Prescribing guidance for treating people with borderline personality disorder (BPD)

This guidance is been compiled using guidance produced by POMH-UK following its audit in 2012, NICE guidance on Borderline Personality Disorder and the guidance provided on the Choice & Medication website by Justine Raynor, a mental health pharmacist working on a specialist BPD unit in Leeds.

Key prescribing messages

1. There are no licensed medications for BPD.
2. Medicines have a role in treating co-morbid psychiatric conditions and these should be prescribed within the appropriate condition guideline.
3. Psychotropic drugs may be useful short-term in a crisis but these should be stopped at the earliest opportunity. Sedative antihistamine drugs like promethazine may be more useful for improving sleep and reducing anxiety than benzodiazepines and 'Z' drugs as the former have less potential for misuse and are less likely to cause paradoxical effects.
4. Some patients may feel they are not being taken seriously if no medication is prescribed. Other strategies need to be used to avoid being pressured into prescribing inappropriately (see ‘Other considerations’ below).
5. A crisis plan should be agreed with the patient and carer if appropriate that clearly indicates if medication should be used during the crisis and which medication might be considered.
6. Because any prescribing for BPD and not a co-morbid condition should be short-term, this should be done by the specialist. If prescribing is needed longer-term for a co-morbid condition then it is reasonable to ask the GP to continue this, (unless a secondary care only drug is being used), but a full explanation as to why it is being prescribed and what the longer-term plan is to review the treatment should be provided.

Background information

The use of medicines to help treat some of the symptoms of BPD is controversial. NICE Clinical Guideline 78 on Borderline Personality Disorder (2009) said that there wasn't enough evidence that medicines work to treat personality disorders. NICE advise that medicines should not be routinely prescribed for symptoms or behaviours likely to be from a BPD. The only times medicines should be prescribed is to help treat other mental health conditions that a person might also have or for short-term use in a crisis.

A Prescribing Observatory for Mental Health (POMH-UK) audit of prescribing for BPD, conducted in 2012, used audit standards that were largely derived from recommendations in the NICE clinical guidelines. They reflected the limited evidence-base available to justify the use of medication for Personality Disorder alone. Some key national findings were as follows:
• Around 80% of patients were prescribed at least one medication from four drug groups: antipsychotics, antidepressants, mood stabilisers and sedatives.

• Just over half of patients with BPD 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-months 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. However, less than half 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.

Other considerations / suggestions:

• Many people with BPD have experienced being let down or ignored by others in the past and may believe that they are not being prescribed medication because their problems are not recognised as important.

• Offering something other than medication, such as clear information about a follow-up appointment or details of how to access another service, may help a patient accept that they are being taken seriously.

• Explain that symptoms that fall short of a comorbid psychiatric diagnosis show a poor response to medication. For example, while people with BPD may experience high levels of emotional distress, their feelings of sadness and despair are unlikely to respond well to antidepressant medication, unless the person fulfils diagnostic criteria for a mood disorder.

• Consider referring service users and carers to national guidelines such as those developed by National Institute for Health and Clinical Excellence: http://guidance.nice.org.uk/CG78

• A patient’s anxiety and frustration that something needs to be done urgently to help them may be experienced by a clinician as pressure to prescribe.

• A thoughtful, joint crisis plan should help people with BPD, as well as carers and the clinical team, manage during difficult times. This crisis plan should be easily accessible and make specific mention of whether or not medication is indicated at such times, and if so, what medication should be considered.

• If medication is judged to be required, consider the short-term use of a drug with a good tolerability and safety profile (where possible). For example, a sedative antihistamine to treat poor sleep at times of crisis will usually be a better choice than a benzodiazepine or Z-drug.

• In the event of prescribing for a person with a borderline personality disorder it is essential that very clear documentation and explanation is presented to them that explains that prescribing is for symptomatic relief of symptoms and that there are no specific psychotropic medications that are indicated for a clear diagnosis of borderline personality disorder.
Medication specific guidance

Antidepressants

Antidepressants have been shown to help people with BPD who also have depression. However some symptoms of depression link into personality disorder and these may not be improved, for example an intense and changeable feeling that may be triggered by the environment or situation a patient finds themself in. Also if the patient doesn’t take antidepressants as prescribed, the discontinuation reactions and side effects may make them feel worse. These effects include agitation, irritability, headaches and nausea.

Mood Stabilizers

NICE guidelines advise that there isn't enough evidence about how well these medicines work to recommend them to treat BPD. Clinical trials to date have been too short and have involved too few people. However there have been some encouraging findings from some small trials on mood stabilisers, which found some improvement in emotional instability. More research is needed before these can be recommended more widely for people with BPD.

Benzodiazepines and related drugs

The problem is that these medicines can be addictive, cause disinhibition, cause paradoxical symptoms (eg. aggression), and work less well, due to tolerance, if used for long periods of time. In many BPD patients, these problems appear to be amplified. In the short term, (ie. for up to 2 weeks), they may be useful to improve sleep and help relieve acute anxiety, and they can also be useful in a crisis situation. However, they should only be prescribed with caution and close monitoring. Sedating antihistamines, e.g. promethazine, can be useful as an alternative to benzodiazepines for short-term use.

Antipsychotics

There is some evidence of the effectiveness of haloperidol in reducing symptoms of depression, hostility and impulsivity in people with borderline personality disorder when given in lower doses than for psychotic disorders. However, this is based on a small number of participants. Haloperidol is known to be associated with extrapyramidal symptoms and can prolong the cardiac QTc interval. Prescribers should monitor for extrapyramidal symptoms and follow the advice in the Summary of Product Characteristics regarding cardiac monitoring, to include ECGs where possible. Evidence for other antipsychotics is limited. If antipsychotic medication is used, make it clear to the patient that this will be for short-term use in the absence of a co-morbid psychotic condition requiring long-term use.

In conclusion

While available evidence suggests that medication is over-prescribed for people with BPD, where patients develop symptoms that reach a threshold for a co-morbid psychiatric diagnosis, they should be treated according to appropriate guidelines.

It must always be acknowledged that there is a lack of evidence regarding the efficacy of psychotropic medication for BPD in the medium to long-term, and that this medication has the potential for side effects that can significantly impact on physical health and quality of life.
Whatever medication is used, this should always form part of a documented individual treatment trial, with planned review. The medication should only be continued if there is clear evidence of benefit that outweighs the risks.

References


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