NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

The NICE Borderline Personality Disorder guideline - the evidence

Bologna, Italy, 11th June 2013

Professor Tim Kendall

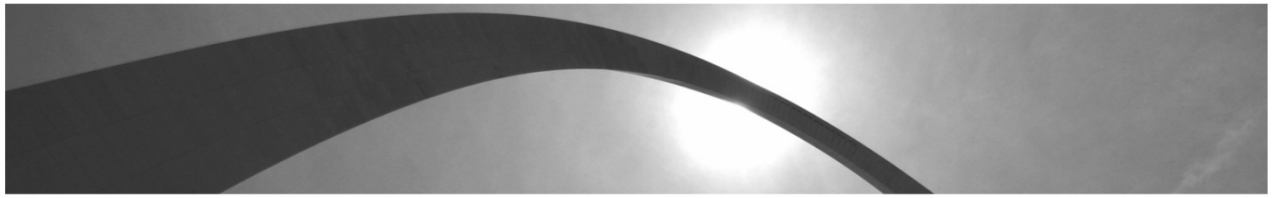
Director of National Collaborating Centre for Mental Health, Royal College of Psychiatrists

Medical Director and consultant psychiatrist for homeless people, Sheffield Health and Social Care FT

Visiting Professor, UCL

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



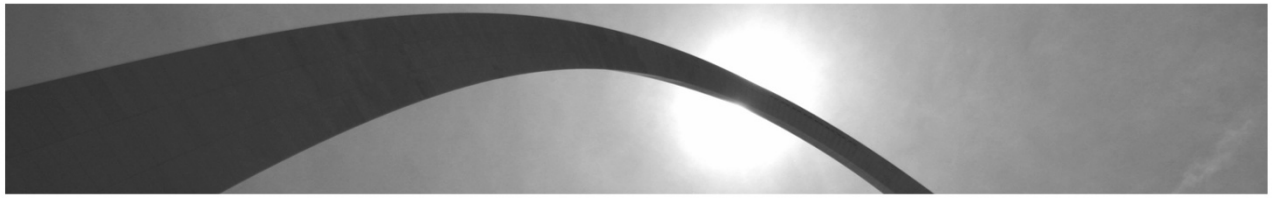
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

menu

- NICE and NCCMH
- Borderline personality disorder NICE guideline – the evidence and conclusions
- National audit of the treatment of PD using the NICE guideline standards

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

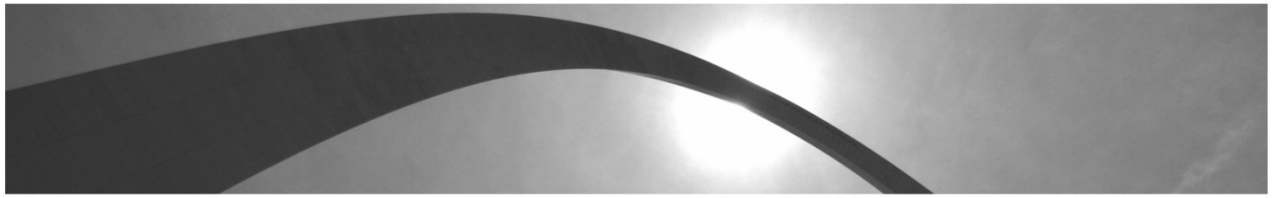
NCCMH AND NICE

The National Collaborating Centre for Mental Health and

The National Institute for Clinical Excellence

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NCCMH and NICE

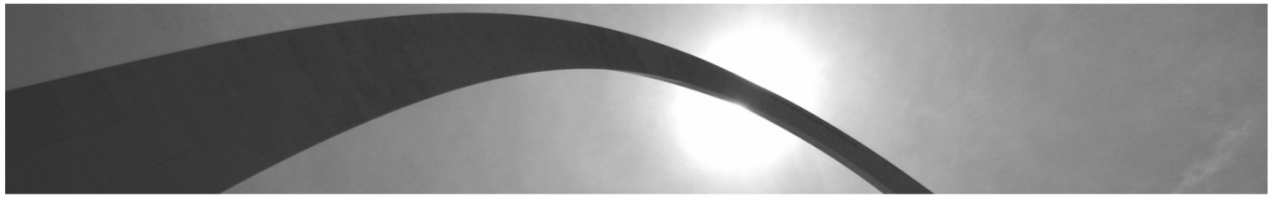
- Evidence based ***clinical practice guidelines factory for NICE***

- Our guidelines are about the ***overall treatment of a condition in the NHS*** of schizophrenia, depression, bipolar disorder, drug misuse etc

- For each guideline we review ***ALL treatments*** (drug, psychological, social, educational, employment, service level, service user experience)

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Guideline methods: systematic review/consensus

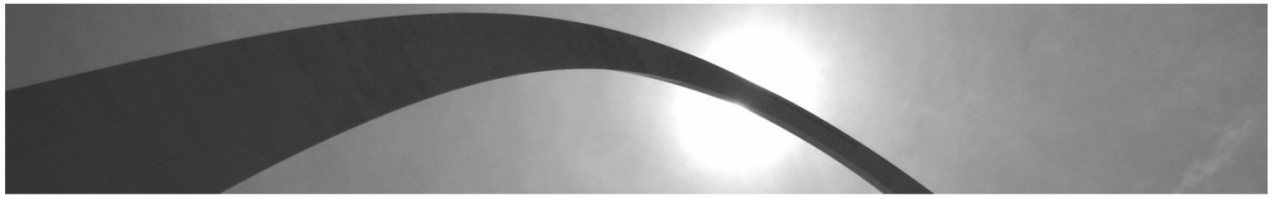
- Scope (settings, people, treatments, outcomes)
- Guideline development group of experts, (including service users/carers)
- **Decide the important clinical questions and critical outcomes (PICO)**

- Collect all studies worldwide
- Bias and quality assurance
- Meta-analysis
- Health economics (cost effectiveness)

- **Answer the clinical questions/make recommendations**
- **Takes 25 people 26 months to do ONE guideline (£440,000)**

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



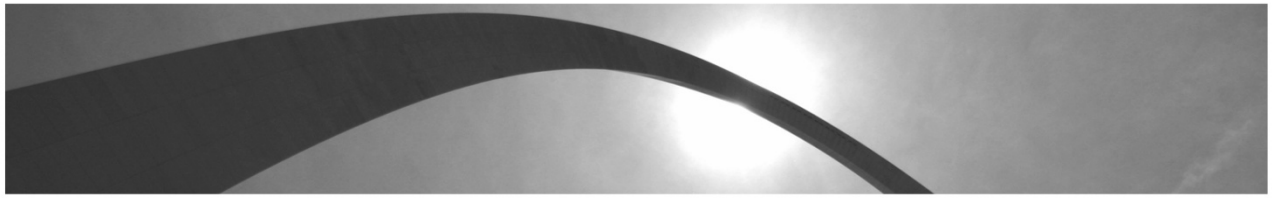
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Completed mental health guidelines

Schizophrenia	Dec 2002	ADHD	Sept 2008
Eating disorders	Jan 2004	Antisocial personality disorder	Jan 2009
Self-harm	July 2004	Borderline personality disorder	Jan 2009
Depression	Dec 2004	Schizophrenia (update)	March 2009
Post-traumatic stress disorder	July 2005	Depression with Chronic Health Problems	Oct 2009
Depression in children	Sept 2005	Depression in Adults	Oct 2009
Obsessive-compulsive disorder	Oct 2005	Generalised Anxiety Disorder	Jan 2011
Bipolar disorder	July 2006	Alcohol dependence	Feb 2011
Dementia	Nov 2006	Psychosis with Substance Misuse	March 2011
Ante- and postnatal mental health	Feb 2007	Common Mental Health Disorders	May 2011
Drug misuse – psychosocial	July 2007	Self-harm: Longer Term Management	Nov 2011
Drug misuse – detoxification	July 2007	Autism in adults (with Dutch)	June 2012

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



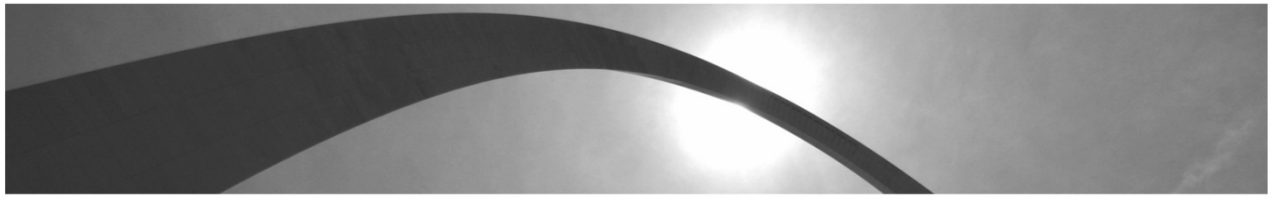
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Guidelines under development

• Psychosis & Schizophrenia in Children & Young People	January 2013
• Conduct Disorders	March 2013
• Social Anxiety Disorder	May 2013
• **Autism in Children & Young People**	**August 2013**
• **Schizophrenia in Adults (Update)**	**March 2014**
• **Bipolar (with Netherlands) (Update)**	**July 2014**
• **Violence and Aggression (update)**	**December 2014**
• **Challenging Behaviour in Learning Disability**	**March 2015**
• **Attachment disorders in looked-after children**	**October 2015**
• **Mental health of people with a Learning Disability**	**December 2015**

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

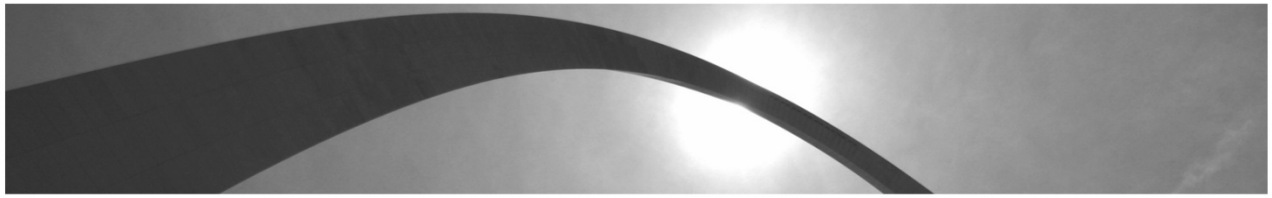


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NICE BORDERLINE PD GUIDELINE

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



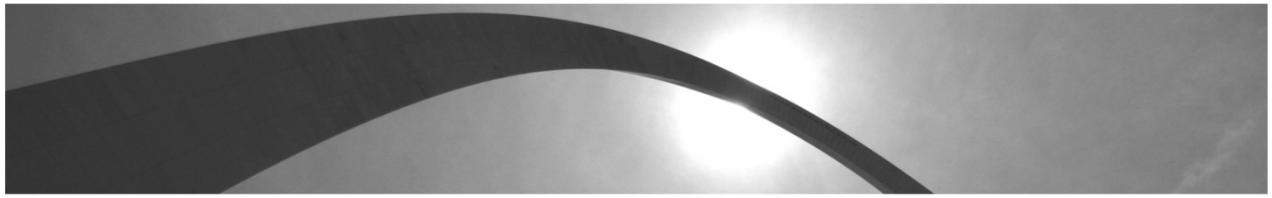
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Why do a NICE guideline on BPD?

- Between 0.7% and 2% in the general population; 20% of in-patients; 10 – 30% of out-patients and highly prevalent in prisons
- Significant impairment (social, personal, occupational, educational, financial)
- Multiple co-morbidities (psychosis, mood disorders, anxiety disorders, drug and alcohol, physical health)
- 1 in 10 people with BPD die by suicide
- High service use: frequent contact with mental health services, social services, A&E, GPs and the criminal justice system

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

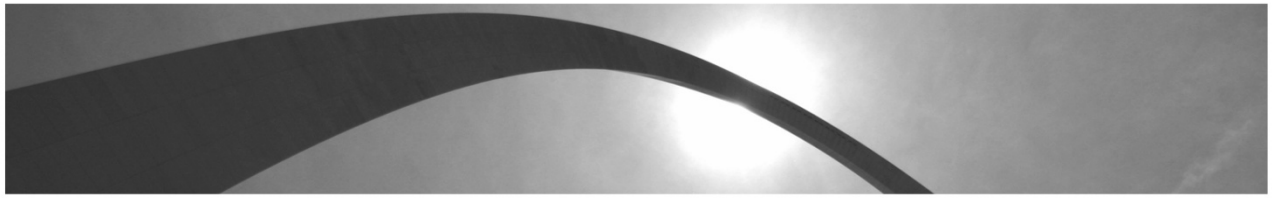
Borderline Personality Disorder – evidence base

- Databases searched for RCT and non-RCT evidence from inception up until May 2008.
- Included RCT evidence
  - 22 Pharmacology trials (N = 1776)
  - 15 Psychology trials (N = 1137)
  - 4 Combination trials of Psychological + pharmacological interventions (N = 224)
- Included non-RCT evidence
  - 21 Psychological trials (N = 1035)
  - 19 Therapeutic Communities trials (N = 2780)

- ***I.e. useable low to good quality data on 3000 (RCTs) and 4000 (non RCT)***

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

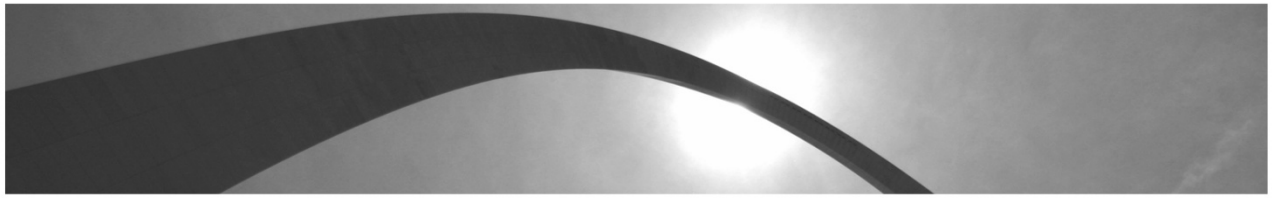
Compare this to schizophrenia

- Number of pharmacology trials included (number of participants)
  - efficacy review
    - Initial treatment: 9 (1,801)
    - Acute phase: 72 (16,556)
    - Promoting recovery – relapse prevention: 17 (3,535)
    - Promoting recovery – inadequate response: 26 (3,932)
  - Side effect review
    - 138 evaluations of one antipsychotic drug versus another antipsychotic drug
  - Effectiveness studies
    - CATIE (1,493 participants) and CUtLASS (227 participants)
- Number of psychology trials included (number of participants)
  - CBT
    - Acute, symptom control and relapse prevention 31 (3052)
  - FI
    - Acute and relapse prevention 32 (2429)

- ***Useable mod/good quality RCT data on 35,000 and another 15,000 on cohorts***

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

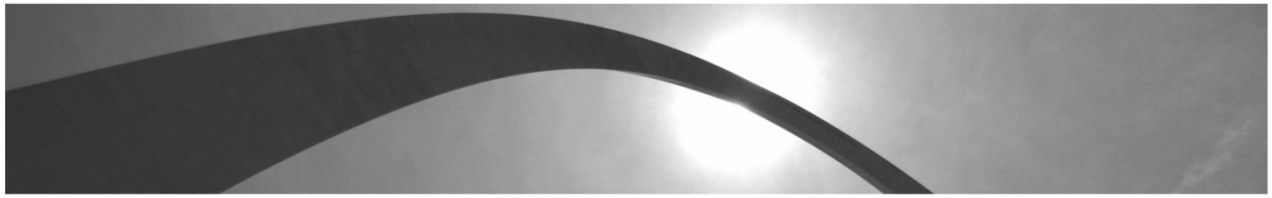


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Pharmacological treatment

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



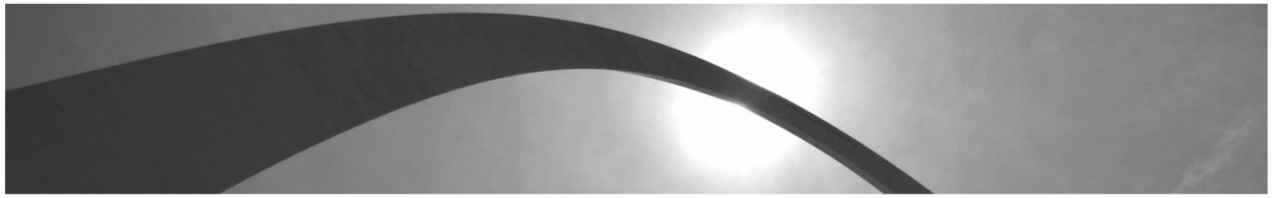
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Why have drugs been used in BPD?

- For the treatment of borderline personality disorder
- For the treatment of individual symptoms of borderline personality disorder
- For the treatment of subtypes of borderline personality disorder

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Pharmacology – clinical evidence

- Clinical question:
  - For people with borderline personality disorder which pharmacological treatments are associated with:
    - Improvement in mental state and Quality of Life
    - Reduction in self-harm, service use and risk-related behaviour
    - Improved social and personal functioning whilst minimising harm.

- Number of placebo-controlled trials included in efficacy review (number of participants)
  - Anticonvulsants and Lithium: 8 (468)
  - Antipsychotics: 8 (1143)
  - Antidepressants: 3 (200)
  - Omega-3 fatty acids: 2 (79)

- Number of head-to-head trials included in efficacy review (number of participants)
  - 1 trial comparing Amitriptyline vs. Haloperidol (90)
  - 1 trial comparing Olanzapine, Fluoxetine and combined Olanzapine and Fluoxetine (45)

- ***Limited evidence for the use of pharmacological interventions***

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

Pharmacology – Depression

Review: BPD pharmacology
Comparison: 01 Placebo-controlled trials - efficacy data
Outcome: 06 Depression - clinician-rated - sensitivity analysis

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 HRSD								
Hallahan2007 Omega-3	19	12.20(8.45)	20	17.40(7.76)		17.25	-0.63 [-1.27, 0.02]	0
Pascual2008 ZIPRAS	30	14.20(6.50)	30	16.10(5.50)		27.65	-0.31 [-0.82, 0.20]	0
Soloff1989 HAL/AMI	29	16.08(9.04)	28	20.96(9.05)		25.62	-0.53 [-1.06, 0.00]	0
Soloff1993 HAL/PHEN	22	13.32(7.91)	18	12.28(8.70)		18.45	0.12 [-0.50, 0.75]	0
Zanarini2003 Omega-3	18	6.20(4.90)	9	8.00(5.50)		11.03	-0.34 [-1.15, 0.46]	0
Subtotal (95% CI)	118		105			100.00	-0.35 [-0.61, -0.08]	

Test for heterogeneity: Chi² = 3.41, df = 4 (P = 0.49), I² = 0%
Test for overall effect: Z = 2.53 (P = 0.01)

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

Pharmacology – Hostility

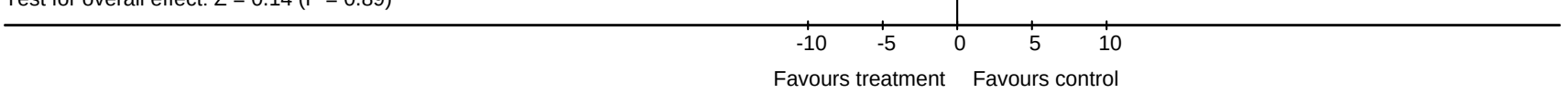
Review: BPD pharmacology
Comparison: 01 Placebo-controlled trials - efficacy data
Outcome: 09 Hostility - sensitivity analysis

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	Weight %	SMD (fixed) 95% CI	Order
01 SCL-90 hostility subscale							
De LaFuente 1994 CBZ	10	5.57(8.46)	10	8.33(6.98)	4.20	-0.34 [-1.23, 0.54]	0
Frankenburg 2002 DVP	20	1.50(0.70)	10	1.60(0.60)	5.69	-0.15 [-0.91, 0.61]	0
Schultz2008 OLZ	155	-1.00(1.00)	159	-0.70(0.08)	65.63	-0.42 [-0.65, -0.20]	0
Soloff1989 HAL/AMI	30	0.79(0.66)	28	1.04(0.97)	12.24	-0.30 [-0.82, 0.22]	0
Soloff1993 HAL/PHEN	30	0.79(0.66)	28	1.04(0.97)	12.24	-0.30 [-0.82, 0.22]	0
Subtotal (95% CI)	245		235		100.00	-0.37 [-0.56, -0.19]	
Test for heterogeneity: Chi² = 0.71, df = 4 (P = 0.95), I² = 0%							
Test for overall effect: Z = 4.05 (P < 0.0001)							
Total (95% CI)	245		235		100.00	-0.37 [-0.56, -0.19]	
Test for heterogeneity: Chi² = 0.71, df = 4 (P = 0.95), I² = 0%							
Test for overall effect: Z = 4.05 (P < 0.0001)							

Pharmacology – Impulsiveness

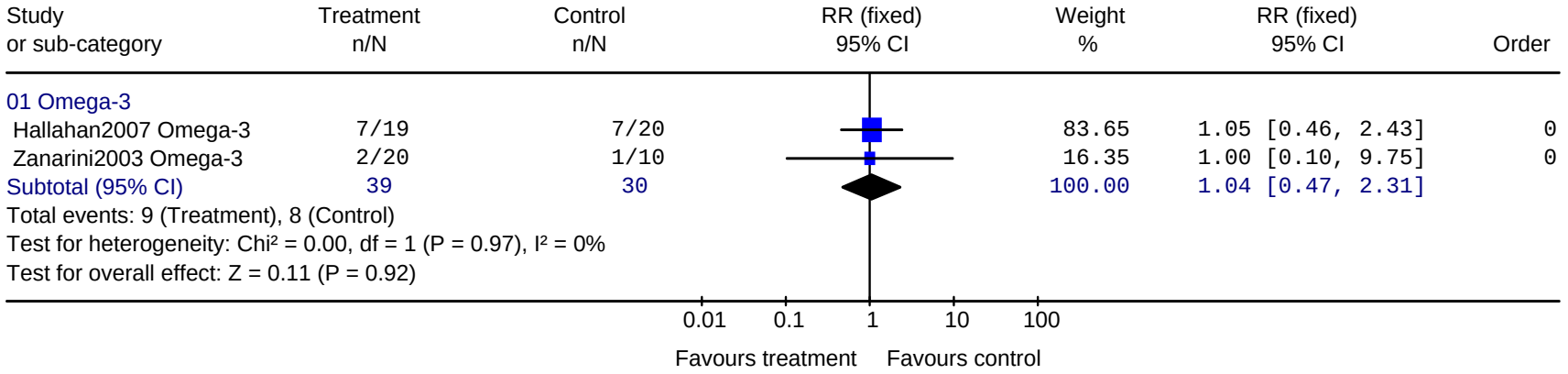
Review: BPD pharmacology
Comparison: 01 Placebo-controlled trials - efficacy data
Outcome: 10 Impulsiveness

Study or sub-category	N	Treatment Mean (SD)	N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 Barratt Impulsiveness Scale								
Pascual2008 ZIPRAS	30	67.70(22.70)	30	69.10(21.20)		34.50	-0.06 [-0.57, 0.44]	0
Soloff1989 HAL/AMI	28	104.02(15.71)	28	103.06(21.48)		32.20	0.05 [-0.47, 0.57]	0
Soloff1993 HAL/PHEN	30	240.95(37.60)	28	237.74(42.02)		33.30	0.08 [-0.44, 0.59]	0
Subtotal (95% CI)	88		86			100.00	0.02 [-0.28, 0.32]	
Test for heterogeneity: Chi² = 0.17, df = 2 (P = 0.92), I² = 0%								
Test for overall effect: Z = 0.14 (P = 0.89)								



Pharmacology – Self-harm

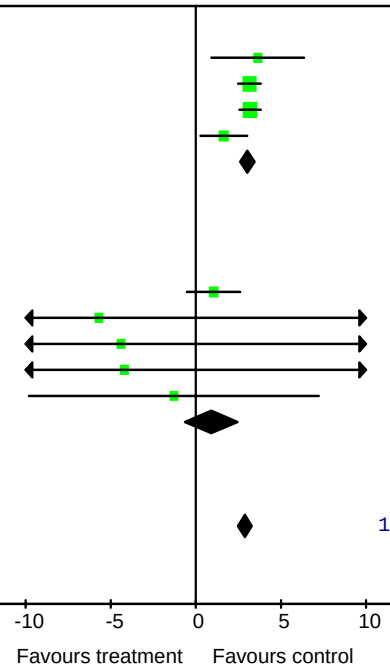
Review: BPD pharmacology
Comparison: 02 Placebo-controlled trials - acceptability/tolerability data
Outcome: 05 Self-harm



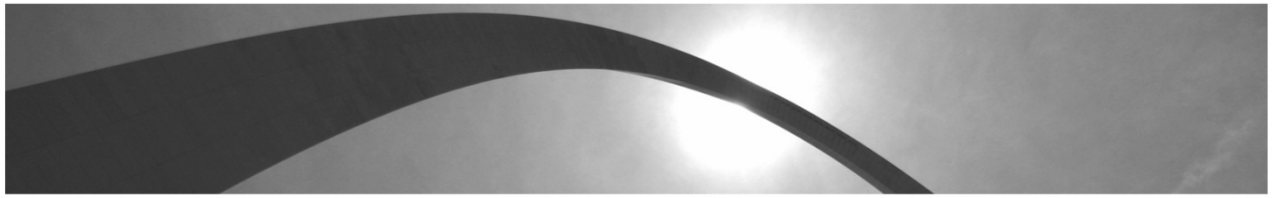
Pharmacology – Weight gain

Review: BPD pharmacology
Comparison: 02 Placebo-controlled trials - acceptability/tolerability data
Outcome: 04 Weight

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	WMD (fixed) 95% CI	Weight %	WMD (fixed) 95% CI	Order
01 Antipsychotics								
Bogenschutz2004 OLZ	16	3.71(3.40)	19	0.08(4.80)		2.31	3.63 [0.90, 6.36]	0
Eli Lilly #6253 (hi)	144	3.17(3.28)	147	0.02(2.47)		38.49	3.15 [2.48, 3.82]	0
Schultz2008 OLZ	155	2.86(3.02)	159	-0.32(2.68)		43.01	3.18 [2.55, 3.81]	0
Zanarini2001 OLZ	19	1.29(2.56)	9	-0.35(1.17)		9.00	1.64 [0.26, 3.02]	0
Subtotal (95% CI)	334		334			92.81	3.03 [2.60, 3.46]	
Test for heterogeneity: Chi² = 4.41, df = 3 (P = 0.22), I² = 32.0%								
Test for overall effect: Z = 13.80 (P < 0.00001)								
02 Anticonvulsants								
Frankenburg 2002 DVP	20	1.18(2.54)	10	0.14(1.81)		6.88	1.04 [-0.54, 2.62]	0
Loew 2006 TOP	28	72.80(11.30)	28	78.50(60.58)		0.03	-5.70 [-28.53, 17.13]	0
Nickel 2004 TOP	19	68.70(9.90)	10	73.10(50.99)		0.02	-4.40 [-36.32, 27.52]	0
Nickel 2005 TOP	22	82.30(3.90)	20	86.50(62.95)		0.02	-4.20 [-31.84, 23.44]	0
Tritt 2003 LAM	18	75.30(9.20)	9	76.60(11.30)		0.24	-1.30 [-9.82, 7.22]	0
Subtotal (95% CI)	107		77			7.19	0.90 [-0.64, 2.45]	
Test for heterogeneity: Chi² = 0.84, df = 4 (P = 0.93), I² = 0%								
Test for overall effect: Z = 1.14 (P = 0.25)								
Total (95% CI)	441		411			100.00	2.88 [2.46, 3.29]	
Test for heterogeneity: Chi² = 12.00, df = 8 (P = 0.15), I² = 33.4%								
Test for overall effect: Z = 13.60 (P < 0.00001)								



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

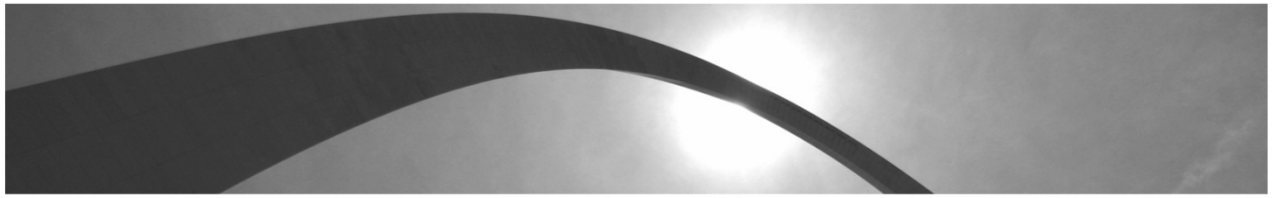


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Combination treatments – drug and psychological treatment

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Combination therapies – clinical evidence

- Clinical question:
  - For people with borderline personality disorder which combined pharmacological and psychological treatments are associated with:
    - Improvement in mental state and Quality of Life
    - Reduction in self-harm, service use and risk-related behaviour
    - Improved social and personal functioning whilst minimising harm.

- Number of included RCTs
  - Fluoxetine + IPT vs. Fluoxetine: 1 (n=39)
  - Fluoxetine + IPT vs. Fluoxetine +CT (n=35)
  - Fluoxetine + DBT vs. Placebo + DBT (n=90)*
  - Olanzapine + DBT vs. Placebo + DBT (n=60)*

*Forest plots presented

- Limited evidence for the use of combination therapies

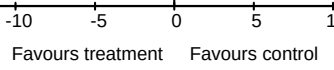
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

Combination therapy– Fluoxetine + DBT vs. placebo + DBT

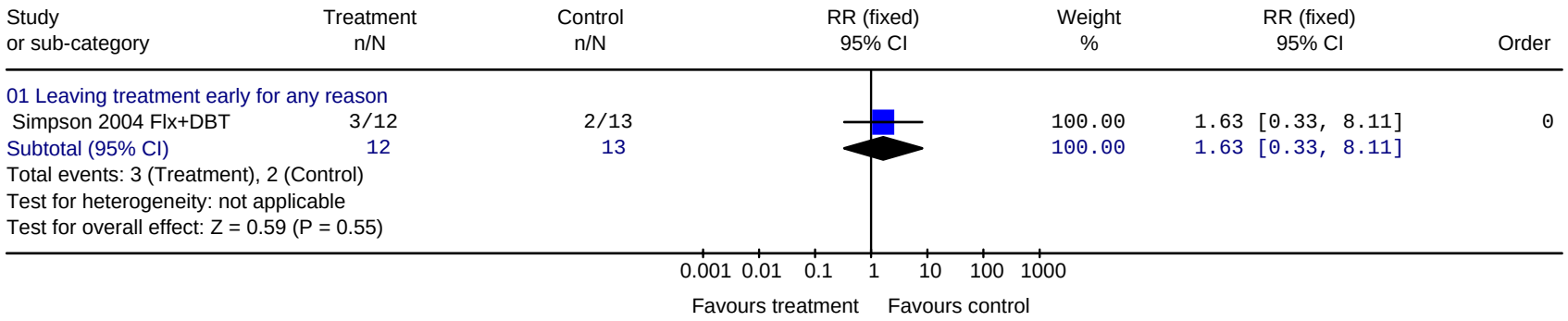
Review: BPD combination pharmacology-psychology
Comparison: 15 Fluoxetine + DBT versus placebo
Outcome: 01 Efficacy measures

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
03 Anxiety (Clinician-rated: STAI 12 weeks)								
Simpson 2004 Flx+DBT	9	101.33(38.06)	11	96.18(28.83)		100.00	0.15 [-0.73, 1.03]	0
Subtotal (95% CI)	9		11			100.00	0.15 [-0.73, 1.03]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.33 (P = 0.74)								
04 Depression (clinician-rated HRSD 12 weeks)								
Soler2005 Olz+DBT	30	13.71(5.46)	30	15.80(6.41)		100.00	-0.35 [-0.86, 0.16]	0
Subtotal (95% CI)	30		30			100.00	-0.35 [-0.86, 0.16]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 1.33 (P = 0.18)								
05 Depression (self-rated BDI 12 weeks)								
Simpson 2004 Flx+DBT	9	25.00(18.04)	11	13.91(9.54)		100.00	0.76 [-0.16, 1.68]	0
Subtotal (95% CI)	9		11			100.00	0.76 [-0.16, 1.68]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 1.62 (P = 0.11)								
07 Suicidality: Overt aggression scale - suicidality subscale (12 weeks)								
Simpson 2004 Flx+DBT	9	2.13(3.48)	11	1.00(1.18)		100.00	0.44 [-0.46, 1.33]	0
Subtotal (95% CI)	9		11			100.00	0.44 [-0.46, 1.33]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.96 (P = 0.34)								
08 Self-injury: Overt aggression scale - self-injury subscale (12 weeks)								
Simpson 2004 Flx+DBT	9	7.00(12.37)	11	6.55(12.64)		100.00	0.03 [-0.85, 0.92]	0
Subtotal (95% CI)	9		11			100.00	0.03 [-0.85, 0.92]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.08 (P = 0.94)								



Combination therapy– Fluoxetine + DBT vs. placebo + DBT

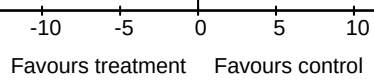
Review: BPD combination pharmacology-psychology
Comparison: 15 Fluoxetine + DBT versus placebo
Outcome: 03 Tolerability and acceptability data



Combination therapy– Olanzapine + DBT vs. placebo + DBT

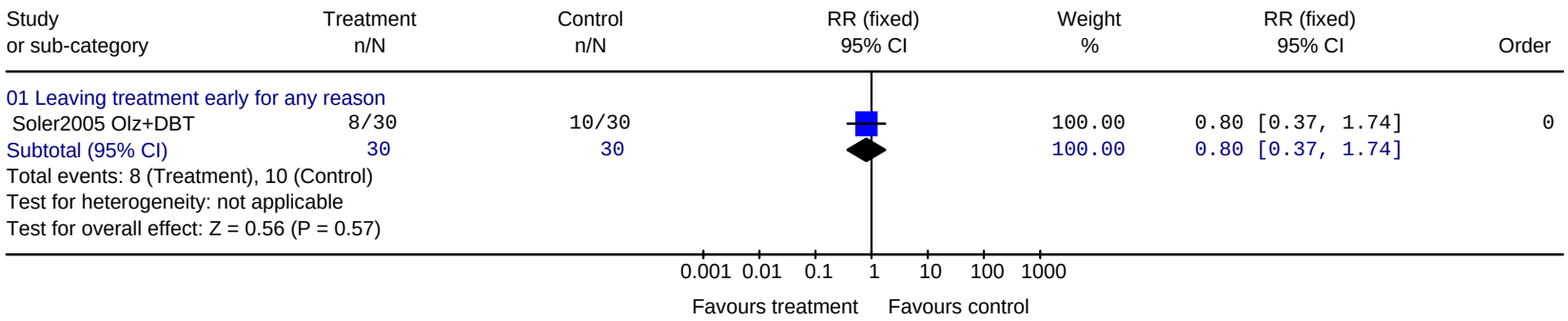
Review: BPD combination pharmacology-psychology
Comparison: 16 Olanzapine + DBT versus placebo
Outcome: 01 Efficacy measures

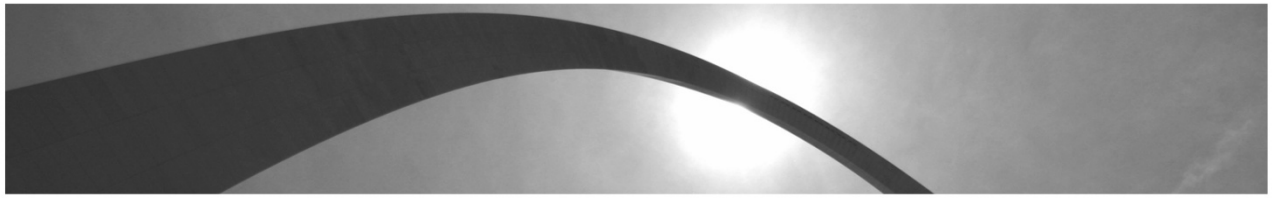
Study or sub-category	N	Treatment Mean (SD)	N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 Anxiety (Clinician-rated: HARS 12 weeks)								
Soler2005 Olz+DBT	30	18.43(5.94)	30	19.93(6.87)		100.00	-0.23 [-0.74, 0.28]	0
Subtotal (95% CI)	30		30			100.00	-0.23 [-0.74, 0.28]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.89 (P = 0.37)								
02 Depression (clinician-rated HRSD 12 weeks)								
Soler2005 Olz+DBT	30	13.71(5.46)	30	15.80(6.41)		100.00	-0.35 [-0.86, 0.16]	0
Subtotal (95% CI)	30		30			100.00	-0.35 [-0.86, 0.16]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 1.33 (P = 0.18)								
03 Self-harm/suicide attempts (12 weeks)								
Soler2005 Olz+DBT	30	1.23(2.87)	30	0.88(1.68)		100.00	0.15 [-0.36, 0.65]	0
Subtotal (95% CI)	30		30			100.00	0.15 [-0.36, 0.65]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.57 (P = 0.57)								



Combination therapy– Olanzapine + DBT vs. placebo + DBT

Review: BPD combination pharmacology-psychology
Comparison: 16 Olanzapine + DBT versus placebo
Outcome: 03 Tolerability and acceptability data



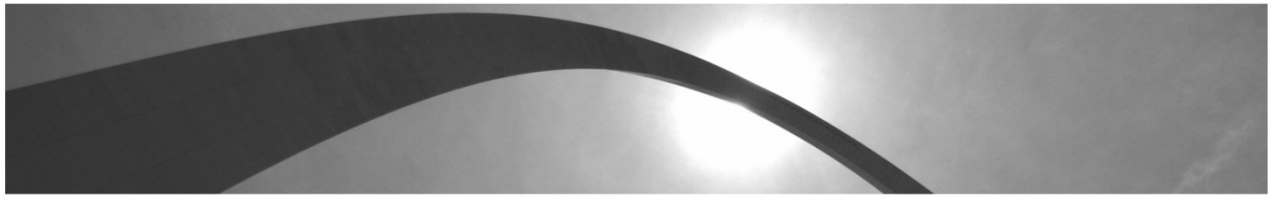


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Psychological treatments

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

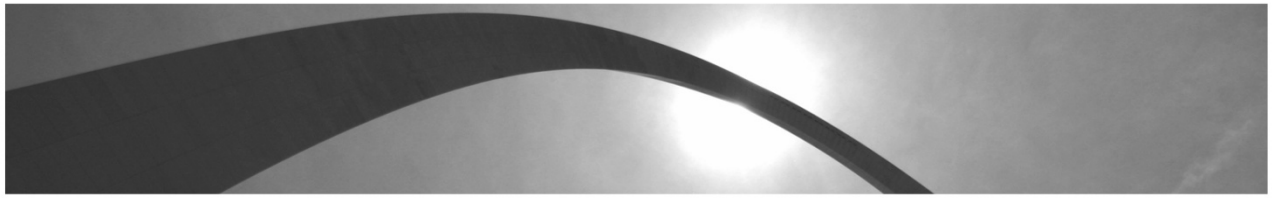
Psychology Review

- Clinical Question:
  - For people with borderline personality disorder which psychological treatments are associated with:
    - Improvement in mental state and Quality of Life
    - Reduction in self-harm, service use and risk-related behaviour
    - Improved social and personal functioning whilst minimising harm.

- Number of included RCT trials in the 3 categories of intervention :
  - Brief psychological Intervention: 2 (N = 100)
  - Individual Psychological therapies: 6 (N=637)
  - Psychological therapy programmes: 8 (n=490)

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

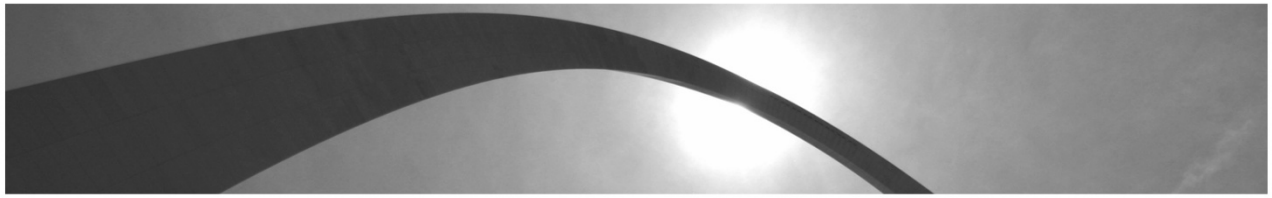


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Brief psychological therapies

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Brief Psychological Interventions

- Interventions included in the analysis
  - Manual-assisted cognitive therapy (MACT)

- Main outcomes:
  - Limited evidence for reduced self-harm and suicidal acts*
  - No evidence for reduction in anxiety or depression*
  - No evidence for improvements in general functioning*

*Forest plots presented

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

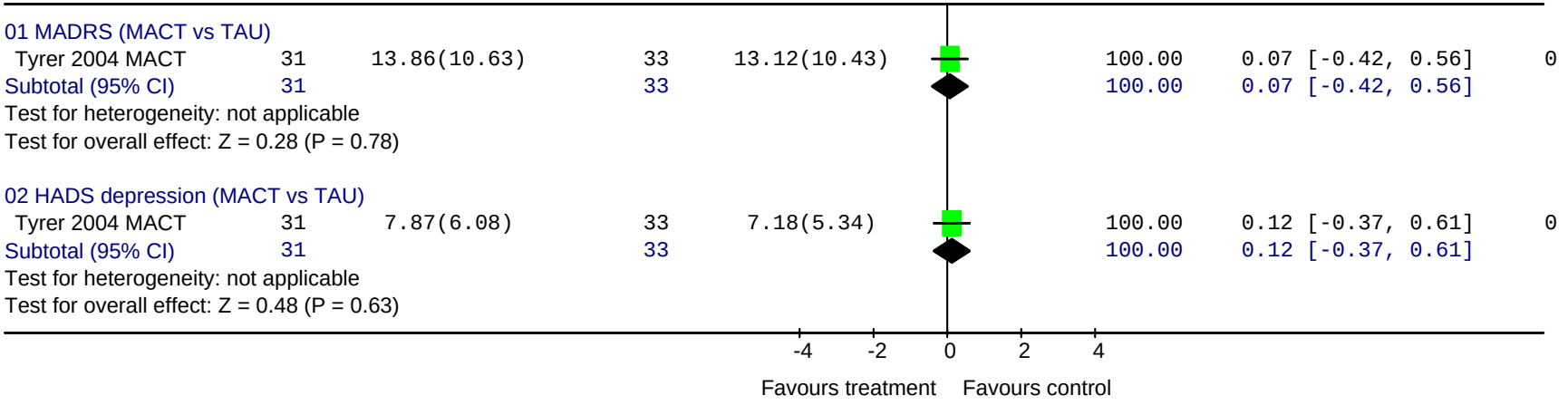
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Brief Psychological interventions – Depression

Review: BPD psychology
Comparison: 03 Low-intensity psychological therapies
Outcome: 02 Depression outcomes

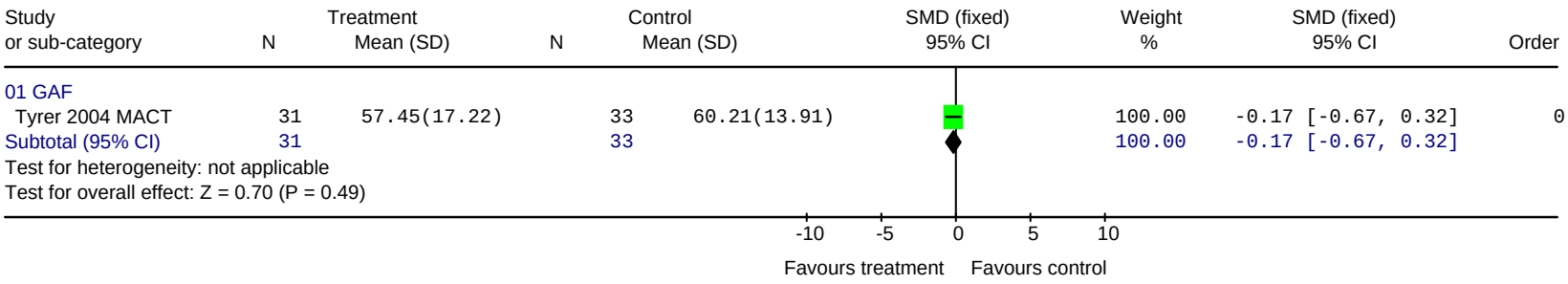
Study or sub-category	N	Treatment Mean (SD)	N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 MADRS (MACT vs TAU)								
Tyrer 2004 MACT	31	13.86(10.63)	33	13.12(10.43)		100.00	0.07 [-0.42, 0.56]	0
Subtotal (95% CI)	31		33			100.00	0.07 [-0.42, 0.56]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.28 (P = 0.78)								
02 HADS depression (MACT vs TAU)								
Tyrer 2004 MACT	31	7.87(6.08)	33	7.18(5.34)		100.00	0.12 [-0.37, 0.61]	0
Subtotal (95% CI)	31		33			100.00	0.12 [-0.37, 0.61]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.48 (P = 0.63)								



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

Brief Psychological interventions – Functioning

Review: BPD psychology
Comparison: 03 Low-intensity psychological therapies
Outcome: 07 General functioning

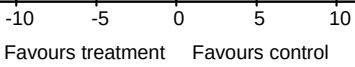


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

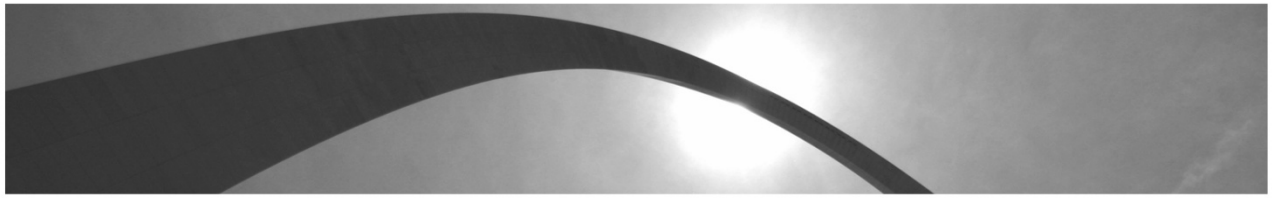
Brief Psychological interventions – Self-harm

Review: BPD psychology
Comparison: 03 Low-intensity psychological therapies
Outcome: 04 Self-harm outcomes

Study or sub-category	N	Treatment Mean (SD)	N	Control Mean (SD)	WMD (fixed) 95% CI	Weight %	WMD (fixed) 95% CI	Order
01 Self-harm and suicidal acts reported together								
Weinberg 2006 MACT	15	0.60(0.91)	13	3.63(4.80)		100.00	-3.03 [-5.68, -0.38]	0
Subtotal (95% CI)	15		13			100.00	-3.03 [-5.68, -0.38]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 2.24 (P = 0.03)								
02 Self-harm and suicidal acts reported together (6-month follow-up)								
Weinberg 2006 MACT	15	1.98(3.57)	15	6.69(12.23)		100.00	-4.71 [-11.16, 1.74]	0
Subtotal (95% CI)	15		15			100.00	-4.71 [-11.16, 1.74]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 1.43 (P = 0.15)								



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

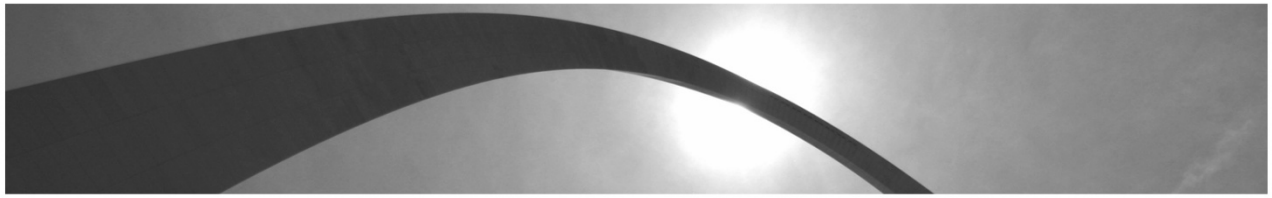


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Individual psychological therapies

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Individual psychological therapies

- Interventions included in the analysis
  - Cognitive behavioural Therapy (CBT)
  - Cognitive analytic therapy (CAT)
  - Systems Training for Emotional Predictability and Problems Solving (STEPPS)
  - Schema-focussed cognitive therapy
  - Transference-focused psychotherapy
  - Individual dynamic psychotherapy

- Main outcomes:
  - No evidence for reduction in anxiety or depression*
  - No evidence for improvements in general functioning*
  - Little effect on reducing self-harm and suicidal acts*

*Forest plots presented

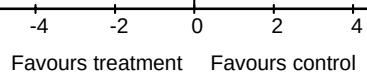
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

Individual psychological therapies – Depression

Review: BPD psychology
Comparison: 02 Individual psychological therapies
Outcome: 02 Depression outcomes

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 BDI								
Blum2008 STEPPS	65	22.00(16.12)	72	25.80(15.36)		57.91	-0.24 [-0.58, 0.10]	0
Davidson2006 CBT	52	29.60(14.80)	47	31.30(16.60)		42.09	-0.11 [-0.50, 0.29]	0
Subtotal (95% CI)	117		119			100.00	-0.18 [-0.44, 0.07]	
Test for heterogeneity: Chi² = 0.25, df = 1 (P = 0.62), I² = 0%								
Test for overall effect: Z = 1.41 (P = 0.16)								
02 BDI (24-month follow-up)								
Davidson2006 CBT	53	26.50(15.30)	48	28.80(15.70)		100.00	-0.15 [-0.54, 0.24]	0
Subtotal (95% CI)	53		48			100.00	-0.15 [-0.54, 0.24]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.74 (P = 0.46)								

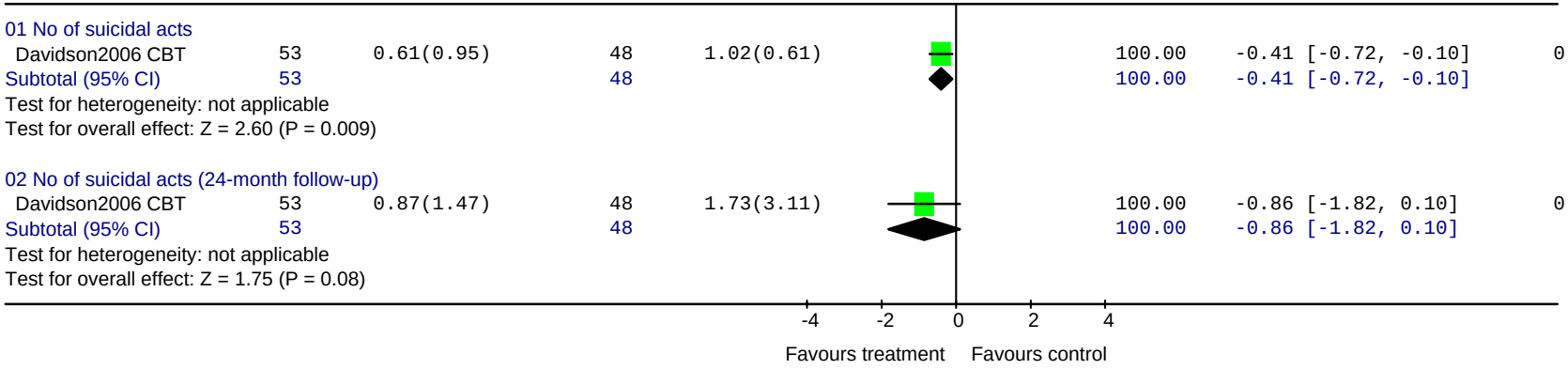


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Individual psychological therapies – Self-harm

Review: BPD psychology
Comparison: 02 Individual psychological therapies
Outcome: 05 Self-harm outcomes

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	WMD (fixed) 95% CI	Weight %	WMD (fixed) 95% CI	Order
01 No of suicidal acts								
Davidson2006 CBT	53	0.61(0.95)	48	1.02(0.61)		100.00	-0.41 [-0.72, -0.10]	0
Subtotal (95% CI)	53		48			100.00	-0.41 [-0.72, -0.10]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 2.60 (P = 0.009)								
02 No of suicidal acts (24-month follow-up)								
Davidson2006 CBT	53	0.87(1.47)	48	1.73(3.11)		100.00	-0.86 [-1.82, 0.10]	0
Subtotal (95% CI)	53		48			100.00	-0.86 [-1.82, 0.10]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 1.75 (P = 0.08)								

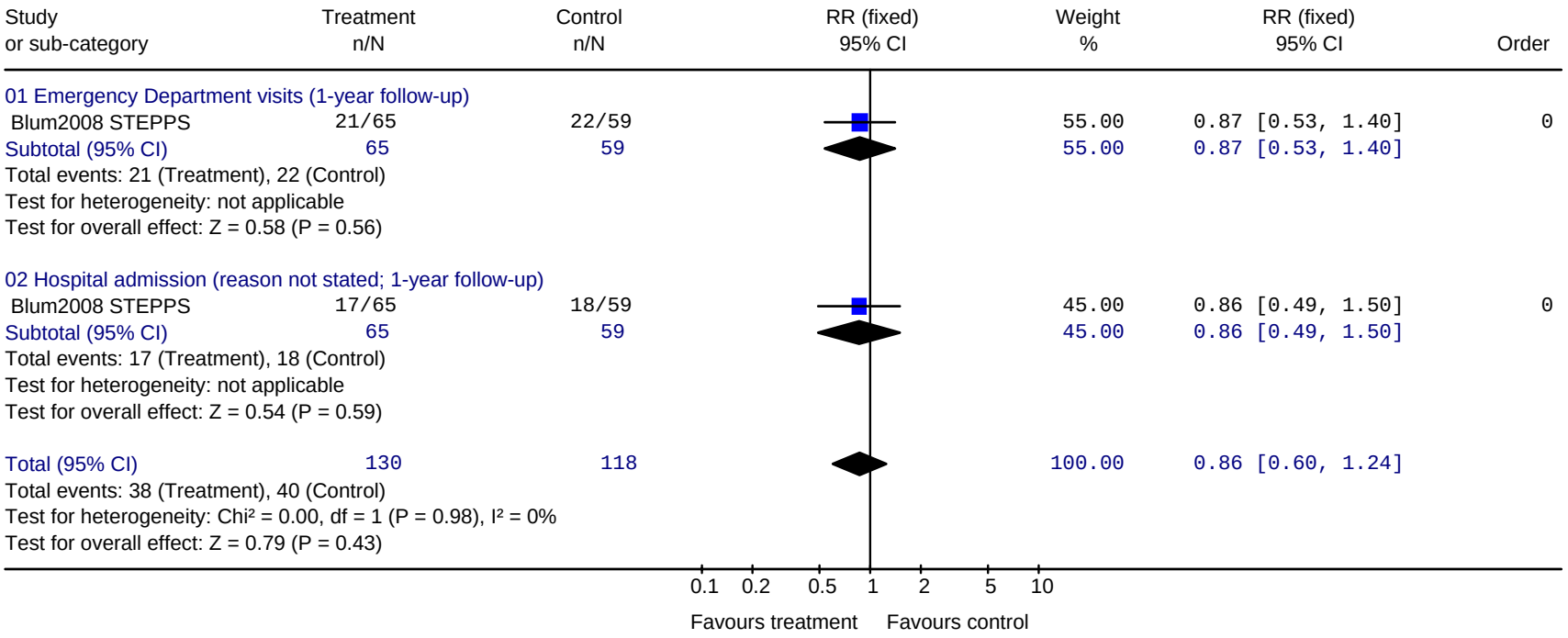


RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Individual psychological therapies – Service-use

Review: BPD psychology
Comparison: 02 Individual psychological therapies
Outcome: 08 Service-use outcomes (dichotomous)



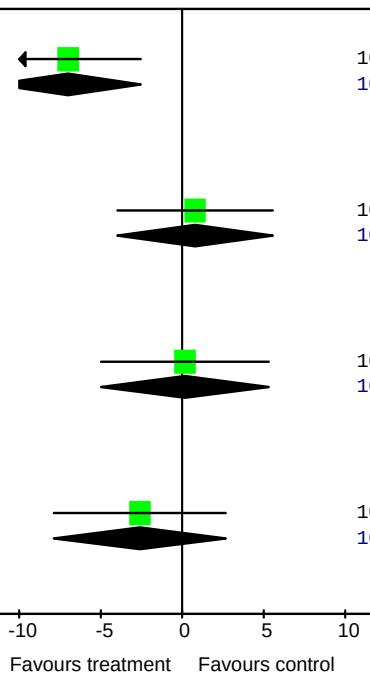
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

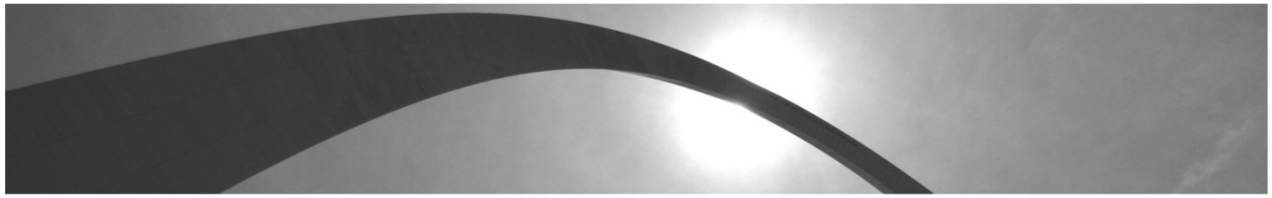
Individual psychological therapies – general functioning

Review: BPD psychology
Comparison: 02 Individual psychological therapies
Outcome: 11 General functioning

Study or sub-category	N	Treatment Mean (SD)	N	Control Mean (SD)	WMD (fixed) 95% CI	Weight %	WMD (fixed) 95% CI	Order
01 GAS								
Blum2008 STEPPS	64	-50.50(12.90)	59	-43.50(12.29)		100.00	-7.00 [-11.45, -2.55]	0
Subtotal (95% CI)	64		59			100.00	-7.00 [-11.45, -2.55]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 3.08 (P = 0.002)								
02 SOFAS - 6 months								
Chanen unpub CAT	41	66.33(9.98)	37	65.54(11.40)		100.00	0.79 [-3.99, 5.57]	0
Subtotal (95% CI)	41		37			100.00	0.79 [-3.99, 5.57]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.32 (P = 0.75)								
03 SOFAS - 12 months								
Chanen unpub CAT	41	67.39(11.43)	37	67.23(11.70)		100.00	0.16 [-4.98, 5.30]	0
Subtotal (95% CI)	41		37			100.00	0.16 [-4.98, 5.30]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.06 (P = 0.95)								
04 SOFAS - 24 months								
Chanen unpub CAT	41	71.94(11.38)	37	74.54(12.27)		100.00	-2.60 [-7.87, 2.67]	0
Subtotal (95% CI)	41		37			100.00	-2.60 [-7.87, 2.67]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 0.97 (P = 0.33)								



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

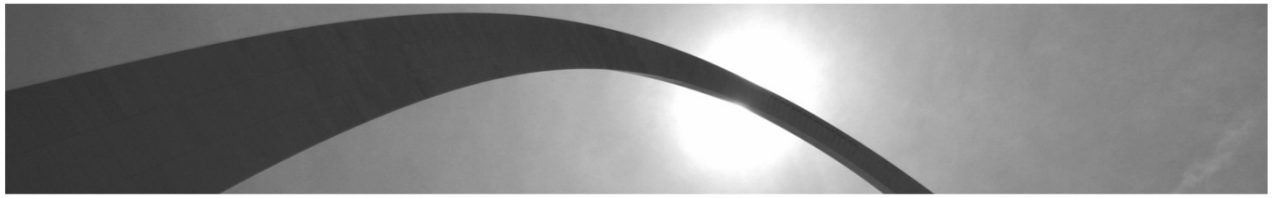


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Psychological therapy programmes/complex interventions

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Psychological therapy programmes / complex interventions

- Interventions included in the analysis
  - Dialectic behaviour therapy (DBT)
  - Mentalisation-based therapy (MBT) and partial hospitalisation

- Main outcomes:
  - Reduced anxiety*
  - Reduced depression*
  - Some evidence for a reduction in self-harm and suicidal acts*
  - Some evidence for a reduction in service use
  - Improved treatment acceptability*

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

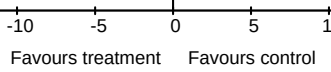
*Forest plots presented

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Psychological therapy programmes – Anxiety

Review: BPD psychology
Comparison: 01 Complex interventions
Outcome: 02 Anxiety outcomes (clinician-completed)

Study or sub-category	N	Treatment Mean (SD)	N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 HARS								
Koons 2001 DBT	10	19.10(7.50)	10	32.20(12.40)		100.00	-1.22 [-2.20, -0.25]	0
Subtotal (95% CI)	10		10			100.00	-1.22 [-2.20, -0.25]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 2.47 (P = 0.01)								
02 STAI state anxiety								
Bateman1999 MBT	19	52.50(11.50)	19	65.50(9.30)		100.00	-1.22 [-1.92, -0.52]	0
Subtotal (95% CI)	19		19			100.00	-1.22 [-1.92, -0.52]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 3.41 (P = 0.0006)								
03 STAI state anxiety (18-month follow-up)								
Bateman1999 MBT	19	23.60(5.90)	14	52.40(10.30)		100.00	-3.49 [-4.63, -2.36]	0
Subtotal (95% CI)	19		14			100.00	-3.49 [-4.63, -2.36]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 6.04 (P < 0.00001)								



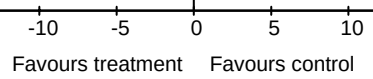
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

Psychological therapy programmes – Depression

Review: BPD psychology
Comparison: 01 Complex interventions
Outcome: 04 Depression outcomes (clinician-rated)

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	SMD (fixed) 95% CI	Weight %	SMD (fixed) 95% CI	Order
01 HRSD at endpoint								
Koons 2001 DBT	10	17.10(5.70)	10	24.30(7.80)		13.89	-1.01 [-1.95, -0.07]	0
Linehan 2006 DBT	50	14.00(7.30)	39	17.00(8.20)		69.20	-0.39 [-0.81, 0.04]	0
Turner 2000 DBT	12	7.50(5.96)	12	12.58(3.90)		16.91	-0.97 [-1.83, -0.12]	0
Subtotal (95% CI)	72		61			100.00	-0.57 [-0.92, -0.22]	

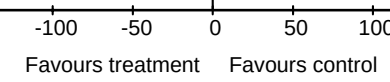
Test for heterogeneity: Chi² = 2.42, df = 2 (P = 0.30), I² = 17.3%
Test for overall effect: Z = 3.19 (P = 0.001)



Psychological therapy programmes – Depression

Review: BPD psychology
Comparison: 01 Complex interventions
Outcome: 05 Depression outcomes (self-rated)

Study or sub-category	Treatment N	Treatment Mean (SD)	Control N	Control Mean (SD)	WMD (fixed) 95% CI	Weight %	WMD (fixed) 95% CI	Order
01 BDI at endpoint (DBT)								
Koons 2001 DBT	10	13.40(7.50)	10	29.30(19.10)		7.24	-15.90 [-28.62, -3.18]	0
Turner 2000 DBT	12	14.92(8.26)	12	24.08(5.55)		36.94	-9.16 [-14.79, -3.53]	0
Subtotal (95% CI)	22		22			44.18	-10.26 [-15.41, -5.12]	
Test for heterogeneity: Chi² = 0.90, df = 1 (P = 0.34), I² = 0%								
Test for overall effect: Z = 3.91 (P < 0.0001)								
02 BDI at endpoint - MBT								
Bateman1999 MBT	19	20.60(7.00)	19	35.20(7.40)		55.82	-14.60 [-19.18, -10.02]	0
Subtotal (95% CI)	19		19			55.82	-14.60 [-19.18, -10.02]	
Test for heterogeneity: not applicable								
Test for overall effect: Z = 6.25 (P < 0.00001)								
Total (95% CI)	41		41			100.00	-12.68 [-16.11, -9.26]	
Test for heterogeneity: Chi² = 2.42, df = 2 (P = 0.30), I² = 17.4%								
Test for overall effect: Z = 7.27 (P < 0.00001)								



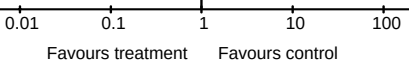
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Psychological therapy programmes – Self-harm

Review: BPD psychology
Comparison: 01 Complex interventions
Outcome: 08 Self-harm outcomes (dichotomous)

Study or sub-category	Treatment n/N	Control n/N	RR (random) 95% CI	Weight %	RR (random) 95% CI	Order
01 Self-harm						
Bateman1999 MBT	7/19	16/19		54.73	0.44 [0.24, 0.81]	0
van den Bosch'02 DBT	8/27	13/31		45.27	0.71 [0.35, 1.44]	0
Subtotal (95% CI)	46	50		100.00	0.54 [0.34, 0.86]	
Total events: 15 (Treatment), 29 (Control)						
Test for heterogeneity: Chi² = 1.00, df = 1 (P = 0.32), I² = 0.2%						
Test for overall effect: Z = 2.60 (P = 0.009)						
02 No of suicide attempts						
Bateman1999 MBT	1/19	12/19		7.09	0.08 [0.01, 0.58]	0
Linehan 2006 DBT	3/52	7/49		14.90	0.40 [0.11, 1.47]	0
Linehan'91 coht2 DBT	14/32	21/31		66.01	0.65 [0.41, 1.02]	0
van den Bosch'02 DBT	2/27	8/31		11.99	0.29 [0.07, 1.24]	0
Subtotal (95% CI)	130	130		100.00	0.37 [0.16, 0.87]	
Total events: 20 (Treatment), 48 (Control)						
Test for heterogeneity: Chi² = 6.45, df = 3 (P = 0.09), I² = 53.5%						
Test for overall effect: Z = 2.27 (P = 0.02)						
03 No of suicide attempts (5-year follow-up)						
Bateman1999 MBT	5/22	14/19		100.00	0.31 [0.14, 0.70]	0
Subtotal (95% CI)	22	19		100.00	0.31 [0.14, 0.70]	
Total events: 5 (Treatment), 14 (Control)						
Test for heterogeneity: not applicable						
Test for overall effect: Z = 2.83 (P = 0.005)						
04 Hospital admission for self-harm						
Carter unpub DBT	8/38	9/35		100.00	0.82 [0.36, 1.89]	0
Subtotal (95% CI)	38	35		100.00	0.82 [0.36, 1.89]	
Total events: 8 (Treatment), 9 (Control)						
Test for heterogeneity: not applicable						
Test for overall effect: Z = 0.47 (P = 0.64)						



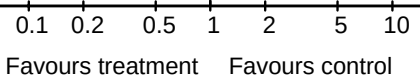
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

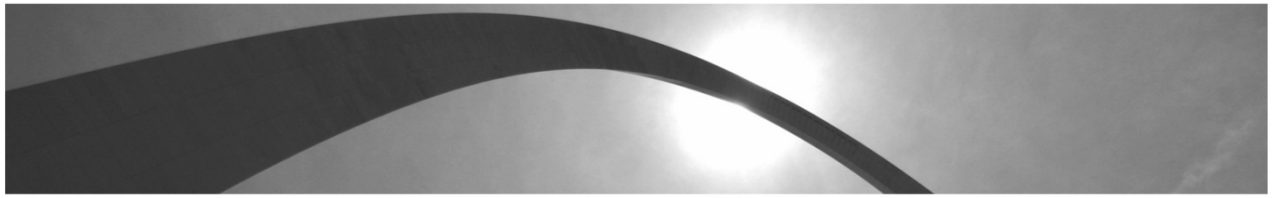
Psychological therapy programmes – Treatment acceptability

Review: BPD psychology
Comparison: 01 Complex interventions
Outcome: 16 Acceptability and tolerability outcomes

Study or sub-category	Treatment n/N	Control n/N	RR (random) 95% CI	Weight %	RR (random) 95% CI	Order
01 Leaving treatment early for any reason (vs TAU)						
Bateman1999 MBT	3/22	3/22		5.29	1.00 [0.23, 4.42]	0
Koons 2001 DBT	0/1	0/1			Not estimable	0
Linehan 2001 DBT	0/1	0/1			Not estimable	0
Linehan 2006 DBT	6/52	14/49		15.19	0.40 [0.17, 0.97]	0
Linehan1991 DBT	10/32	9/31		20.30	1.08 [0.51, 2.29]	0
Turner 2000 DBT	4/12	6/12		12.10	0.67 [0.25, 1.78]	0
van den Bosch'02 DBT	11/27	25/31		47.13	0.51 [0.31, 0.82]	0
Subtotal (95% CI)	147	147		100.00	0.61 [0.43, 0.86]	
Total events: 34 (Treatment), 57 (Control)						
Test for heterogeneity: Chi² = 4.08, df = 4 (P = 0.40), I² = 2.0%						
Test for overall effect: Z = 2.82 (P = 0.005)						



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Main conclusions

- People with BPD have been neglected/traumatised by carers
  - **Don't make it worse (as professional carers)**

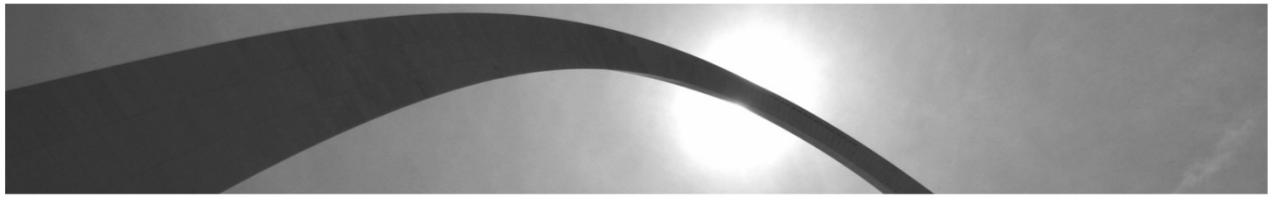
- Not very good evidence for brief psychological therapies
  - **Complex psychological interventions in a structured setting**

- Evidence for drugs is poor – trials show little benefit, and some harm
  - **Don't use drugs** if you can avoid it – and **stop them ASAP**

- Comorbidity is very common (psychosis, depression, self harm, drug misuse, alcohol dependence)
  - **Treat co-existing problems** as in NICE guidelines

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

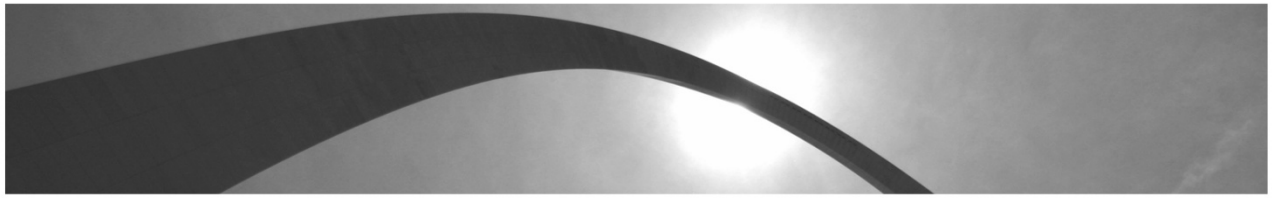


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

KEY RECOMMENDATIONS

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key recommendations

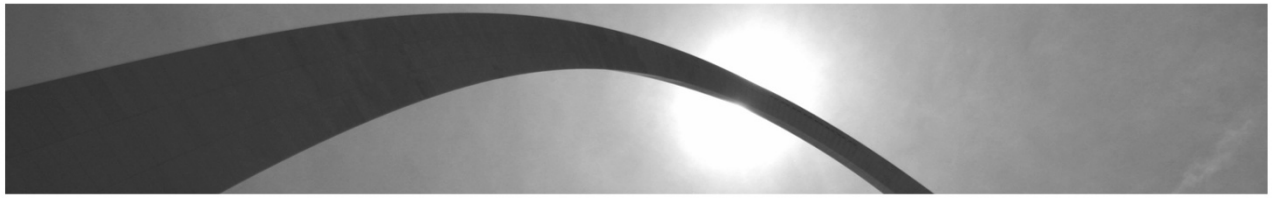
- General recommendations

  - Access to services and discrimination
  - Autonomy, choice and independence
  - Be optimistic and develop trusting relationship
  - Anticipate and manage endings and transitions

  - Community teams should be main service provider in secondary care – try to avoid hospital

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



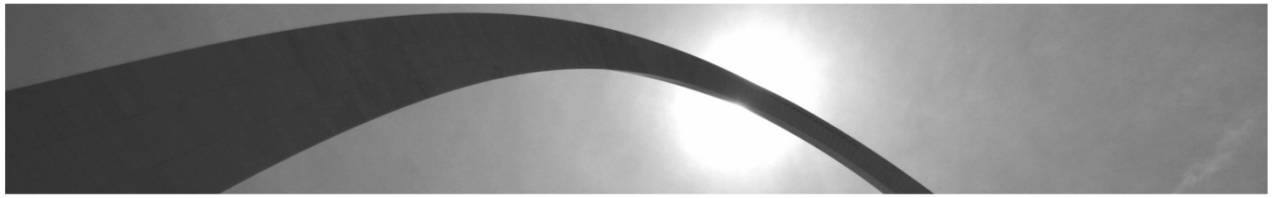
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key recommendations

- Care plans should specify:
  - Roles and responsibilities
  - Long term plans
  - Short term plans (and fit with long term)
  - Crisis plans
  - Share plans with GP and service user

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key recommendations

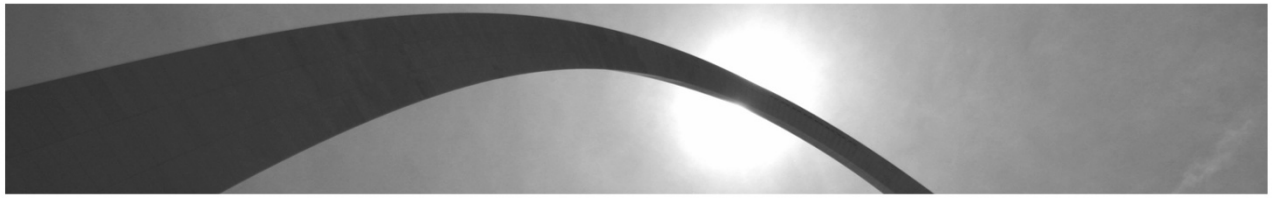
- Psychological treatments

  - Team based treatment
  - Agree how to work together as a team with service user
  - Therapist supervision
  - Consider twice weekly (fit the SU needs context)
  - Don’t do brief (<3/12) therapy without support

  - (CBT may work for less severe?)

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



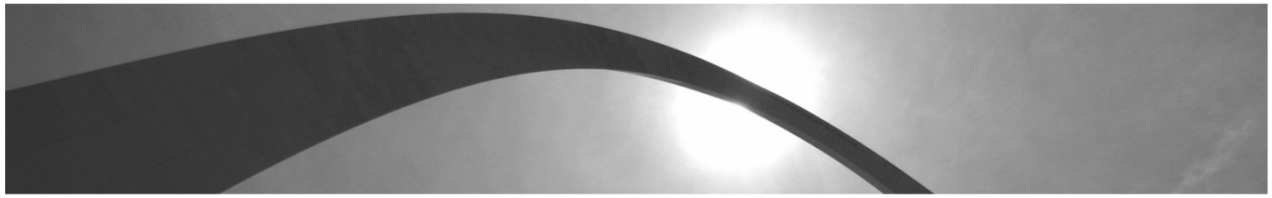
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key recommendations

- Drug treatments
  - Don’t use drugs for:
    - BPD itself
  - Don’t use drugs for
    - Individual symptoms of BPD
      - repeated self-harm
      - marked emotional instability
      - risk-taking behaviour
      - transient psychotic symptoms

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

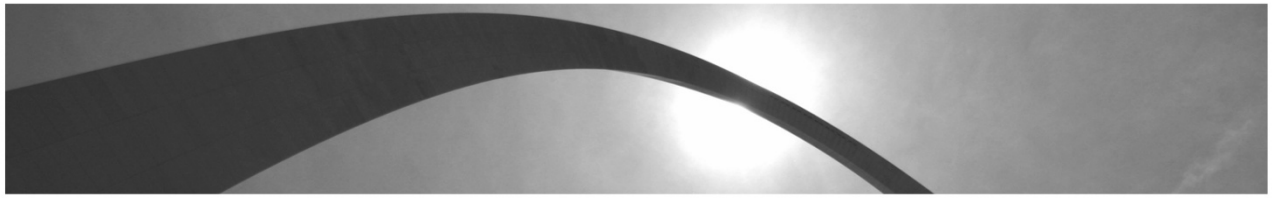
Key recommendations

- Do use drugs for
  - treatment of comorbidities (depression, psychosis etc) in line with NICE guidelines for (depression, psychosis, etc)

- Consider drugs for sedation during crisis
  - But don't use for long
  - Stop at earliest opportunity

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



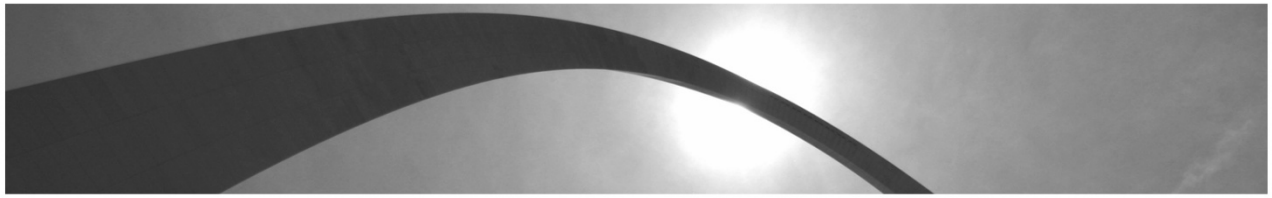
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key recommendations

- Specialist service for personality disorder
  - Consultation, advice and guidance
  - Diagnostic assessment if in doubt
  - Training in treatment and management of PD
  - Lead and implement guideline
  - Only see very complex/difficult cases for treatment
  - Join in national multi-centre research

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

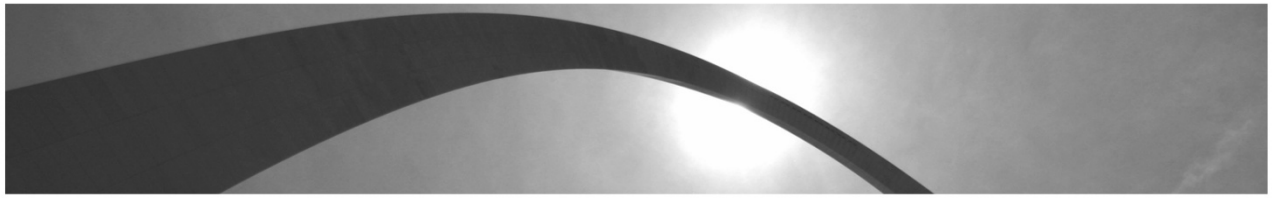


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NATIONAL AUDIT OF PRESCRIBING FOR PEOPLE WITH PERSONALITY DISORDER

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

PRESCRIBING OBSERVATORY IN MENTAL HEALTH

POMH-UK

Tom Barnes, Carol Paton and the Centre for Quality Improvement

August 2012

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

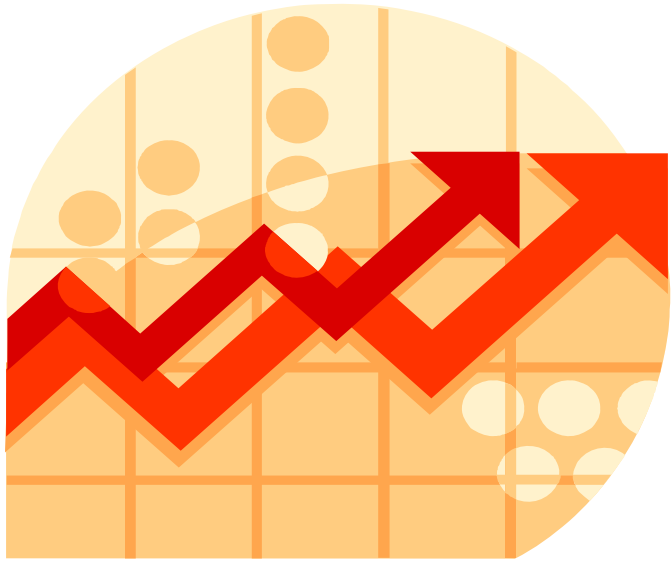
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Outline

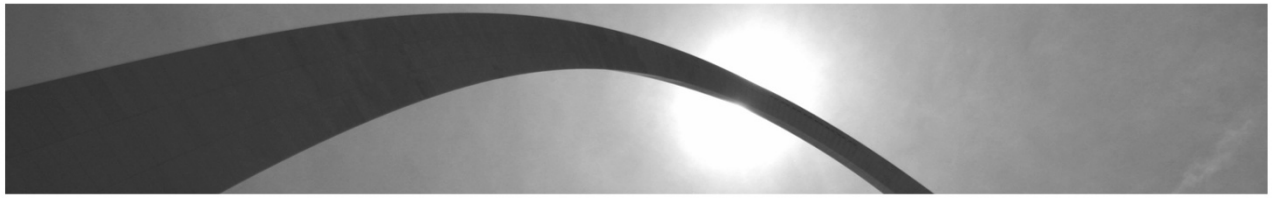
Summary of the baseline findings of POMH national audit – Prescribing for people with a personality disorder (12a).

- **Audit standards**
- **Method**
- **National findings**
- **Trust level findings**



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Audit standards

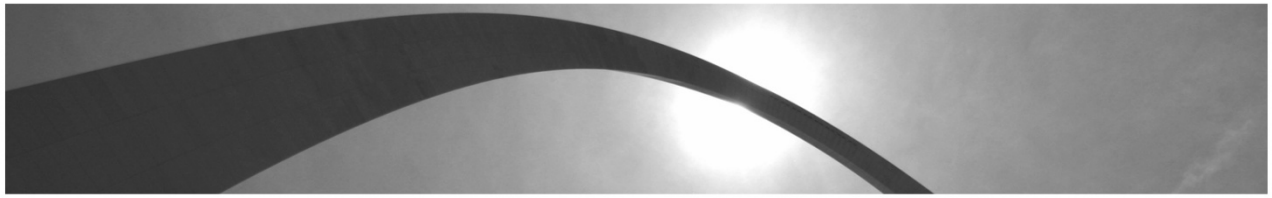
1. There is a written crisis plan in the clinical records.

2. There is evidence that the patient's views have been sought in the development of the crisis plan.

3. A clinician's reasons for prescribing antipsychotic medication (i.e. target symptoms or behaviour) are documented in the clinical records.

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Treatment targets

1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.

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

   3.12.1.3: Drug treatment may be considered in the treatment of comorbid conditions.

2. Z-hypnotics should not be prescribed for more than four consecutive weeks.
3. Benzodiazepines should not be prescribed for more than four consecutive weeks.
4. Medication prescribed for more than four consecutive weeks should be reviewed, and such a review should take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records.

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Method

Participants:

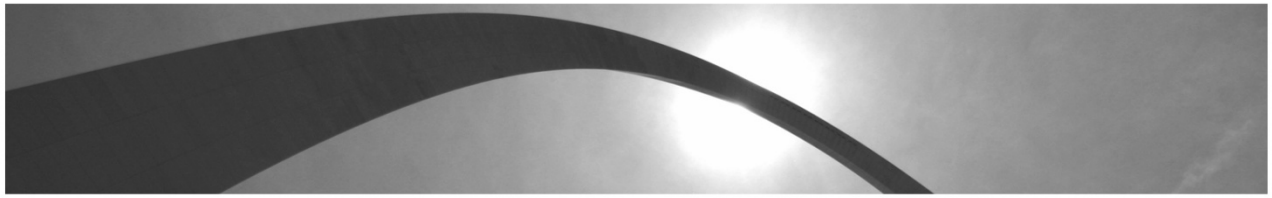
- 41 Mental Health Trusts participated
- 438 clinical teams
- 2,600 patients

Data collected:

- Demographic, diagnosis, type of service
- Antipsychotic(s) prescribed, duration
- Clinical indications
- Other medicines prescribed
- Information about medication review

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key national findings

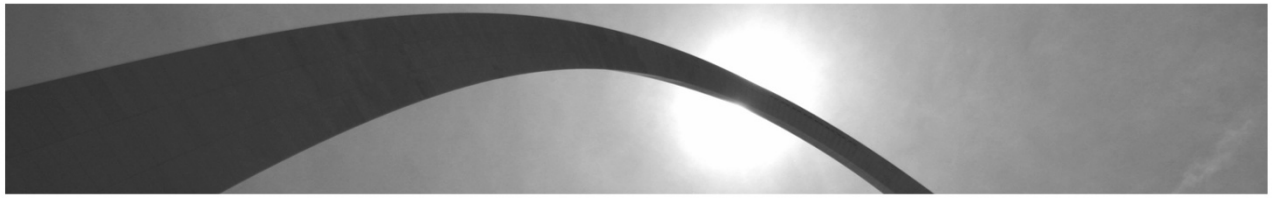
MEDICATION

- 82% of patients with no comorbid mental illness were prescribed at least one medication (antipsychotic, anticonvulsant, antidepressant, hypnotic)

- 55% of people with no comorbid mental illness were given antipsychotics
  - Of these almost all were on the drugs for 6 months or longer

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key national findings

MEDICATION

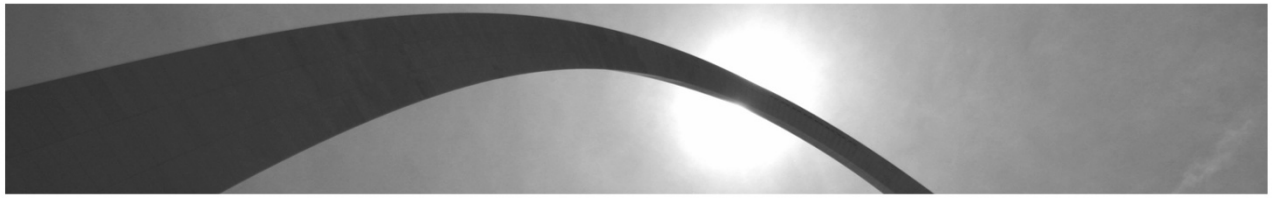
- 64% of patients with no comorbid mental illness were prescribed and antidepressant

- 20% of people with no comorbid mental illness were given a Z-hypnotic

- 32% of people with no comorbid mental illness were given a benzodiazepine

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key national findings

MEDICATION REVIEW

•67% of patients with no comorbid mental illness and given a drug had a formal medication review in their notes

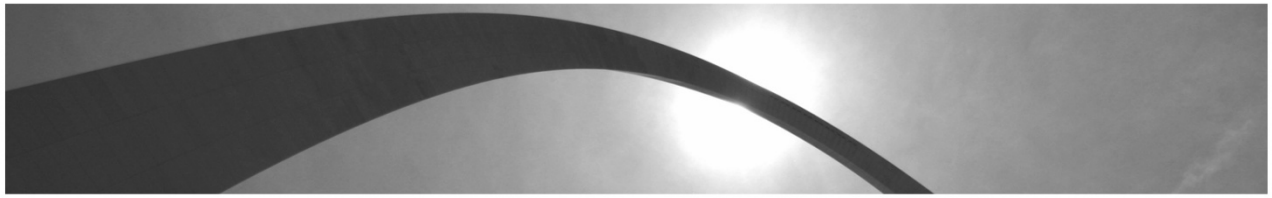
•At the medication review the following was considered:

- Therapeutic response (84%)
- Side effects/tolerability (65%)
- Patients views (74%)
- Adherence (54%)

•The outcome of the most recent medication review was documented in 94% of cases

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Key National findings

CRISIS PLAN

- 68% of patients had a crisis plan
  - Of these, 72% had been developed with the patient

CLINICAL INDICATION

- Of all patients given an antipsychotic, 83% there was a documented clinical reason

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

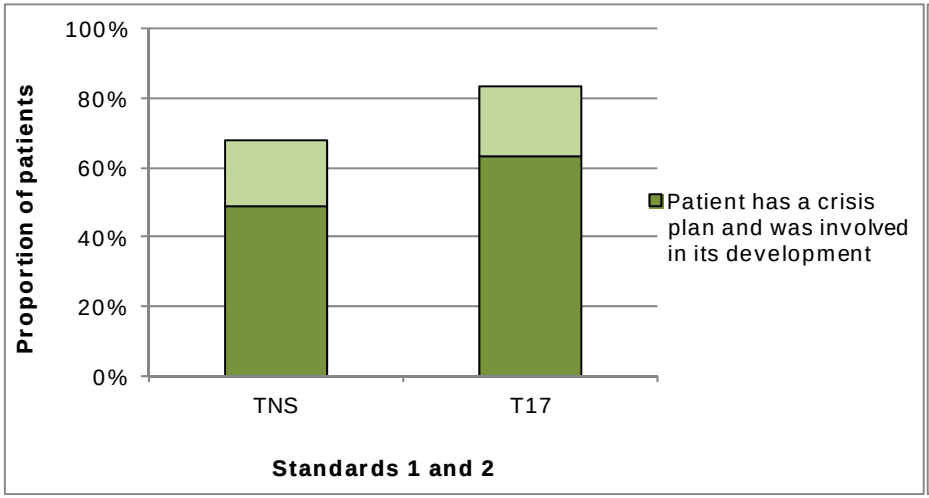
The End

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

National and Trust level results for Standards 1, 2 and 3



National and Trust level results for Standards 1 and 2: proportion of all patients with a crisis plan

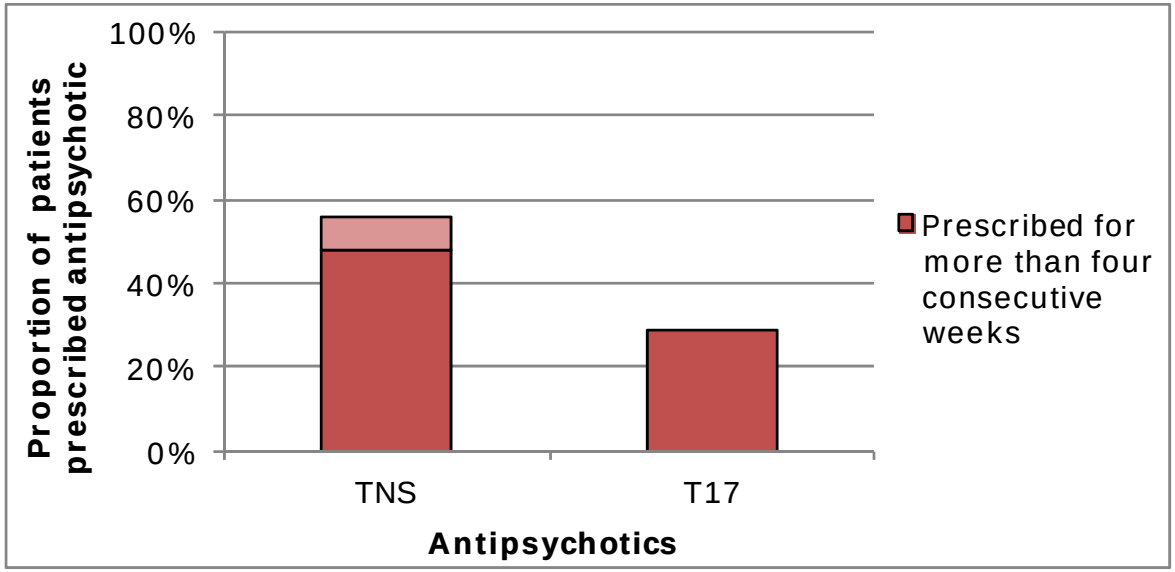
National and Trust level results for Standard 3: proportion of patients for whom the clinical reasons for prescribing the most recently initiated antipsychotic were documented

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

National and Trust level results for Treatment targets 1

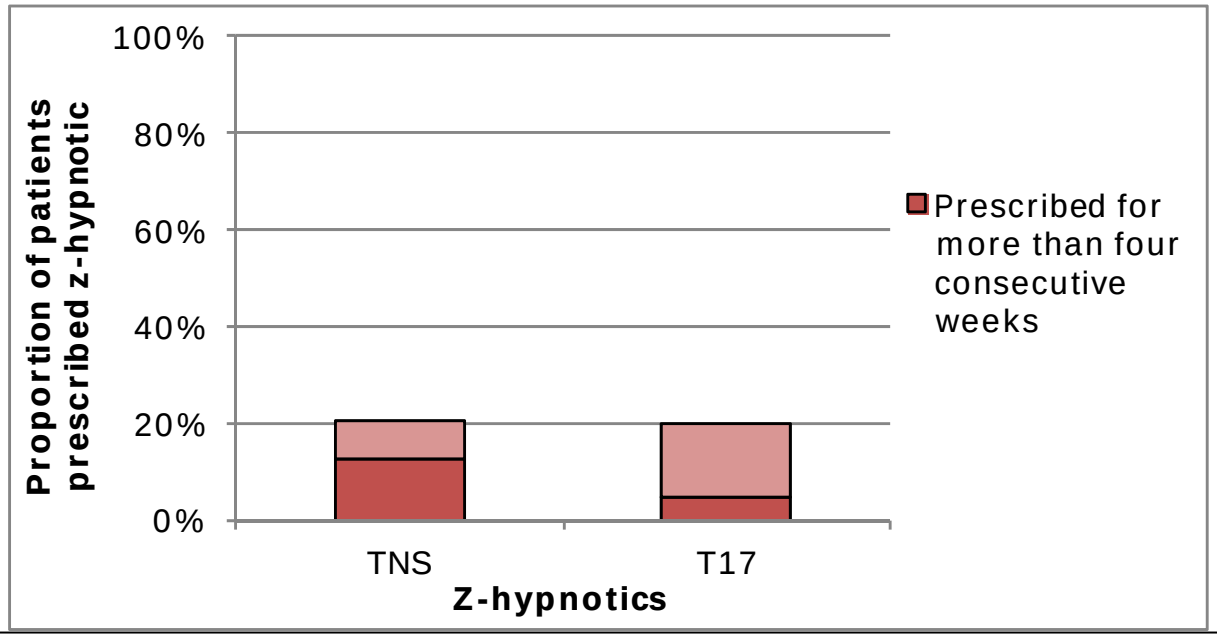


Treatment target 1: proportion of patients with a PD diagnosis alone (i.e. no co-morbid psychiatric diagnosis) prescribed antipsychotics

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

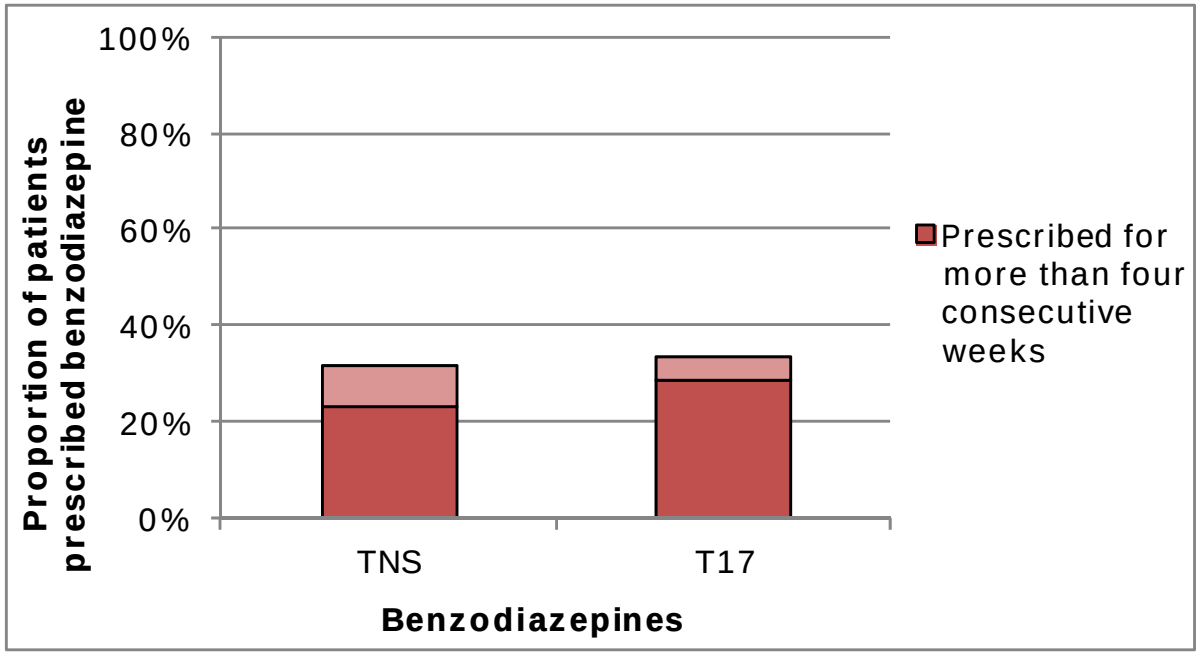
The British Psychological Society

National and Trust level results for Treatment targets 2

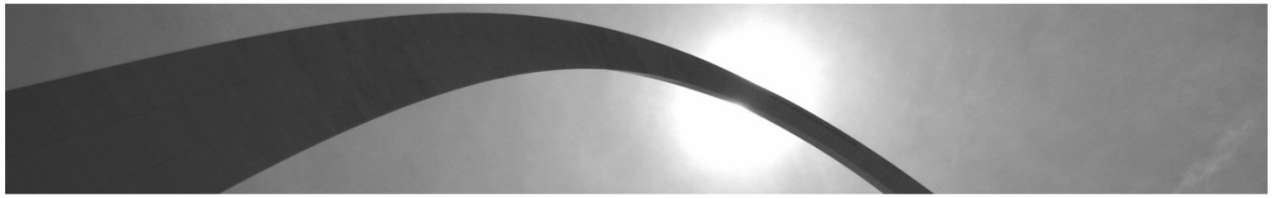


Treatment target 2: proportion of patients with a PD diagnosis alone (i.e. no co-morbid psychiatric diagnosis) prescribed z-hypnotics

National and Trust level results for Treatment targets 3



Treatment target 3: proportion of patients with a PD diagnosis alone (i.e. no co-morbid psychiatric diagnosis) prescribed benzodiazepines



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

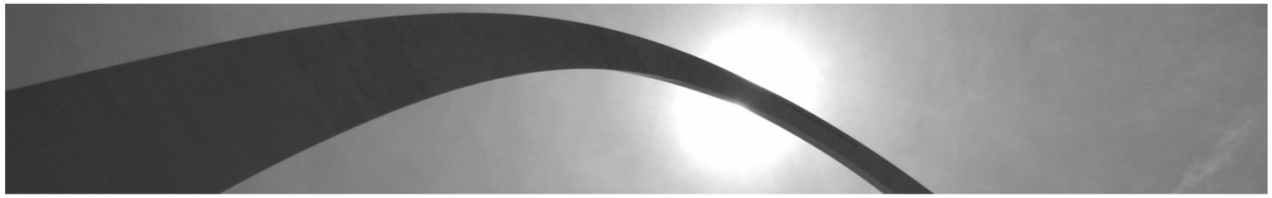
National and Trust level results for Treatment target 4

Treatment target 4: review of medication prescribed for more than four weeks

	Proportion prescribed medication for more than four weeks	Proportion of those patients prescribed medication for more than four weeks with documented evidence of a medication review	Proportion of medication reviews considering:		Outcome of medication review documented
			Therapeutic response	Side effects/tolerability	Yes, clearly or partially documented
TNS	82%	82%	84%	65%	94%
T17	89%	78%	91%	60%	98%

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



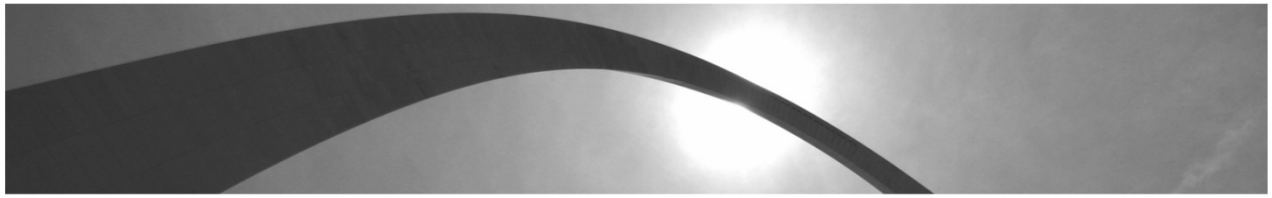
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Patient demographics and clinical characteristics

Key demographic characteristics		Baseline	
		n	%
Gender	Female	1533	59%
	Male	1067	41%
Ethnicity	White/White British	2281	88%
	Black/Black British	81	3%
	Asian	57	2%
	Mixed or other	46	2%
	Not specified or unknown	135	5%
Clinical setting*	General adult – inpatient	199	8%
	General adult – outpatient	1426	55%
	Specialist personality disorder service - inpatient	52	2%
	Specialist personality disorder service - outpatient	260	10%
	Forensic – inpatient	382	15%
	Forensic – outpatient	53	2%
	Forensic specialist personality disorder service - inpatient	261	10%
	Forensic specialist personality disorder service - outpatient	14	<1%
	Other setting	21	1%
Age	Mean age in years (SD)	39 (11.8)	
	Min-max	18-78	
	16-25 years	402	16%
	26-35 years	651	25%
	36-45 years	749	29%
	46-55 years	564	22%
	56-65 years	180	7%
	66 years and over	54	2%

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Patient demographics and clinical characteristics continued

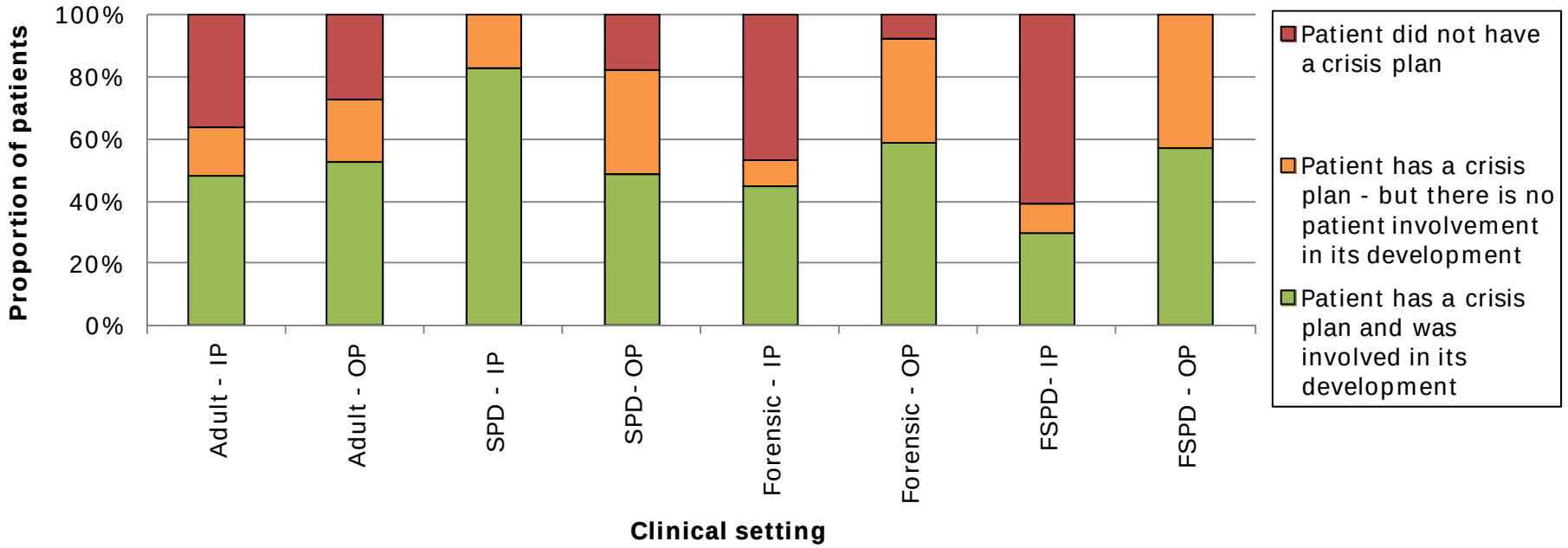
	Key demographic characteristics	N	%
Subtype of personality disorder diagnosis: ICD-10 category*	F60.0: Paranoid personality disorder	152	6%
	F60.1: Schizoid personality disorder	44	2%
	F60.2: Dissocial personality disorder	484	19%
	F60.3: Emotionally unstable borderline personality disorder	1776	68%
	F60.4: Histrionic personality disorder	44	2%
	F60.5: Anankastic personality disorder	29	1%
	F60.6: Anxious avoidant personality disorder	102	4%
	F60.7: Dependent personality disorder	73	3%
	F60.8: Other specific	33	1%
	F60.9: Personality disorder, unspecified	141	5%
	F61: Mixed and other personality disorders	140	5%
	Sub-type not yet determined	78	3%
	More than one personality disorder diagnosis	356	14%
Other ICD-10 diagnoses*	F00-F09: Organic, including symptomatic, mental disorders	18	<1%
	F10-F19: Mental and behavioural disorders due to psychoactive substance use	324	13%
	F20-F29: Schizophrenia, schizotypal and delusional disorders	406	16%
	F21: schizotypal disorder subgroup n=54 (13%)		
	F30-F39: Mood (affective) disorders	609	23%
	F31: bipolar disorder subgroup n=135 (22%)		
	F40-F48: Neurotic, stress-related and somatoform disorders	266	10%
	F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors	87	3%
	F70-F79: Mental retardation	107	4%
	F80-F89: Disorders of psychological development	29	1%
	F90-F98: Behavioural and emotional disorders with onset occurring in childhood and adolescence	64	3%
	F99: Unspecified mental disorder	4	<1%
	None documented	1054	41%
	Other	49	2%
Crisis plan in the clinical records	Yes	1759	67%
	No	841	32%

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Crisis plan: across clinical settings

Audit standards

1. There is a written crisis plan in the clinical records.
2. There is evidence that the patient's views have been sought in the development of the crisis plan.



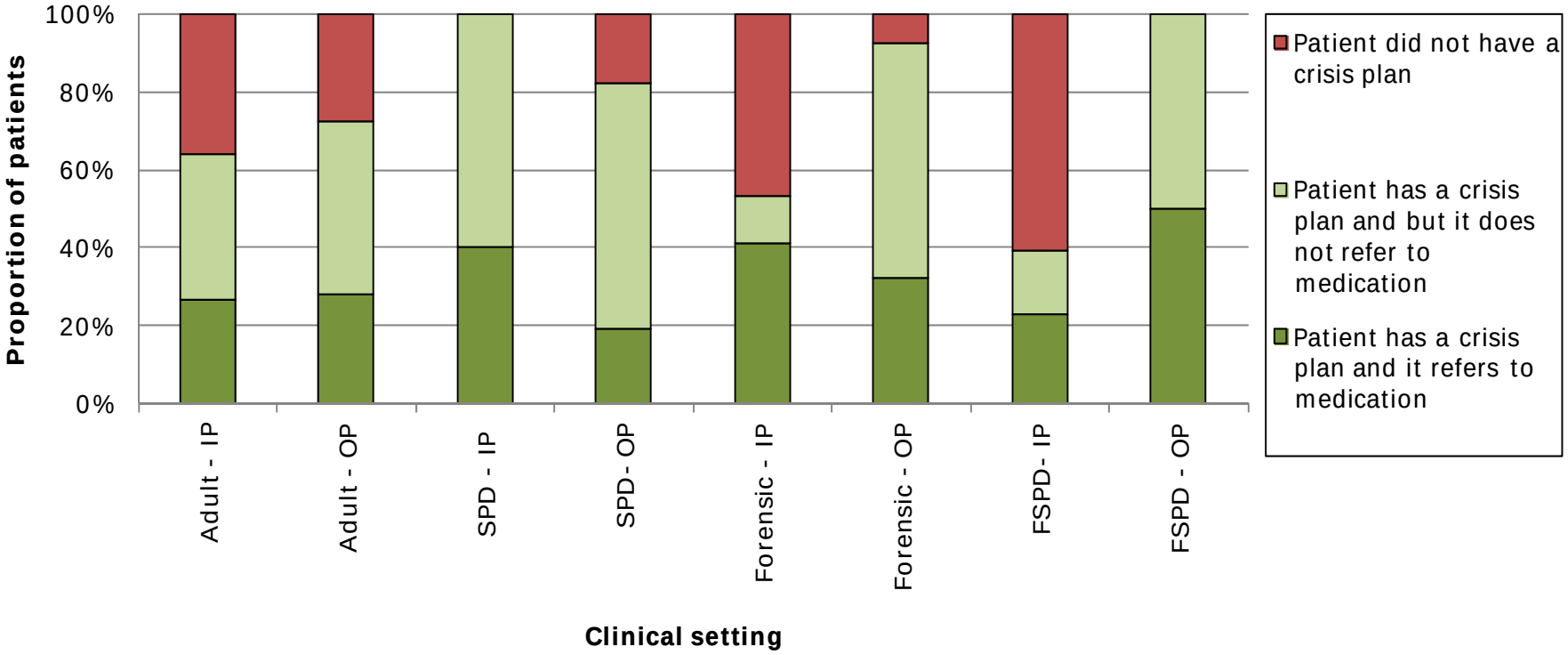
Key: IP = inpatients, OP =outpatients, SPD= specialist personality disorder, FSPD = forensic specialist personality disorder

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

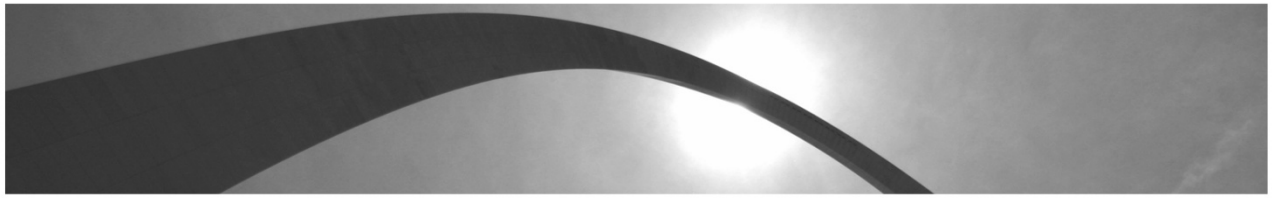
Reference to medication in the crisis plan



Key: IP = inpatients, OP =outpatients, SPD= specialist personality disorder, FSPD = forensic specialist personality disorder

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Clinical reasons for prescribing across the four groups of medication – for PD alone

	Antidepressant n=1746	Antipsychotic n=1720	Mood stabiliser n=655	Sedative n=1327
	Personality disorder alone n=679	Personality disorder alone n=578	Personality disorder alone n=210	Personality disorder alone n=452
Affective / emotional instability	21%	41%	71%	8%
Aggression / hostility	2%	24%	15%	15%
Anxiety (including phobic anxiety and panic)	25%	23%	7%	41%
Depressive symptoms	71%	10%	1%	2%
Distress	10%	16%	8%	22%
Disturbed sleep	12%	11%	2%	59%
Epilepsy	-	-	6%	-
Impulsivity	5%	18%	13%	5%
Known or suspected psychotic illness	0	7%	1%	<1%
Self harm; deliberate / repeated	11%	18%	14%	7%
Transient psychotic-like experiences or symptoms	<1%	23%	2%	1%
Patient request	4%	6%	3%	7%
Long-term treatment – reason unclear	7%	7%	4%	4%
Other*	13%	17%	8%	10%
Not known	10%	12%	11%	10%

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

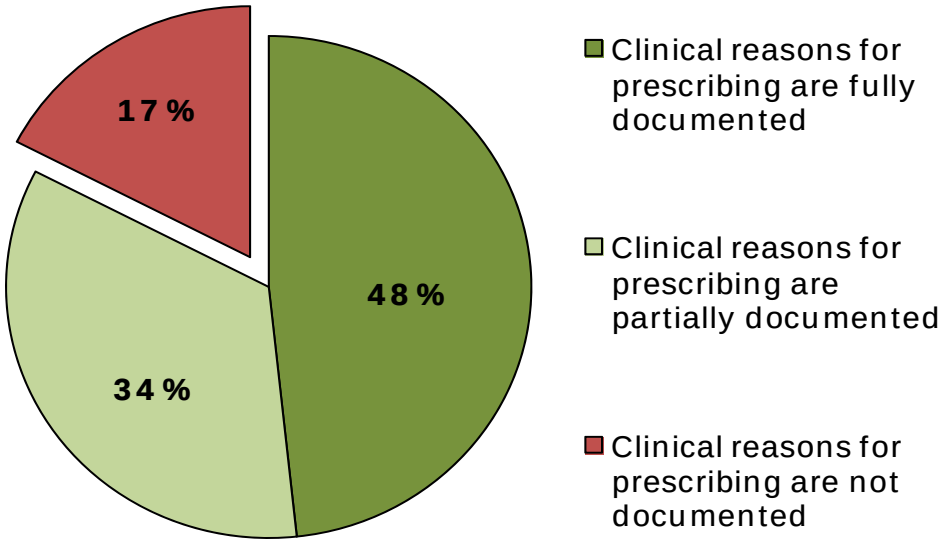
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Documentation of clinical reasons for prescribing the most recently initiated antipsychotic

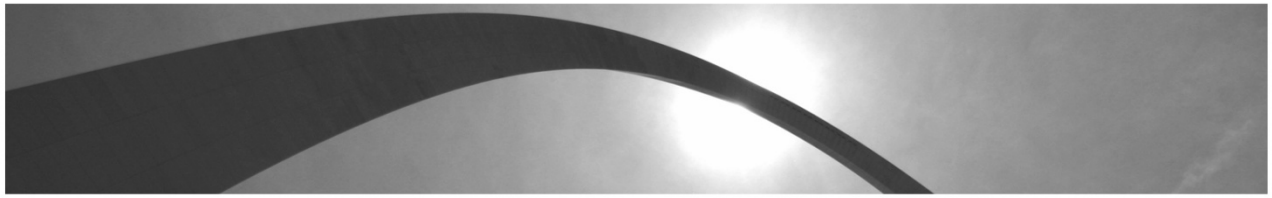
Audit standard

3. A clinician's reasons (i.e. target symptoms or behaviour) for prescribing antipsychotic medication are documented in the clinical records.



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



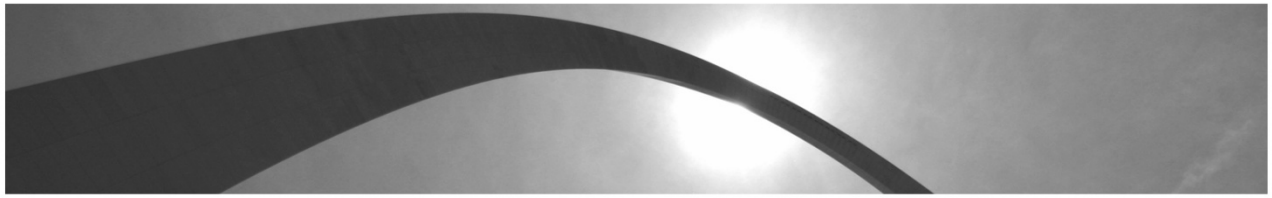
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Medications prescribed for patients with and without co-morbid psychotic or affective disorder

	No medications prescribed	Prescribed at least one medication	Antipsychotic	Antidepressant	Mood stabiliser	Sedative
Any personality disorder diagnosis only n=1054	193 (18%)	861 (82%)	579 (55%)	679 (64%)	210 (20%)	452 (43%)
Any personality disorder with psychotic illness n=485	10 (2%)	475 (98%)	457 (94%)	242 (50%)	220 (45%)	271 (56%)
Any personality disorder with affective disorder n=606	12 (2%)	594 (98%)	411 (68%)	515 (85%)	199 (33%)	347 (57%)

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Medication review for patients prescribed any medication for more than four consecutive weeks

Proportion with documented evidence of a medication review	Evidence that medication review considered:				Outcome of medication review clearly documented		
	Therapeutic response	Side effects/tolerability	Patient's views sought	Adherence	Yes, clearly documented	Yes, partially documented	Not documented
1,744 (82%)	1,471 (84%)	1,135 (65%)	1,300 (74%)	947 (54%)	1,211 (69%)	441 (25%)	92 (5%)

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Trust level findings

Analyses presented in this section were conducted for each Trust individually and for the total sample to allow benchmarking.

Data from each Trust are presented by code.

Your Trust code is 17

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

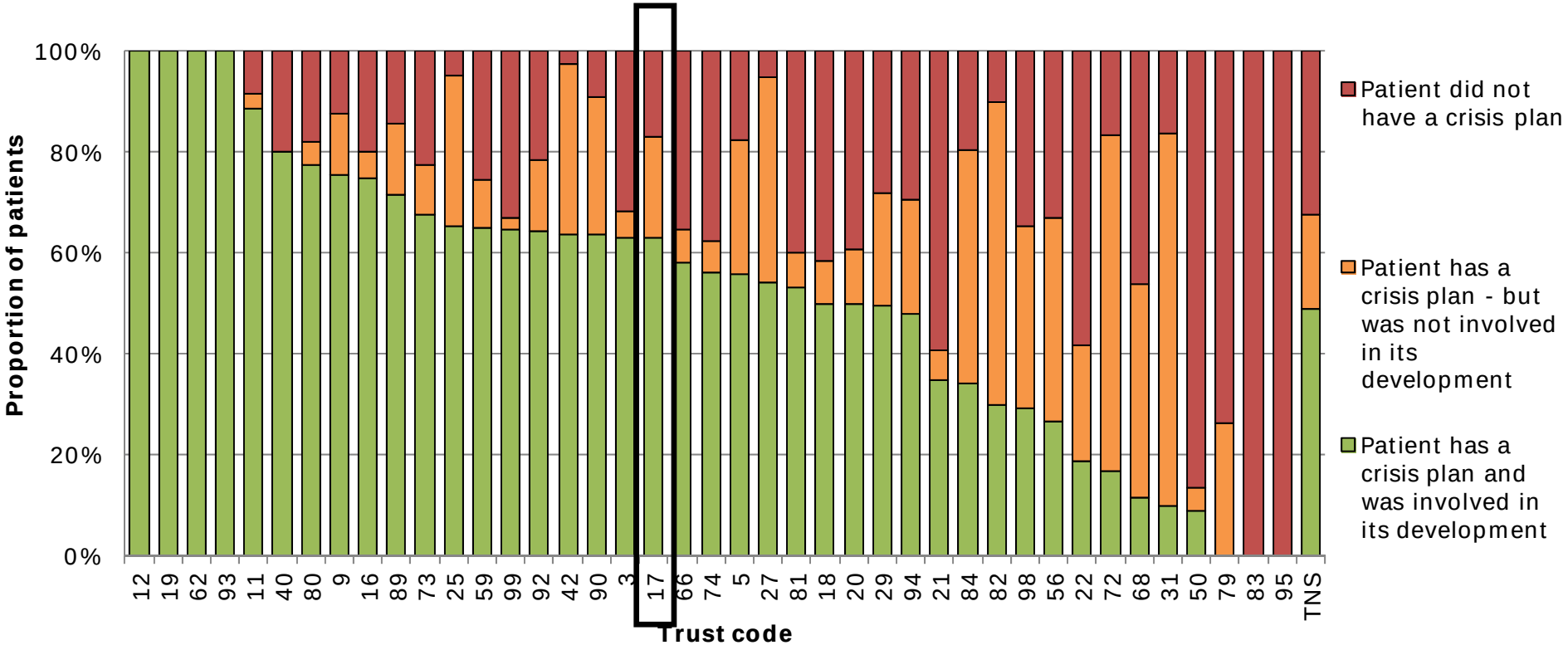
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Crisis plan

Audit standards

1. There is a written crisis plan in the clinical records.
2. There is evidence that the patient's views have been sought in the development of the crisis plan.

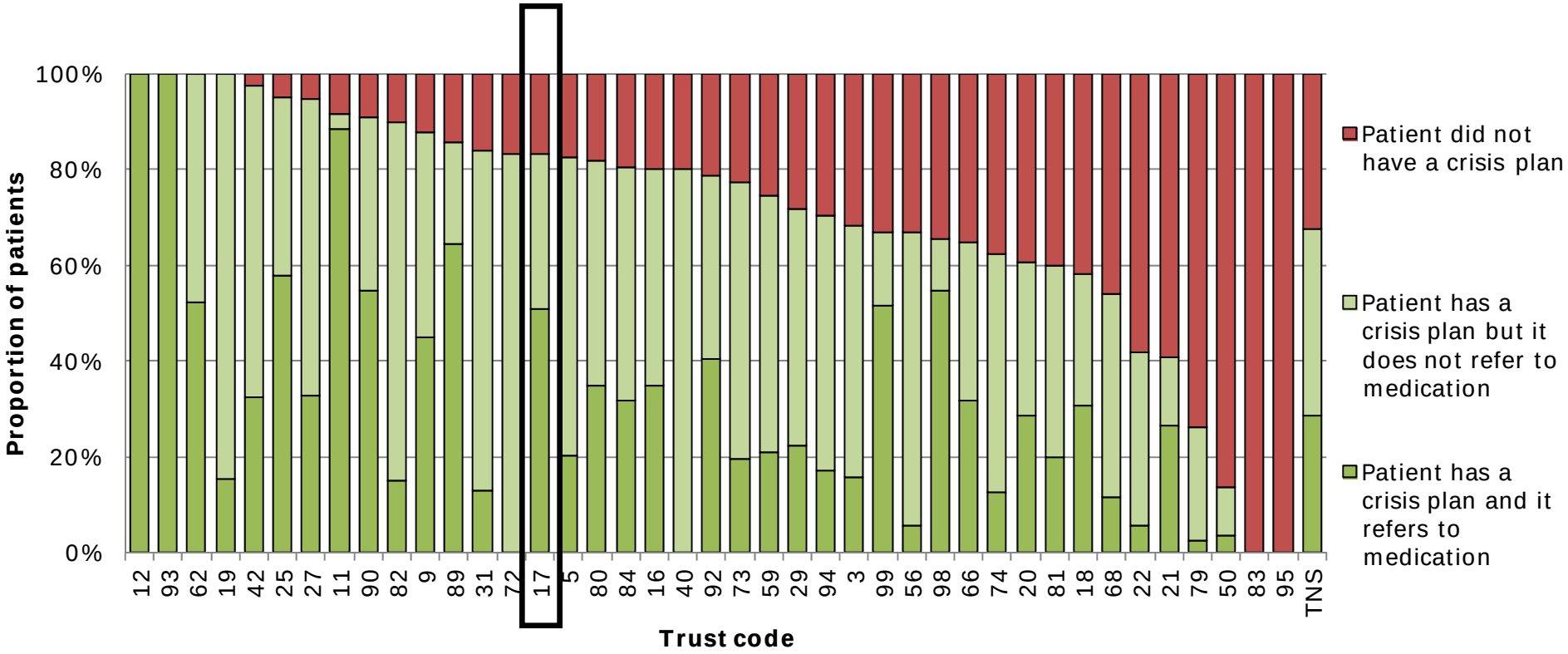


PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Reference to medication in the crisis plan



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

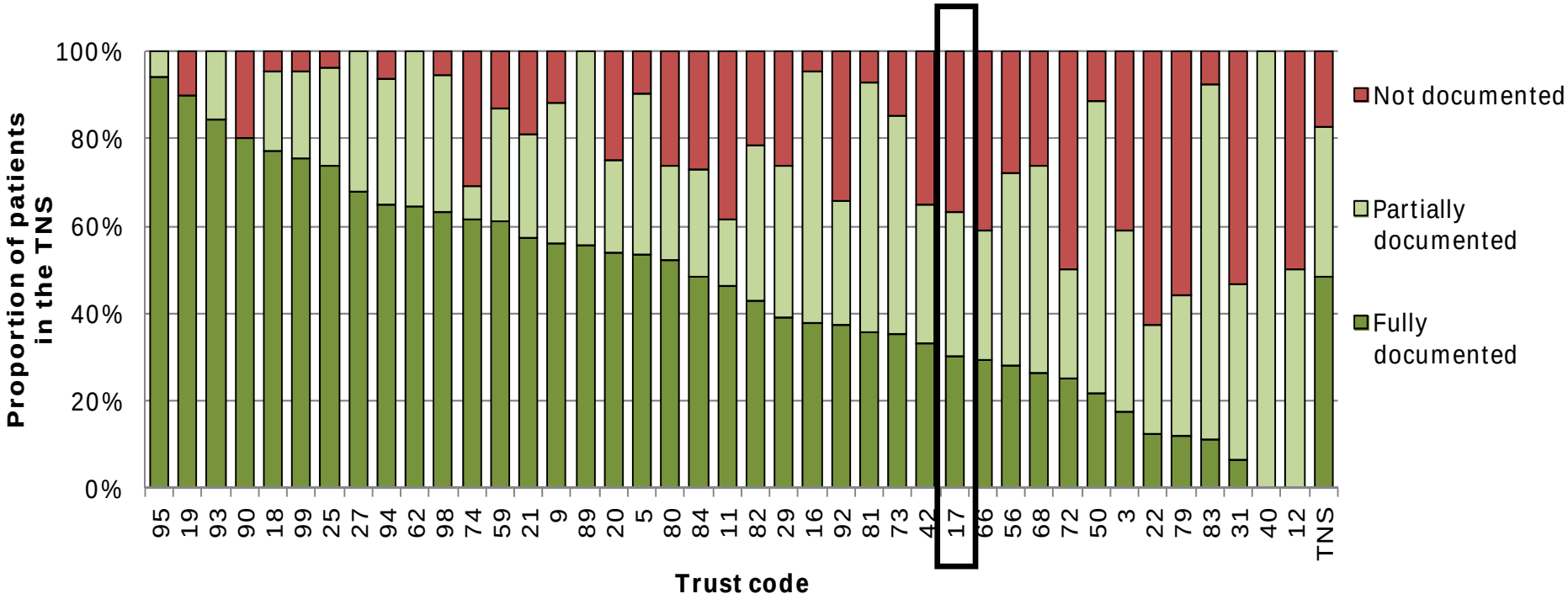
The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Documentation of clinical reasons for prescribing the most recently initiated antipsychotic

Audit standard

3. A clinician's reasons (i.e. target symptoms or behaviour) for prescribing antipsychotic medication are documented in the clinical records.



PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

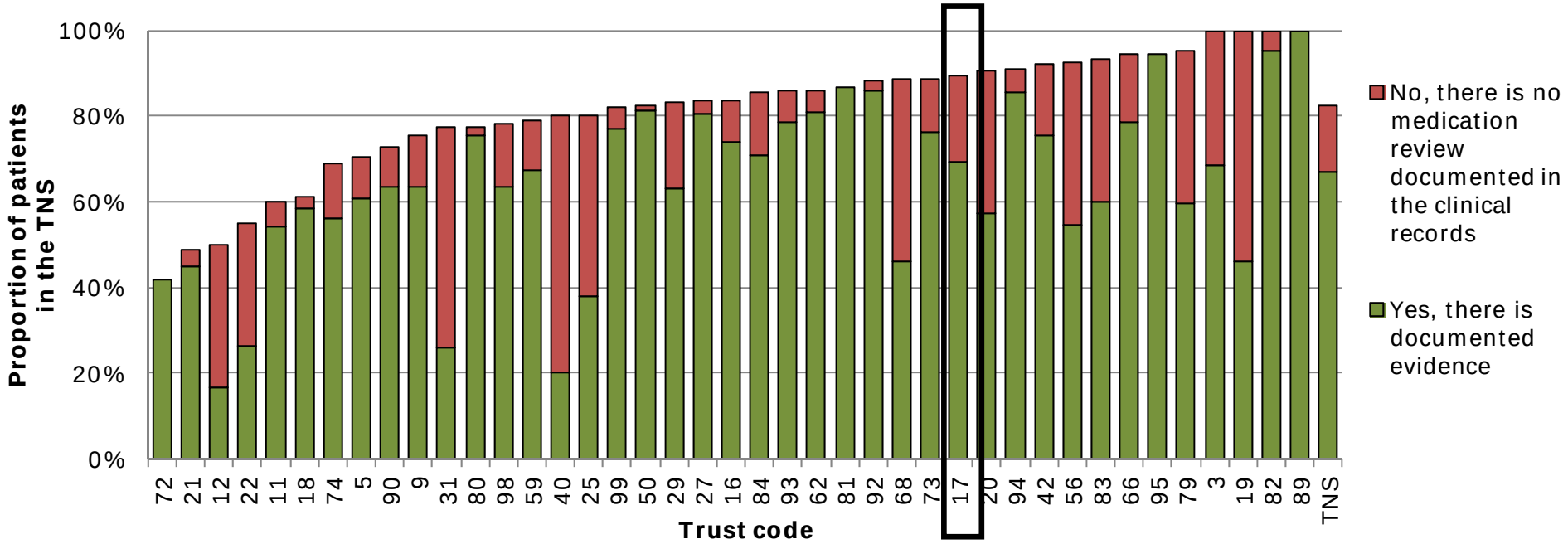
British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Proportion of patients prescribed any medication for more than four weeks and documented evidence of a medication review

Treatment target

4. Medication prescribed for more than four consecutive weeks should be reviewed



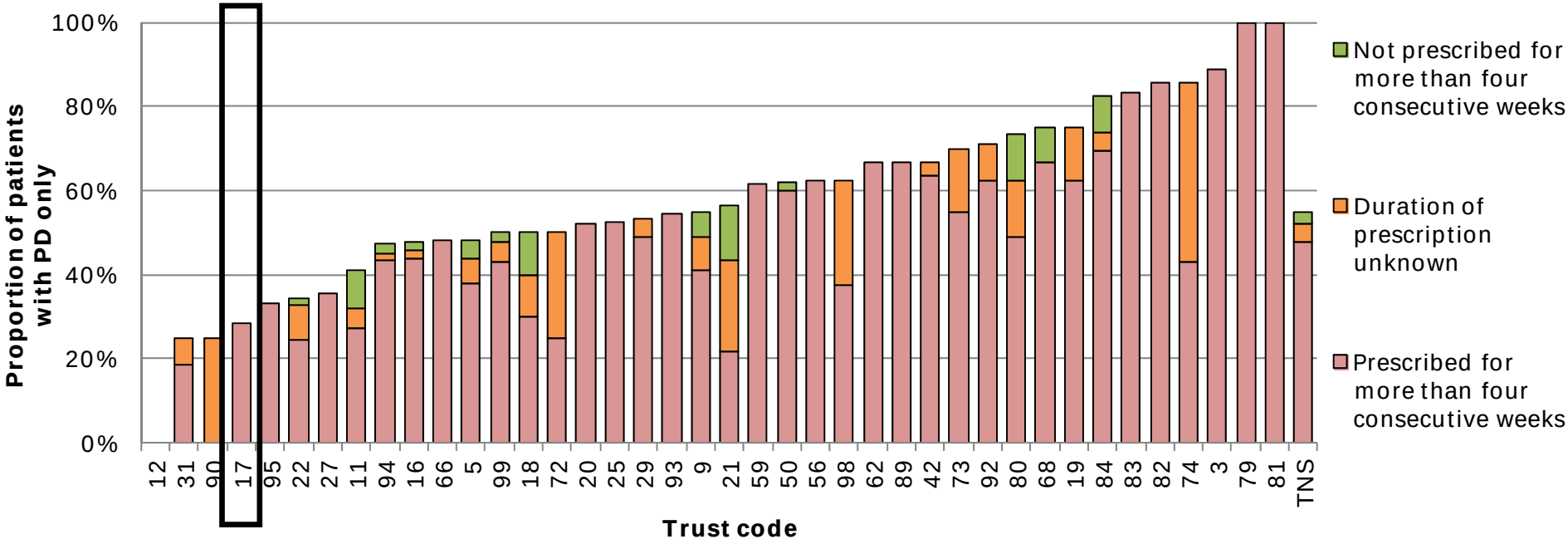
PSYCH ROYAL COLLEGE OF PSYCHIATRISTS Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Patients with personality disorder alone prescribed at least one antipsychotic and length of prescription

Treatment target

1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.



PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

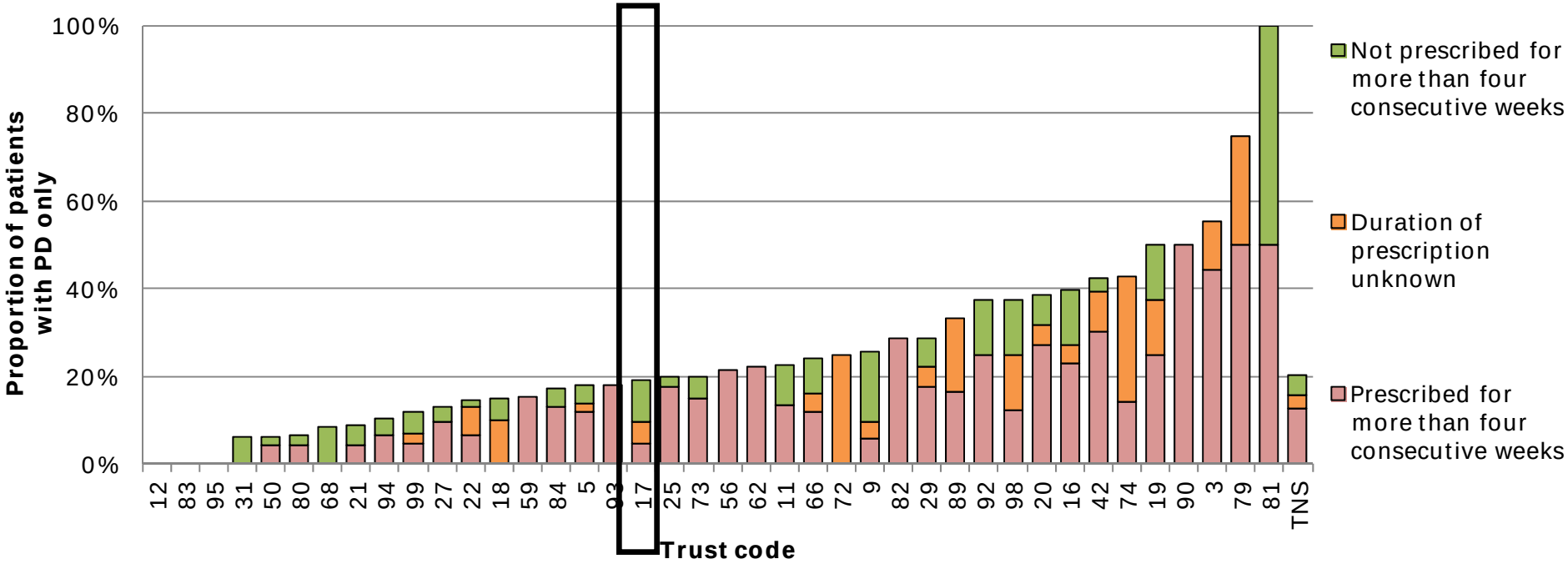
British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Patients with personality disorder alone prescribed at least one z-hypnotic and length of prescription

Treatment targets

2. Z-hypnotics should not be prescribed for more than four consecutive weeks.

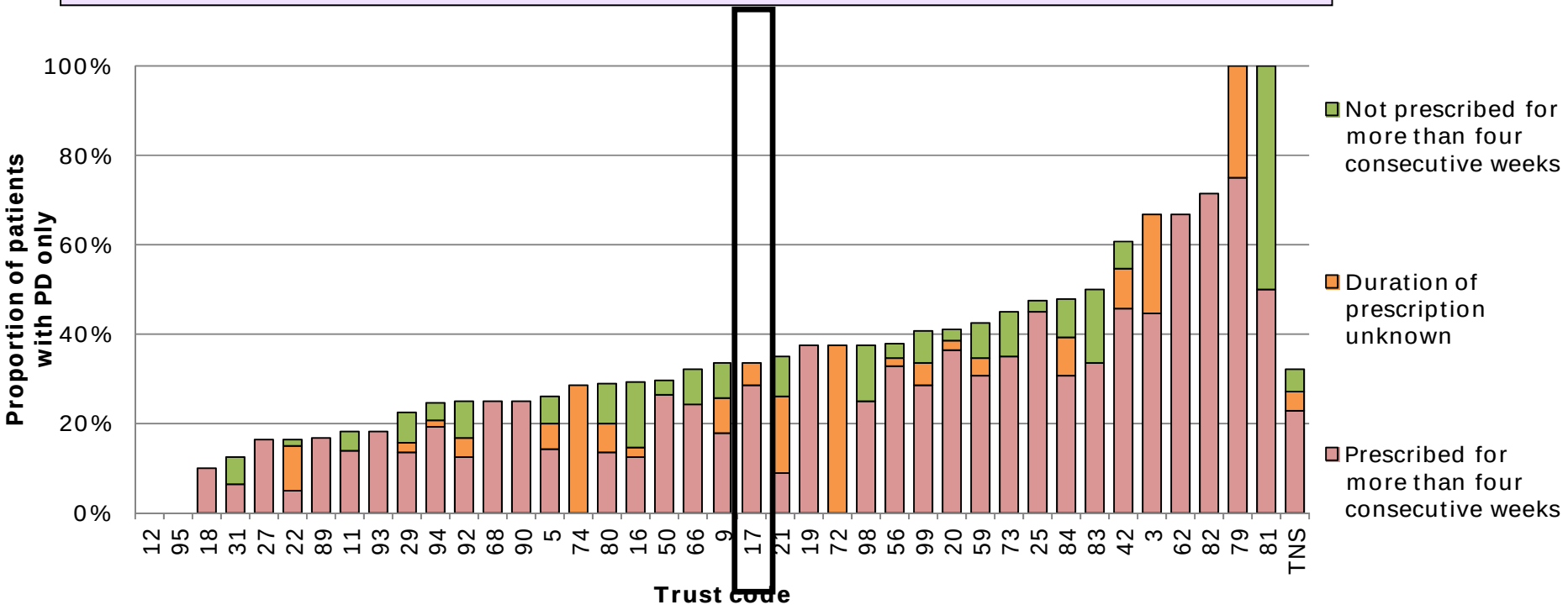


NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Patients with personality disorder alone prescribed at least one benzodiazepine and length of prescription

Treatment targets

3. Benzodiazepines should not be prescribed for more than four consecutive weeks.



RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

What happens next...

- **Discussions** within your Trust/team about your own practice.

- **Trust action planning** – a template is included in the report.

- POMH will develop bespoke **change interventions** including opportunities for sharing good practice between services.

- A **re-audit** will be conducted in October 2013

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The British Psychological Society