Prescribing for people with borderline personality disorder (PD)

For the POMH-UK QIP on prescribing for PD, conducted in 2012, audit standards and treatment targets were largely derived from recommendations in the NICE guideline on borderline personality disorder (2009). They reflected the limited evidence-base available to justify the use of medication for PD alone. For example, one treatment target was that antipsychotic drugs should not be used for the medium and long term treatment of borderline personality disorder. Performance against the standards and targets was assessed in a national baseline audit that included over 2,500 patients. Some key findings were as follows:

- 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 a 6-month duration.
- Benzodiazepines were prescribed in a third of those patients without co-morbid 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.

These findings highlight the discrepancy between national guideline recommendations and clinical practice in this area. POMH-UK sought advice on this from clinicians with expertise in the management and treatment of people with borderline PD. They provided some general principles that they apply in their clinical practice, and these have been summarised overleaf. They may be a helpful addition to induction packs for psychiatric trainees, and serve as a useful prompt for prescribers in supervision sessions or peer-review groups.
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While available evidence suggests that medication is over-prescribed for people with personality disorder (PD), where they develop symptoms that reach a threshold for a comorbid psychiatric diagnosis, this should be treated according to appropriate guidelines. However, when managing PD itself, the following points may be helpful:

- Many people with PD have experienced being let down or ignored by others in the past and may jump to the conclusion 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 PD 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/PublicInfo/doc/English
  - 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 PD, 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.

  - If medication is judged to be required, consider the short-term use of a drug that is relatively well tolerated and relatively safe in overdose – such as a sedative antihistamine for those who experience poor sleep at times of crisis.
  - If antipsychotic medication is used, make it clear to the patient that this will be for short-term use.

- There is a lack of evidence regarding the efficacy of psychotropic medication for PD in the medium to long-term, although it has the potential for side effects that can impact negatively on physical health and quality of life.

- Whatever medication is used, this should be as 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.