with a copy of these guidelines if requested.

2. Fundamental Guiding Principles

The following fundamental principles should be followed when considering medication for a client on the PD pathway, or on another pathway who may have some co-morbid personality problems within their presentation and requires some cross-pathway work in their care plan.

- There are no licensed medications for use in the management of PD.
- Medicines have a role to play in treating co-morbid conditions and these should be prescribed within the appropriate NICE condition guideline.
- Psychotropic medicines may be useful in the short-term management of a crisis, but should be discontinued within 1 week once the crisis has resolved. These should be clearly linked to the Livesley phase in the overall care pathway for the client.
- Since assessments of PD are often imprecise or unstructured and comorbid conditions are difficult to distinguish, it is best to start with psychosocial management and treatment and review the symptom/problem profile and formulation at the earliest opportunity.
- Some clients put pressure on clinicians to prescribe in order to feel “heard” or “taken seriously”. Best practice would be to tolerate this, validate the client’s
need or feelings, and explain the limits of prescribing and the alternatives available (psychosocial treatments).

- A crisis plan should be one of the first tasks, after assessment and formulation, the SCM clinician will do with the client. This will then be used at all times of crisis, and will refer to the aspects of how crises will be managed, including the role of hospital admission and prescribing expectations that are realistic.

- A full explanation of the reasons for medication being prescribed should be documented and how this will be reviewed in the context of the overall care plan.

2.1 Managing the Client’s Expectations

Where there is a request from the client and/or the carer or family member to provide medication and this may not appear indicated, the following guidance is recommended:

- Provide information about the evidence base for medication in the treatment and management of the personality and other problems, as applicable.
- Validate (express the positive value of) the client’s needs or feelings behind their request in a non-judgmental and compassionate way.
- Identify how the evidence base supports the use of psychosocial approaches, and how these underpin the current care plan.
- Say no to the request if this is indicated but balance this with a positive statement about the client’s autonomy and role in their care plan and recovery.
- Suggest linking up with the care coordinator or SCM clinician to review their expectations from treatment and their treatment goals if needed.
- Offer to review and see them again if they wish.

2.2 The Medical Review

Since many clients are receiving medication, and this is likely in most cases to be off-license or used inappropriately, the SCM approach recommends that regular meetings occur with a psychiatrist and this is integrated into the overall treatment plan. Bateman and Krawitz (2013) recommend that this occurs every 3-4 months, but with the proviso that either the clinician or client can request an earlier appointment if they feel this is necessary. It is expected that that the care coordinator liaises with the psychiatrist before and after each appointment, but they also discuss with the client beforehand how they will use the appointment and to meet up afterwards to see how it went.
Prescribers may wish to ask themselves the following questions when reviewing medication with their client at these reviews:

- Do you need to revisit the treatment plan rather than change medication?
- Can you avoid using medication if you implement an appropriate psychological or other intervention?
- Are you aware of only using a single drug wherever possible and avoiding polypharmacy?
- Can you withdraw any medication prescribed outside of a crisis or for comorbidity?
- Have you reflected on the influence of your relationship with the client on your prescribing decisions?
- Are you sure you are not prescribing as a result of professional anxiety (see section 3.3. below)?

3. **Good Practice Guidance**

3.1 **Management of Emotionally Unstable (Borderline) Personality Disorder**

There is **no role for prescribing medication in the long-term management of EUPD** within the PD pathway as described above, outside of crisis presentations (Livesley phase 1-2). NICE guidance states the following:

- **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).
- **Antipsychotic drugs should not be used** for the medium- and long-term treatment of borderline personality disorder.
- **1.3.5.3** Drug treatment may be considered in the overall treatment of comorbid conditions (see section 1.3.6).
- **1.3.5.4** Short-term use of sedative medication may be considered cautiously as part of the overall treatment plan for people with borderline personality disorder in a crisis. The duration of treatment should be agreed with them, but should be no longer than 1 week (see section 1.3.7).
- **1.3.5.5** When considering drug treatment for any reason for a person with borderline personality disorder, provide the person with written material about the drug being considered. This should include evidence for the drug’s effectiveness in the treatment of borderline personality disorder and for any
comorbid condition, and potential harm. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for the person to discuss the material.

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

### 3.2 Management of co-morbid conditions

Prescribing in this situation is linked to **phase 3 of the Livesley framework** of the PD pathway, as described above. Here, it is important for the prescribing clinician to consider whether the comorbidity as presented could be attributed to the personality disorder or the attachment style of the client’s relating to them (e.g. a strong pressure to prescribe that could be linked to either a hypomanic episode of a client with comorbid bipolar disorder or to a client with strong attachment insecurity, impulsivity and abandonment anxiety as shown in EUPD). If in doubt, we recommend the decision to be made is done in the context of the MDT and the overall care plan.

- **1.3.6.1 Before starting treatment for a comorbid condition in people with borderline personality disorder,** **review:**
  
  - The diagnosis of borderline personality disorder and that of the comorbid condition, especially if either diagnosis has been made during a crisis or emergency presentation.
  - The effectiveness and tolerability of previous and current treatments; discontinue ineffective treatments.

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

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

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

Prescribing in this situation is linked to **phases 1 and 2 of the Livesley framework** of the PD pathway, as described above. A good risk assessment and management plan is important here.

Assessment and management of risk in relation to clients with personality disorder is usually taxing for the clinician, and may engender strong feelings of wanting to keep the client alive or avoid being blamed by the clients family or their host organisation if they do not act conservatively and cautiously (Gonzalez & Mosquera, 2012; Bateman and Krawitz, 2013; Gunderson, 2008). It is not uncommon for clinicians to act out of fear and ‘professionally-based’ anxiety in order to try and keep their client safe and protect themselves (Krawitz, et al, 2004; Gunderson, 2008; Paris, 2008).

Working with clients with personality disorder, especially emotionally unstable personality disorder, creates a unique set of complex dilemmas around life, death and responsibility which the clinician, team and host organisation should consider (National Health and Medical Research Council, 2012; Gonzalez & Mosquera, 2012). Clients may have persistent thoughts of suicide, made suicide attempts and frequently self-harmed in order to manage their distress (Bateman & Krawitz, 2013; Swenson, 2016). Such behaviours may serve as a way to regulate inner distress or as an attempt to seek help or communicate to others, including family, friends and mental health services (Krawitz, et al, 2004). Suicidality and self-harm may range from low lethality and intent to high lethality and intent, with the caveat that such patterns of coping may change rapidly according to the clients circumstances. Although self-harm may be used as an emotion-regulating strategy with suicidal intent being low, it is important for the clinician to clearly distinguish between the two and the relationship between them (National Health and Medical Research Council, 2012). This will help militate against the risk of underestimating suicidal intent when self-harm is present (NCISH, 2013). Most clients are often extremely ambivalent about their own life or death (Krawitz, et al, 2004; Krawitz & Jackson, 2008).

Since the risk of self-harm, risk to others and suicide may fluctuate almost daily or within minutes, risk assessment by the clinician should be monitored before, during and after every session (Bateman & Krawitz, 2013; National Health and Medical Research Council, 2012). The ‘standard’ approach to increased suicidality may be to increase observation, monitoring and taking direct responsibility for managing the client’s suicidality and safety (Krawitz, et al, 2004). However, since clients with personality disorder usually experience persistent and problematic relationship difficulties which can be repeated within the therapeutic relationship (Bateman & Fonagy, 2016; Gonzalez & Mosquera, 2012; Bateman & Krawitz, 2013; DoH, 2014), there is evidence that such an approach might be ineffective or even harmful (Krawitz, et al, 2004; Bateman & Krawitz, 2013). Several studies and expert consensus has
found that some clients with personality disorder deteriorate (increase in long-term risk; lowered self-efficacy and competence; removal of responsibility and autonomy) when they are treated with overly intense interventions (Bateman & Fonagy, 2016; Krawitz, et al, 2004; Bateman & Krawitz, 2013; Gunderson, 2008).

Whilst there are no absolute risk-free care pathways to follow for clients with personality disorder, the aim of all evidence-based treatments for personality disorder, including SCM, is to reduce overall long-term risk and improve adaptive functioning (Bateman & Krawitz, 2013; Swenson, 2016). Krawitz and colleagues suggest the use of ‘professionally-indicated short-term risk taking’, which they see as a “thorough decision-making process in which risk assessment considers the balance of short-term and long-term risk and leans in the direction of increasing short-term risk in order to minimise overall risk (Krawitz, et al, 2004). The clinician will need to synthesise current and historical factors and decide at what point positive risk taking may be applied and how much support to actively provide to the client (Krawitz, et al, 2004).

In terms of assessment, it is important first of all to follow the organisation’s policies and procedures they have in relation to Clinical Risk Assessment and Management and related areas. In CNTW, we have recently introduced a helpful Clinical Risk Assessment and Management Strategy along with a suite of service-specific appendices where additional specific advice or guidance is offered. This includes an appendix on Clinical Risk Management in Personality Disorder and Co-morbid Conditions (Nadkarni et al, 2015; Mitchell, et al, 2015). Further guidance on risk assessment and risk management, including how to develop collaborative crisis plans with clients, is contained within the SCM Manual (Mitchell, 2016).

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

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

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Part of – CNTW (C) 38 Pharmacological Therapy
1.3.7.2 Before starting short-term drug treatments for people with borderline personality disorder during a crisis (see recommendation 1.3.5.4):

- ensure that there is consensus among prescribers and other involved professionals about the drug used and that the primary prescriber is identified
- establish likely risks of prescribing, including alcohol and illicit drug use
- briefly discuss the risks of iatrogenic harm and dependency which may arise through the inappropriate use of medication
- take account of the psychological role of prescribing (both for the individual and for the prescriber) and the impact that prescribing decisions may have on the therapeutic relationship and the overall care plan, including long-term treatment strategies
- ensure that a drug is not used in place of other more appropriate interventions
- use a single drug
- avoid polypharmacy whenever possible.

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

- choose a drug (such as a sedative antihistamine) that has a low side-effect profile, low addictive properties, minimum potential for misuse and relative safety in overdose
- use the minimum effective dose
- prescribe fewer tablets more frequently if there is a significant risk of overdose
- agree with the person the target symptoms, monitoring arrangements and anticipated duration of treatment
- agree with the person a plan for adherence
- discontinue a drug after a trial period if the target symptoms do not improve (maximum of one week) or if it is not tolerated or felt to be beneficial and the patient requests it to be stopped
- consider alternative treatments, including psychological treatments, if target symptoms do not improve or the level of risk does not diminish
- Consider the use of a “contract”, outlining that the prescription is for a 1 week period only and the reason for this, and the reasons for stopping it as described above
- arrange an appointment to review the overall care plan, including pharmacological and other treatments, after the crisis has subsided.

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

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

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

4. Why do we prescribe when it is not recommended or supported by the evidence?

Clinicians prescribe for a variety of reasons for clients with personality disorder, leading to the current inconsistent situation, where practice does not match evidence-based guidance. These reasons usually fall into one or more of the following four categories:

1. **Clinical plausibility**: There are often mixed presentations with a wide range of symptoms and features, diagnostic overlap between different conditions (e.g. bipolar mood and EUPD mood), extensive comorbidity and lack of formulation-based approaches. **Diagnostic uncertainty** may be uppermost here. The recent POMH-UK national audit found that almost three-fifths of their sample had at least one diagnosed co-morbid condition and the most common reasons for prescribing psychotropic medication to those clients without a comorbid condition were clinically plausible (POMH, 2014). It is also recognised that a prescriber may justify prescribing by maintaining that the symptoms for which they are prescribing are those of a co-morbid disorder when they are more readily associated with the personality disorder. The debate over the overlapping nature of EUPD with primarily affective disorders, and to a lesser extent, psychotic phenomena, reflects the uncertainty to which prescribers are accustomed. We may move closer to certainty further down the line in a client’s care episode, but this will require being open as to the hypothetical nature upon which we base our intentions to invoke a treatment strategy.

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2. **Professional alliance/relationship issues**: Here, the clinician may be acting from an anxiety of wanting to be ‘helpful’ or ‘do something’ for the client when significant interpersonal pressure is being exerted on them (not always consciously) by the client. This may ‘fit’ the client as they enact their interpersonal attachment difficulties of being dependent, helpless, preoccupied, controlling or in need of a significant stronger other to rescue them (Gonzalez & Moquera, 2012). The client may also feel validated by the prescribing clinician who is doing something helpful for them when they have faced past experiences of invalidation or negative attitudes. There may also be professional anxiety in the clinician of not wanting to take short-term positive risks for fear of the client deteriorating, complaining or them being sued (Krawitz et al, 2004).

3. **Guidance/research inconsistency**: Since the guidance issued by NICE (NICE, 2009) appears different from the American Psychiatric Association guidance in 2001 (APA, 2001) and more recent Cochrane reviews (Stoffers et al, 2010), clinicians may feel the tendency to ignore the guidance and practice what they feel is best, based on their own reading of the research and guidance. The recent POMH-UK national audit finding that once prescribed, most psychotropic medications are continued for at least 4 weeks and probably longer suggests that clinicians extrapolate from the evidence underpinning the use of medication in mental illness, and may not accept the recommendations from NICE for the treatment of PD as being clinically valid (POMH, 2014). The APA Practice Guideline for Borderline Personality Disorder (APA, 2001) suggests that the primary treatment of choice is psychotherapy, complemented by symptom targeted pharmacotherapy. They draw upon clinical experience for some of their recommendations. There are some small RCTs suggesting some effect of drug treatment on symptoms. Trials of topiramate and aripiprazole showed large effect sizes favouring treatment compared with those from other trials for a range of symptoms. The NICE Guideline Development Group attempted to clarify funding arrangements and received responses from authors and journals that were unclear and hence they did not consider these trials when drawing their conclusions. NICE identified 28 RCTs for inclusion in their considerations. The number of participants was generally small meaning that the power to detect significant effects is quite low. The overall robustness of findings must also be considered low given that they are based upon one single RCT effect. The mean duration of the studies was 12 weeks. A brief summary of the evidence for each class of medication is available in the appendix.

4. **Team inconsistency issues**: Here, the clinician may be acting independently of the team who is managing and treating the client. This may be because the
prescribing clinician is less present for clinical team meetings, or because they have a unique and different role to the rest of the team. The main issue here is that there may be a lack of integration of the prescribing into the overall care plan, so it becomes compartmentalised. There may also be issues to do with leadership or authority in the team (e.g. who diagnoses and prescribes, who can challenge who in this). It is recommended that the prescribing clinician draw upon the authority of the MDT in reaching a consensus about the best clinical approach given diagnostic and pharmacological uncertainty.

5. What are the risks of prescribing medication when it is not recommended or indicated for the client?

1. Dependency and preventing recovery: Here, the client may feel a sense that they ‘need’ medication in order to help them recover, so they become more and more dependent on it. This may lead to greater helplessness in the face of adversity, less self-responsibility and the idea that they do not have confidence in their own abilities to solve life problems (i.e. a ‘negative orientation’ to problem-solving: D’Zurilla & Nezu, 2007).

2. Polypharmacy: Polypharmacy is widely described, and in an American follow-up study (Zanarini, 2004), it was found that at 6 years over 50% were taking two or more drugs, 36% ≥ 3 or more, 19% ≥ 4 or more. There is no support in the literature for combination therapy, and indeed there is consistency in that all the major guidelines recommend against this. Polypharmacy could indicate that treatment failures are not readily accepted as such.

3. Misuse/overdose: Here, clients may take the wrong dosage through an attempt at emotion regulation, or through misuse due to poor impulse management, addiction problems or suicidal behaviour.

4. Ineffective psychosocial treatment: Since medication is used to help manage emotions, thinking and behaviour, this may lead the client to lower their tolerance of emotions and motivation to work on psychological alternatives of learning new ways to manage emotions and impulses. They may learn that it is easier to seek an ‘escape’ type strategy for their problems where they don’t have to do the hard work of learning skills and practicing them.

6. Some clinical vignette examples

The following vignettes have been developed around common themes of presentations to aid decision making in prescribing. They could not hope to capture the individual circumstances of our patients or circumvent a clinician’s autonomy or responsibility.

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1. **New Presentation**

20 year old female. First presentation to CMHT. Close family members think she has Bipolar, her moods fluctuate markedly often within hours. No clear link with affective syndrome upon screening. Emerging emotionally unstable personality seems more likely. Seeks mood stabilisation strategy.

- Share the hypothesis that both EUPD and Bipolar are possibilities, but EUPD seems more likely. And that both are difficult conditions to live with.
- Assess the presence of hypomanic episodes, and if present, prescribe for this only.
- Offer something other than medication such as a follow-up appointment, to further inform the chronology of the difficulties and further psychoeducation on non-pharmacological strategies.
- With the best efforts in empathy and psychoeducation, no prescription may yield dissatisfaction in a patient and/or carer.
- If it is agreed that a trial in medication is a worthy endeavour, then a clear timeframe for reviewing the effectiveness should be stated alongside the rationale to share with the patient.

2. **Crisis Presentation**

Young person diagnosed with EUPD presents in crisis. Derogatory voices. Commands to kill self. Not felt to exist as part of co-morbid psychosis. Current therapy olanzapine 20mg nocte, mirtazapine 45mg, Diazepam 10mg total daily (iatrogenic dependence). Patient seeks additional medication/revision.

- Dopaminergic antagonism has unlikely been effective in this case.
- Sedation may be contributing to inability to problem solve through difficulties.
- There is an opportunity to introduce the idea of rationalisation to medications, one change at a time.
- Could begin by switching antipsychotic, and introducing a much lower %BNF (e.g quetiapine 100mg nocte)
- Alternate strategy could be to add temazepam 10mg nocte for 7 days, upon explicit communicated plan to convert this to diazepam and begin a total slow reduction regimen.

3. **Iatrogenic Harm**

40 year old person diagnosed with EUPD. Regular presentations to psychiatrist and GP over many years. Currently prescribed olanzapine 20mg nocte, sodium valproate 1.2g total daily, gabapentin 2.7g total daily, codeine 60mg qds, naproxen 1g total daily, temazepam 10mg nocte, zopiclone 7.5mg nocte, sertraline 200mg,
alongside many medications for metabolic problems. Continues to present with dysphoria alongside chronic pain.

- Complex pain management strategies may represent the same process by which complex psychopharmacological strategies have been implemented.
- Reflection on doctor-patient interactions, and with these shared with the GP may assist in decreasing overall burden of pharmacotherapy
- Strategies could be devised to reduce the medication in a slow and careful way, one agent at a time in an incremental reduction on a monthly basis. Benefit from reduction could outweigh the costs/potential for exacerbations.

7. References


Cumbria Northumberland, Tyne and Wear NHS Foundation Trust
Appendix 1-Good Practice Guidance
PPT-PGN-28 – Prescribing Medicines and the Personality Disorder Pathway V01-iss2-Nov 19
Part of – CNTW (C) 38 Pharmacological Therapy


National Health and Medical Research Council (2012) *Clinical Practice Guideline for the Management of Borderline Personality Disorder*. Canberra, Australia: NHMRC.


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