The NICE guidelines for Borderline Personality Disorder were first published in 2009. These followed on from No Longer A Diagnosis of Exclusion which came out in 2003. While this highlighted the discrimination of people labelled with this diagnosis, the NICE guidelines were explicit about what organisations needed to do to provide a quality service. Perhaps not explicit enough as it turns out: almost 1 in 10 trusts opt to ignore the guidance about setting up specialist services for those with this label and barely half offer equal access to the services they have put together. There are excellent services in some areas; however others have merely paid lip service to the guidelines. While NICE talk a little more about diagnosis than we would like, the aim of their guidance is to improve the experience of mental health services for those labelled with a BPD diagnosis. This is our aim too. If you’ve just been given this diagnosis please read something else and take heart that there is an evidence base for things that can help you. You may well be in an area where you’re able to get useful help and support. If you’ve lived with the label for a while this might, sadly, seem a bit more familiar...

These 'Not so NICE guidelines to Borderline Personality Disorder' are the result of a collaboration between a clinician and a service user. Both have extensive experience of BPD - the clinician having worked in a number of specialised teams and the service user having experience of accessing mental health services with a diagnosis of BPD. Research estimates 30% community mental health patients have a diagnosis of personality disorder (Coid et al 2006) with 10% of psychiatric outpatients and 20% of psychiatric inpatients meeting the diagnostic criteria for BPD (NHS 2013). However BPD is a contentious diagnosis which many argue, as a construct, is invalid. The notion of personality disorder is highly stigmatised and challenged. Those with a BPD diagnosis tend to be viewed as difficult to work with - their learned behaviours and means of coping in the face of their life experiences are often interpreted as attention seeking and manipulative by staff: why else would somebody wilfully choose to cut their arms or burn themselves with cigarette ends...? Because such ways of being were often laid down in childhood in the face of traumatic experiences they are well engrained making change difficult - this is often interpreted as non engagement or an inability to recover by staff. Despite 85% of those labelled with BPD reporting a history of childhood trauma (Christmas 2008) the link between trauma and what are classed as BPD symptoms is rarely reflected in treatment approaches. How we experience the world contributes to shaping who we are and how we interact. BPD patients frequently report a lack of knowledge and understanding by mental health staff and certainly within community mental health services and on the wards derogatory comments and language can be heard when discussing 'pd'. This only perpetuates the negative experiences of the so called 'care' patients receive. Currently community mental health services are made up of professionals whose training did not cover what the medical model terms 'personality disorder' or the difficulties this umbrella term covers.

Services are overwhelmed and tend to be set up to assess and treat with time limited interventions. This way of working is not suitable for people who have difficulties with trust, have little expectation they can make change and who take time to build rapport. Indeed NICE guidelines advise against any intervention under 3 months for those with a personality disorder diagnosis.

A lack of training, a load of stigma and services set up in a way that does not take into account the needs of BPD labelled patients leads to a significant lack of effective and suitable support. NICE guidelines do exist to guide commissioners and service developers on how to develop specific services for this group but we both find this is rarely put into practice. Where personality disorder...
services do exist they tend to be a dumping ground for 'complex', 'difficult', 'beyond hope' patients. Generic services have written off.

Most staff who join the NHS do it because they want to help people. To be able to stay compassionate and empathic when faced with extreme emotion and self injury takes a lot of work. With little preparation to meet the needs of the client group, with services at breaking point and with little space to be able to process the difficulties of the job it is understandable that staff blame service users for how they 'make' them feel, and thus become punitive or defensive in their practice or try to keep away. It may be understandable but it is in no way acceptable. For the 10% of those with a BPD label who will die by suicide, for the 1 in 50 people going to A&E with self harm who will be dead within the year, a change needs to come.

So considering all of the above the following is what Personality Disorder services look like - we offer a more accurate reflection of how NICE guidelines are implemented (or not) in our experience. We hope you can’t (but expect you will be able to) relate.

References:


1.1 General principles for working with people with borderline personality disorder

1.1.1 Access to services

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

1.1.1.3 Ensure that people with borderline personality disorder from black and minority ethnic groups have equal access to culturally appropriate services based on clinical need.

1.1.1.4 When language is a barrier to accessing or engaging with services for people with borderline personality disorder, provide them with:

- information in their preferred language and in an accessible format
- psychological or other interventions in their preferred language
- independent interpreters.

1.1 General principles for NOT working with people with borderline personality disorder

1.1.1 Lack of access to services

1.1.1.1 People with borderline personality disorder should be excluded from services because they do not obviously have schizophrenia or bipolar. You can also use “They might become dependent”, “Services will only make them worse” or “They’ve been referred before and didn’t engage”.

1.1.1.3 Where all attempts to exclude fail, services should be populated almost exclusively by white females.

1.1.1.4 Any barrier to someone engaging with services is entirely located within that person. Use the “give an inch and they will take a mile” principle when considering how needs can be accommodated.
1.1.2 Borderline personality disorder and learning disabilities

1.1.2.1 When a person with a mild learning disability presents with symptoms and behaviour that suggest borderline personality disorder, assessment and diagnosis should take place in consultation with a specialist in learning disabilities services.

1.1.2.2 When a person with a mild learning disability has a diagnosis of borderline personality disorder, they should have access to the same services as other people with borderline personality disorder.

1.1.3 Autonomy and choice

1.1.3.1 Work in partnership with people with borderline personality disorder to develop their autonomy and promote choice by:

- ensuring they remain actively involved in finding solutions to their problems, including during crises
- encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make.

1.1.2 Borderline personality disorder and learning disabilities

1.1.2.1 When a person with a mild learning disability presents with symptoms and behaviour that suggest borderline personality disorder, assessment and diagnosis should immediately decline the referral and send to the LD team. (See the Drug and Alcohol Policy)

1.1.2.2 When a person with a mild learning disability has a diagnosis of borderline personality disorder, they, along with everyone else with borderline personality disorder, should be excluded from services.

1.1.3 Authority and choice

1.1.3.1 Work in dictatorship with people with borderline personality disorder to develop their passivity and promote choice by:

- ensuring they are informed that their choices are causing all the problems
- encouraging them to consider the one treatment option you have or nothing at all.
- “It’s your choice” should be repeated frequently and with relish when people react with intense emotion.
1.1.4 Developing an optimistic and trusting relationship

1.1.4.1 When working with people with borderline personality disorder:

- explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable
- build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable
- bear in mind when providing services that many people will have experienced rejection, abuse and trauma, and encountered stigma often associated with self-harm and borderline personality disorder.

1.1.4 Developing an hierarchical and inconsistent relationship

1.1.4.1 When you have failed to follow the above steps to avoid working with people with borderline personality disorder:

- Explain that there is nothing that can be done. Treatment, if there was any, can only be done by specialists and that the patient’s kids will have died of old age before they get to the end of the waiting list.
- Start by trying to signpost to a different service as soon as possible. Wear your pessimism and reluctance to do this work on your sleeve to avoid building any kind of rapport. Sigh audibly and sit with crossed arms and legs in a judgemental manner when the patient discloses their life experiences. Cancel appointments at a moment’s notice (or better yet, none at all) and follow up after a few weeks with a discharge letter citing non engagement.
- Replicate previous relationships by locating all problems within the individual (especially ones that appear in your relationship). Label any genuine display of emotion as attention seeking, manipulative or playing games. Explain any difficulties in making progress being due to the client ‘sabotaging’ or not wanting to get better. (It is essential not to examine these explanations in any detail). At any mention of abuse, send them to the local trauma counselling unit or refer them to a psychological coping skills group to dissect their most painful memories. Watch as their levels of self-injury explode.
The Not So NICE Guidelines for Borderline Personality Disorder  
A satirical overview by Lara Quinn and Erik

1.1.5 Involving families or carers
1.1.5.1 Ask directly whether the person with borderline personality disorder wants their family or carers to be involved in their care, and, subject to the person's consent and rights to confidentiality:
- encourage family or carers to be involved
- ensure that the involvement of families or carers does not lead to withdrawal of, or lack of access to, services
- inform families or carers about local support groups for families or carers, if these exist.

1.1.6 Principles for assessment
1.1.6.1 When assessing a person with borderline personality disorder:
- explain clearly the process of assessment
- use non-technical language whenever possible
- explain the diagnosis and the use and meaning of the term borderline personality disorder
- offer post-assessment support, particularly if sensitive issues, such as childhood trauma, have been discussed.

1.1.5 Excluding families or carers
1.1.5.1 Ask directly whether the person labelled with borderline personality disorder wants their family or carers to be involved in their care, and, subject to the person's consent and rights to confidentiality:
- Either refuse to tell the family/carer anything, including information that they already know OR divulge everything under the pretence of safeguarding. Ensure that not one syllable voiced by the client is withheld from their family, friends and employers. Consider using social media to communicate secrets more effectively.
- If the involvement of families or carers will lead to withdrawal of, or lack of access to services pursue it with all the resources at your disposal.
- Build false expectations of support by offering a carer's assessment. Inform families or carers that you have no idea about local support groups for families or carers, if these exist.

1.1.6 Principles for assessment
1.1.6.1 When stuck with assessing a person with borderline personality disorder:
- Drearily go through the motions of assessment with a particular emphasis on reasons not to offer help.
- use non-technical language whenever possible to hide your ignorance of this diagnosis.
- Make your gut feeling sound informed by using the term personality disorder and whatever myths you’ve picked up over the years. Try to explain that this isn’t a real illness and is ‘just behaviour’.
- Chase the client from the building and lock the doors behind them.
1.1.7 Managing endings and supporting transitions

1.1.7.1 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder. Ensure that:

- such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased;
- the care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis;
- when referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.

1.1.8 Managing self-harm and attempted suicide

1.1.8.1 Follow the recommendations in 'Self-harm' (NICE clinical guideline 16) to manage episodes of self-harm or attempted suicide.

1.1.8 Accelerating endings and instigating abandonment

1.1.8.1 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder. This is medically known as sabotage. Ensure that:

- Discharge or a change of worker happens with no notice at all: Use the principle of the ‘short, sharp shock’ to elicit strong emotional reactions thus confirming the patient is sabotaging their recovery;
- the care plan, if it is ever written, is a secret document never to be shown to anyone. If it must be shown, ensure it has meaningless phrases like “increase self-esteem” or “monitor mental health”;
- referring a person for assessments in other services (including for psychological treatment) is as good as a cure. Use the ‘out of sight, out of mind’ principle here. If entirely unavoidable see them as little as possible and be sure to convey that this contact is tokenistic, merely to tick a box rather than provide anything useful. Or anything at all.

1.1.8 Managing self-harm and attempted suicide

1.1.8.1 Follow the recommendations in 'Self-harm' (NASTY clinical guideline 16) to manage episodes of self-harm or attempted suicide.

Label all self-harm as attention seeking. Mock any suicidal behaviour for not working, unless it works. In which case it should then be labelled a cry for help gone wrong.
1.1.9 Training, supervision and support

1.1.9.1 Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline. Training should also be provided for primary care healthcare professionals who have significant involvement in the assessment and early treatment of people with borderline personality disorder. Training should be provided by specialist personality disorder teams based in mental health trusts (see recommendation 1.5.1.1).

1.1.9.2 Mental health professionals working with people with borderline personality disorder should have routine access to supervision and staff support.

1.1.9 Training, supervision and support

1.1.9.1 Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with the folklore, myths and legends of the ‘old hands’ on the ward. Training should also be provided for primary care healthcare professionals who have significant involvement in the assessment and early treatment of people with borderline personality disorder as they will need to cope with the repeated rejection of all their referrals to other services. Training should be provided by specialist personality disorder teams based in mental health trusts often located near the unicorn enclosure or the porcine aviation unit. (see recommendation 1.5.1.1).

1.1.9.2 Mental health professionals working with people with borderline personality disorder should have an echo chamber to confirm and strengthen any stigma, prejudices or punitive attitudes towards this client group. Fostering the most damning interpretation of a client’s behaviour is the ideal way to keep staff feeling competent and effective. The concept that staff may play a part in the client’s difficulties must never be spoken of. If the client suggests this is possible identify this as a sign of mental disorder.
1.2 Recognition and management in primary care

1.2.1 Recognition of borderline personality disorder

1.2.1.1 If a person presents in primary care who has repeatedly self-harmed or shown persistent risk-taking behaviour or marked emotional instability, consider referring them to community mental health services for assessment for borderline personality disorder. If the person is younger than 18 years, refer them to CAMHS for assessment.

1.2.2 Crisis management in primary care

1.2.2.1 When a person with an established diagnosis of borderline personality disorder presents to primary care in a crisis:

- assess the current level of risk to self or others
- ask about previous episodes and effective management strategies used in the past
- help to manage their anxiety by enhancing coping skills and helping them to focus on the current problems
- encourage them to identify manageable changes that will enable them to deal with the current problems
- offer a follow-up appointment at an agreed time

1.2 Recognition and management in primary care

1.2.1 Recognition of borderline personality disorder

1.2.1.1 If a person presents in primary care who has repeatedly self-harmed or shown persistent risk-taking behaviour or marked emotional instability, consider referring them to community mental health services if you are feeling particularly malevolent. If in a kinder mood advise them nothing is going to happen unless they up their game in the suicide/self-harm area.

1.2.2 Crisis management in primary care

1.2.2.1 When a person with an established diagnosis of borderline personality disorder presents to primary care in a crisis:

- send to A&E
- identify as too risky
- refer to CMHT/CRHHT and enjoy the break
- use the principle of ‘they’re always someone else’s business’ – it can be very useful here.
1.2.3 Referral to community mental health services

1.2.3.1 Consider referring a person with diagnosed or suspected borderline personality disorder who is in crisis to a community mental health service when:

- their levels of distress and/or the risk to self or others are increasing
- their levels of distress and/or the risk to self or others have not subsided despite attempts to reduce anxiety and improve coping skills
- they request further help from specialist services.

1.3 Assessment and management by community mental health services

1.3.1 Assessment

1.3.1.1 Community mental health services (community mental health teams, related community-based services, and tier 2/3 services in CAMHS) should be responsible for the routine assessment, treatment and management of people with borderline personality disorder.

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1.2.3 Referral to community mental health services

1.2.3.1 Consider referring a person with diagnosed or suspected borderline personality disorder who is in crisis to a community mental health service when:

- You think they have BPD
- Your 6 week anxiety management group hasn’t undone a lifetime of trauma
- they request further help from specialist services: File this under “being dependent”. This will save the CMHT valuable time while rejecting the referral.

1.3 Assessment and management by community mental health services

1.3.1 Assessment

1.3.1.1 Community mental health services should consider themselves in no way responsible for the routine assessment, treatment and management of people with borderline personality disorder. Hold the dual position where their needs are either not severe enough or requiring of specialist treatment.
1.3.1.2 When assessing a person with possible borderline personality disorder in community mental health services, fully assess:

- psychosocial and occupational functioning, coping strategies, strengths and vulnerabilities
- comorbid mental disorders and social problems
- the need for psychological treatment, social care and support, and occupational rehabilitation or development
- the needs of any dependent children.

1.3.1.2 If you are doing an assessment consider yourself to have failed. When assessing, fully discount:

- If drugs or alcohol are a coping strategy immediately end the assessment, refer on to substance misuse services and high five your peers.
- coping strategies – these will, needless to say, be destructive and employed at will to manipulate those around them, including staff, into doing what they want. Be guarded, wary and suspicious at all times. Consider a second member of staff for backup for when the patient undoubtedly complains. Coping mechanism may include but not be limited to self-harm – cutting, burning, drinking alcohol excessively, drug use including misuse of prescription medications, excessive spending, threats to end their life or harm themselves in some way, being argumentative and inconsistent in their views of other people – idolising them one minute and despising them the next due to some perceived (yet imaginary) slight.
- The only strength will be a stubborn determinism to maintain things that they are doing ‘just for attention’ long beyond it seems to have any value or success in its aim.
- Social problems should be rebranded as ‘choices’.
- Comorbid mental disorders and social problems: consider anxiety, depression, eating disorders, PTSD, bipolar,
psychotic symptoms. But remember all of these are secondary to their fundamentally flawed personality.

- Look for ways to say no. Previous ‘non engagement’, the mildest of forensic histories, dependency, hostility...pretty much any identified symptom of BPD is a reason to decline.

- Once the patient has described a background where: others abandoned and hurt them, care was only allowed when physically injured, asking politely was never enough, they were worthless and unlovable, they were unable to succeed, that trust is always violated and that nothing can bring about change – inform them that they’re current presentation is in no way excusable or explicable by having had these experiences.
1.1.3.2 Care planning

1.3.2.1 Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person). The care plan should:

- identify clearly the roles and responsibilities of all health and social care professionals involved
- identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them
- identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims
- develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies and establishes how to access services when self-management strategies alone are not enough
- be shared with the GP and the service user.

1.3.2 Care planning

1.3.2.1 Teams working with people with borderline personality disorder should write box ticking, pre-printed care plans. The document masquerading as a care plan should:

- Have TAKE RESPONSIBILITY written in bold all over it.
- Absolve all health and social care professionals of any responsibility of being involved with the patient.
- Identify meaningless, non-realistic, clinician imposed short term treatment aims for the patient to independently work on. Do not specify how the patient may do this. To waste time, ink and paper doing so would be futile as it is obvious the patient will never achieve any aspect of any care plan.
- All of the above should be considered when identifying long-term goals. Even if the patient is able to articulate any long term goals these should be immediately discounted and in way used to underpin any long term treatment strategy as you are seeking to discharge these patients as soon as possible – anything else will only play into their tendency to become dependent: these patients are not going to be staying in your service.
1.3.2.2 Teams should use the CPA when people with borderline personality disorder are routinely or frequently in contact with more than one secondary care service. It is particularly important if there are communication difficulties between the service user and healthcare professionals, or between healthcare professionals.

- develop a crisis plan that identifies tea drinking, baths and walks, and establishes which services will reject you out of hours. Under no circumstances provide the duty or crisis CMHT phone numbers – to do so encourages dependence.

1.3.2.2 Teams should use CPA so they are aware of other services they can discharge to.
### 1.3.3 Risk assessment and management

**1.3.3.1 Risk assessment in people with borderline personality disorder should:**

- take place as part of a full assessment of the person's needs
- differentiate between long-term and more immediate risks
- identify the risks posed to self and others, including the welfare of any dependent children.

**1.3.3.2 Agree explicitly the risks being assessed with the person with borderline personality disorder and develop collaboratively risk management plans that:**

- address both the long-term and more immediate risks
- relate to the overall long-term treatment strategy
- take account of changes in personal relationships, including the therapeutic relationship.

**1.3.3.3 Risk assessment and management**

**1.3.3.1 Risk assessment in people with borderline personality disorder should:**

- be a coercive exercise in making someone say they can keep themselves safe.
- Place undue emphasis on something that happen once, in exceptional circumstances 20 years ago.
- Be a lecture around the client having capacity

**1.3.3.2 Listen to what the client thinks is a risk and tell them why they are wrong.**

**Write down:**

- That they said they could stay safe until (whichever professional you are passing responsibility onto) could see them.
- When deciding to take no action, be as vague as possible for the reasons behind this. Tell the client it is in their best interests but be sure not to elaborate why.
- dismiss changes in personal relationships, including the therapeutic relationship, as potentially increasing a persons’ risk. Remember the terms ‘attention seeking’ and ‘manipulative’ instead.
1.3.3.3 When managing the risks posed by people with borderline personality disorder in a community mental health service, risks should be managed by the whole multidisciplinary team with good supervision arrangements, especially for less experienced team members. Be particularly cautious when:

- evaluating risk if the person is not well known to the team
- there have been frequent suicidal crises.

1.3.3.4 Teams working with people with borderline personality disorder should review regularly the team members' tolerance and sensitivity to people who pose a risk to themselves and others. This should be reviewed annually (or more frequently if a team is regularly working with people with high levels of risk).

1.3.3.3 When managing the risks posed by people with borderline personality disorder in a community mental health service, risks should be managed by one person, if at all.

When:

- evaluating risk if the person is not well known to the team
- there have been frequent suicidal crises.

It is useful to use a “if you’ve seen one, you’ve seen them all” approach.

1.3.3.4 When allocating clients with BPD, it is useful to identify one team member who is viewed as soft by the others. They will eventually have a caseload entirely made up of people with BPD and the others can sneer at her efforts to be human and compassionate. When she goes off with stress the resulting back slapping and cries of “I told you so” can be wonderful for a team’s moral.

Team members who are more punitive and want to get a few digs in without the hassle of care coordinating can seize the opportunities that duty provides.
1.3.4 Psychological treatment

1.3.4.1 When considering a psychological treatment for a person with borderline personality disorder, take into account:

- the choice and preference of the service user
- the degree of impairment and severity of the disorder
- the person's willingness to engage with therapy and their motivation to change
- the person's ability to remain within the boundaries of a therapeutic relationship
- the availability of personal and professional support.

1.3.4.2 Before offering a psychological treatment for a person with borderline personality disorder or for a comorbid condition, provide the person with written material about the psychological treatment being considered. 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 them to discuss not only this information but also the evidence for the effectiveness of different types of psychological treatment for borderline personality disorder and any comorbid conditions.

1.3.4 Psychological treatment

1.3.4.1 Remember that you have absolutely nothing to offer and the answer only lies in other people. When desperately trying to pass the buck to psychological therapies consider:

- whether the client wants the one treatment on offer or discharge with nothing.
- Whether they are too risky for treatment aimed at reducing risks
- If the reason that they are here e.g. difficulty maintaining relationships, this could actually be a reason to deny them a service.

1.3.4.2 Before offering a choice of one psychological treatment or nothing, give them the vaguest overview of what it might entail. What you skip on detail you can dwell on with an emphatic insistence that this will work and that any failing of this ‘choice’ is entirely due to the service-user who will most likely sabotage any treatment attempt anyway. Advise them to google their condition and intervention. You may find that the quantity of online venom and pessimism around this diagnosis is enough to get them to opt out.
The Not So NICE Guidelines for Borderline Personality Disorder
A satirical overview by Lara Quinn and Erik

1.3.4.3 When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

- an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user
- structured care in accordance with this guideline
- provision for therapist supervision.

Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, twice-weekly sessions may be considered.

1.3.4.4 Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics outlined in 1.3.4.3.

1.3.4.5 For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme.

1.3.4.6 When providing psychological treatment to people with borderline personality disorder as a specific intervention in their overall treatment and care, use the CPA to clarify the roles of different services, professionals providing psychological treatment and other healthcare professionals.

1.3.4.7 Monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms of borderline personality disorder

1.3.4.3 When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

- a level of staffing that is farcical in proportion to the demand.
- A waiting list longer than the life expectancy of those waiting.
- a training plan that ensures therapists have no opportunity to develop their skills but do know how to wash their hands and identify terrorists.

The ‘what can I get away with principle’ is ideal for deciding the frequency of contact.

1.3.4.4 If people can be in and out of the service in 3 months, you may have failed at keeping them out but have managed their presentation well.

1.3.4.5 Because DBT is the only therapy mentioned explicitly in NICE guidelines, dogmatically insist that it is THE recommended treatment. Despite this, ensure DBT is not available. Where unavoidable, dilute the model until it is barely recognisable e.g. a 1 year treatment condensed into a 12 week group.

1.3.4.6 When psychological treatment for people with borderline personality disorder is miraculously being provided, take the opportunity to take a backward step. Reduce visits, avoid contact and ensure duty phone calls consist of a parrot like “talk about it in therapy”.

1.3.4.7 Do nothing to prepare someone with dangerous ways of coping for therapy, then feign surprise when reliving their most intense trauma results in a severe relapse. Discharge immediately. Pat yourself on the back for your assertion that ‘they weren’t ready’.
1.3.5.1 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).

1.3.5.2 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.

1.3.5.1 You did not go to medical school all those years only to faff about with ‘talking therapies’. There is a drug that will work, you need only be persistent enough. Remember Copernicus and do not let conventional wisdom hold you back from increasingly creative pharmaceutical cocktails.

1.3.5.2 Antipsychotic drugs should only be used for real psychosis, not these pantomime symptoms. Inform the patient of this and prescribe them anyway. More than 1 at a time shows true devotion.

1.3.5.3 A comorbid condition should be dismissed as malingering or a pathetic attempt to get medication.

1.3.5.4 Short-term use of sedative medication should be considered on a long term basis. Once began, all reported distress should be interpreted as an attempt to get more benzos and any paranoia treated aggressively with antipsychotics.

1.3.5.5 When considering drug treatment for any reason for a person with borderline personality disorder, give them the postage stamp sized leaflet of the evidence of its efficacy. In the absence of psychological therapy, collude with the patient in the idea that drugs are the answer.

1.3.5.6 Success has been achieved when the patients prescription looks less like the menu of a French bistro and more like that of a Chinese takeaway. If medication must be rationalised, do this all at once. Ward staff will be grateful of the opportunity to watch the patient’s chemical dependency and withdrawal play out in an inpatient setting.

Remember that massive sedation cures almost everything. Where huge doses of benzodiazepines over a short term 10 year period have been ineffective, clozaril is your friend. Weight gain and 16 hour sleep cycles are a small price to pay for huge increases in quality of life, for staff.
The Not So NICE Guidelines for Borderline Personality Disorder
A satirical overview by Lara Quinn and Erik

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.

1.3.6.1 Any and all medical complaints are simply manifestations of BPD. The sole exception to this is drug/alcohol addiction, which is a reason to refer on/discharge.
1.3.7 The management of crises

The following principles and guidance on the management of crises apply to secondary care and specialist services for personality disorder. They may also be of use to GPs with a special interest in the management of borderline personality disorder within primary care.

**Principles and general management of crises**

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.

1.3.7 The management of crises

Following this guideline should ensure frequent and severe crisis presentations. Better to manage these than waste resources on a structured, trauma informed service.

**Principles and general management of crises**

1.3.7.1 When a person labelled with borderline personality disorder presents during a crisis, think on the spot as if nothing like this has ever happened before:

- Panic. This is your job on the line now and this person could get you struck off
- Explain in condescending terms the 'mountain out of molehill' principle.
- dismiss the person's reasons for distress
- use all means at your disposal to get them to say something vaguely interpretable as 'I can keep myself safe'.
- Blame client for their situation.
- avoid validating the person's stated reasons for the crisis
- Drink, Bath, Trek (walk). This DBT approach should be used as soon as you hear the distress in their voice. Offer a solution that cannot be implemented until you are off duty.
- Do whatever you can to make this someone else’s problem. If the crisis team refuse to assess you’re covered.
- Advise to call back whenever. Someone else will be on then and the patient will find it cathartic to explain themselves again
<table>
<thead>
<tr>
<th>Drug treatment during crises</th>
<th>Drug treatment during crises</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term use of drug treatments may be helpful for people with borderline personality disorder during a crisis.</strong></td>
<td><strong>Ensure that after refusing all of the clients appropriate requests for help, you only give them what they originally asked for in response to potentially lethal behaviour. Label your bizarre behavioural approach as them being manipulative.</strong></td>
</tr>
<tr>
<td>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):</td>
<td></td>
</tr>
<tr>
<td>- ensure that there is consensus among prescribers and other involved professionals about the drug used and that the primary prescriber is identified</td>
<td>- Crisis time is a magical time where anything can happen. Take a punt on an off licence drug or make sweeping changes to long prescribed medications.</td>
</tr>
<tr>
<td>- establish likely risks of prescribing, including alcohol and illicit drug use</td>
<td>- Ignore the fact that people won’t go to the chemist every day to pick up drugs they don’t want. It means you won’t be blamed for their overdose.</td>
</tr>
<tr>
<td>- 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</td>
<td>- Undermine any talking therapy by medicalising their distress and giving medication for being appropriately sad. E.g. benzodiazapines work well for tolerating an abusive relationship</td>
</tr>
<tr>
<td>- ensure that a drug is not used in place of other more appropriate interventions</td>
<td>- ensure that a drug is not used in place of other more appropriate interventions that are not available.</td>
</tr>
<tr>
<td>- use a single drug</td>
<td>- use a single drug. Lots of them. All at once.</td>
</tr>
<tr>
<td>1.3.7.3 When prescribing short-term drug treatment for people with borderline personality disorder in a crisis:</td>
<td>- avoid polypharmacy whenever possible. This is a parrot like repetition of medications that haven’t helped before.</td>
</tr>
<tr>
<td>- choose a drug (such as a sedative antihistamine[^2] that has a low side-effect profile, low addictive properties, minimum potential for misuse and relative safety in overdose</td>
<td></td>
</tr>
<tr>
<td>- use the minimum effective dose</td>
<td></td>
</tr>
<tr>
<td>- prescribe fewer tablets more frequently if there is a significant risk of overdose</td>
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<tr>
<td>- agree with the person the target symptoms, monitoring arrangements and anticipated duration of treatment</td>
<td></td>
</tr>
<tr>
<td>- agree with the person a plan for adherence</td>
<td></td>
</tr>
<tr>
<td>- discontinue a drug after a trial period if the target symptoms do not improve</td>
<td></td>
</tr>
</tbody>
</table>

[^2]: Antihistamine refers to a class of medications used to relieve allergic symptoms.
Follow-up after a crisis

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 to reflect current concerns and identify which treatment strategies have proved helpful. This should be done 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.

Follow-up after a crisis

1.3.7.4 After a crisis has resolved or as much as they ever do with these people, chalk it up to experience, get back into the bunker and cross your fingers that it was a one off. This strategy should be employed regardless of how many crises there have been in the past. You may wish to think about:

- How the service user was to blame for what happened.
- Whether they abused or didn’t take their prescribed medication
- See them again in about a month by which point there’s no point changing meds.
- Whether there is anything that the service user can be blamed for that can result in discharge.

Under no circumstances should the notion that services may have played even a small part in instigating, escalating or prolonging the crisis be entertained.

Follow-up after a crisis

1.3.8 The management of insomnia

1.3.8.1 Provide people with borderline personality disorder who have sleep problems with general advice about sleep hygiene, including having a bedtime routine, avoiding caffeine, reducing activities likely to defer sleep (such as watching violent or exciting television programmes or films), and employing activities that may encourage sleep.

Follow-up after a crisis

1.3.8 The management of insomnia

1.3.8.1 If following this guideline correctly feeling sedated should not be a problem. They will probably sleep all day and be up terrified all night but that will generally be someone else’s problem.
1.3.9 Discharge to primary care

1.3.9.1 When discharging a person with borderline personality disorder from secondary care to primary care, discuss the process with them and, whenever possible, their family or carers beforehand. Agree a care plan that specifies the steps they can take to try to manage their distress, how to cope with future crises and how to re-engage with community mental health services if needed. Inform the GP.

1.4 Inpatient services

1.4.1.1 Before considering admission to an acute psychiatric inpatient unit for a person with borderline personality disorder, first refer them to a crisis resolution and home treatment team or other locally available alternative to admission.

1.4.1.2 Only consider people with borderline personality disorder for admission to an acute psychiatric inpatient unit for:

- the management of crises involving significant risk to self or others that cannot be managed within other services, or
- detention under the Mental Health Act (for any reason).

1.4.1.3 When considering inpatient care for a person with borderline personality disorder, actively involve them in the decision and:

- ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission
- you have said no again and again but they’ve ‘upped the ante’ so much you need to fold. This should ensure less wasted time next presentation as you subconsciously reinforce the idea that help is only available once risk is off the scale.

1.4.1.3 When trying to avoid inpatient care for a person with borderline personality disorder:

- ensure your reluctance is palpable OR hugely coercive. Try not to section them, but make it clear you will if they don’t toe the line.
1.4.1.4 Arrange a formal CPA review for people with borderline personality disorder who have been admitted twice or more in the previous 6 months.

1.4.1.5 NHS trusts providing CAMHS should ensure that young people with severe borderline personality disorder have access to tier 4 specialist services if required, which may include:

- inpatient treatment tailored to the needs of young people with borderline personality disorder
- specialist outpatient programmes
- home treatment teams.

1.5 Organisation and planning of services

1.5.1 The role of specialist personality disorder services within trusts

1.5.1.1 Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder and should:

- provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
- provide consultation and advice to primary and secondary care services
- offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder
- develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services.

1.4.1.4 Arrange a formal CPA review for people with borderline personality disorder as infrequently as possible. Build it up to be a radical, life changing experience before giving a “more of the same then” summary. The CPA experience can be enhanced by a locum doctor and an absent care coordinator.

1.4.1.5 NHS trusts providing CAMHS should ensure that young people with severe borderline personality disorder are discharged the moment they hit 18. If not discharged, the change from ‘a child to be cared for’ to ‘an adult with an almost survivalist sense of responsibility and independence’ should be as brutal, abrupt and disorientating as possible to promote maximum disengagement.

1.5 Disorganisation and planning of services

1.5.1.1 Mental health trusts shouldn’t develop multidisciplinary specialist teams and/or services for people with personality disorders. So far only 8% of you have managed to stick to this but the majority have made the teams inaccessible for many of your service users. Teams should:

- Provide a diagnostic service so that the people who have baffled you for months/years now have a new label. “What to call it” should be pursued more strongly than “How to respond to it”
- Be a dumping ground for those the CMHTs have been unable to reject. If someone with a BPD diagnosis does not meet the “particularly complex needs and/or high levels of risk” criteria of the specialist service this bizarrely is a reason not to let them into generic services either.
- Be totally isolated with no influence over anything other than the treatment service they offer.
• be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia

• work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services

• ensure that clear lines of communication between primary and secondary care are established and maintained

• support, lead and participate in the local and national development of treatments for people with borderline personality disorder, including multi-centre research

• oversee the implementation of this guideline

• develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline (see 1.5.1.2)

• monitor the provision of services for minority ethnic groups to ensure equality of service delivery.

The size and time commitment of these teams will depend on local circumstances (for example, the size of trust, the population covered and the estimated referral rate for people with borderline personality disorder).

• be able to advise on social and psychological interventions that are not available. Most statements will begin “In an ideal world...”

• work with CAMHS to ensure cliff edge lack of transitions to adult services.

• Watch helplessly as CMHTs routinely reject referrals for this clientele.

• Engage in squabbles about which treatment the service lead likes best so that this can be the only treatment on offer.

• develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline. They must ensure they are only ever attended by those already invested in providing a good service, leaving the wise old heads of the ward untainted.

• monitor whether white females continue their dominance of the service.

• The size and time commitment of these teams will depend on what trusts feel they can get away with it. Kudos to those 8% of trusts who just thought “Fuck it, Why pretend?”

• Ideally these services will be set up by those with no specialist experience of working with this clientele or living with this label.
1.5.1.2 Specialist teams should develop and provide training programmes that cover the diagnosis and management of borderline personality disorder and the implementation of this guideline for general mental health, social care, forensic and primary care providers and other professionals who have contact with people with borderline personality disorder. The programmes should also address problems around stigma and discrimination as these apply to people with borderline personality disorder.

1.5.1.3 Specialist personality disorder services should involve people with personality disorders and families or carers in planning service developments, and in developing information about services. With appropriate training and support, people with personality disorders may also provide services, such as training for professionals, education for service users and families or carers, and facilitating peer support groups.

1.5.1.2 Specialist teams, if they are unable to avoid doing training, should only provide it to people in their own organisation. There should be no budget available to pay service user facilitators.

1.5.1.3 Specialist personality disorder services should be isolated and involve no one in the planning of their service.

Regardless of how positive the feedback about service user trainers and regardless of how much trusts shout that they value user involvement, involvement should be tokenistic at best. Service users can donate time for free at recovery colleges, take part in meetings where they are the only people not being paid or turn up at corporate events to ‘tell their story’ in the most exploitative piece of entertainment since Hostel.

Where trusts are unable to avoid employing service users, ensure they are the lowest paid in their teams. If in a more nebulous role, ensure they have no power or accountability