



Health and
Social Care

A white outline map of New South Wales, Australia, centered on a blue background. The text 'Regional Care Pathway for Personality Disorders' is overlaid on the map.

Regional Care Pathway for Personality Disorders

Promoting Hope, Opportunity and Personal Control

Equality and Human Rights

In line with Section 75 of the Northern Ireland Act 1998, Mental Health Services will be provided and available to all irrespective of gender, ethnicity, political opinion, religious belief, disability, age, sexual orientation, and dependant, marital status.

The services are designed to diagnose, treat and improve the wellbeing of all those people requiring mental health care. Mental Health Services have a duty to each and every individual that they serve and must respect and protect their human rights. At the same time, mental health services also have a wider social duty to promote equality through the care it provides and in the way it provides care. This includes addressing the needs of those groups or sections of society who may-be experiencing inequalities in health and well-being outcomes.

Alternative Formats

This report can also be made available in alternative formats: large print, computer disk, Braille, audio tape or translation for anyone not fluent in English. Please contact the Communications Office at the Health and Social Care Board, www.hscboard.hscni.net.

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1.0 Introduction

In June 2010, the Department of Health, Social Services and Public Safety (DHSSPS) published a document entitled: *‘Personality Disorder: A Diagnosis for Inclusion, outlining a strategy for the enhancement of Personality Disorder services in Northern Ireland’*.

With the economic downturn the strategy was only partially funded. Nonetheless, all five Health and Social Care Trusts (including within Prison Health) currently have community based services for people with Borderline Personality Disorder, guidance, and evidence based interventions.

This Care Pathway outlines the mental health care available in Northern Ireland for people with a Personality Disorder, the steps involved in accessing that care, the types of interventions that may be offered, and what service users and their family carers can expect from the professionals providing care and treatment.

Evidence (NICE 2009) would suggest that people with Personality Disorders often experience co-morbid conditions such as depression, anxiety, substance misuse, and thoughts and actions relating to self-harm and suicidality. They can also experience varying degrees of subjective distress and problems in personal and social functioning that can lead to social care needs, particularly in relation to parenting and childcare.

This means that they are often high users of other services including mainstream mental health, addictions, emergency medical, criminal justice, primary care, and social care services. Sometimes the presentation of Personality Disorder traits inhibits the individual's ability to get the best out of these services. Therefore this care pathway includes arrangements for consultation and co-working across interfaces with key mainstream services, with the intention of supporting staff to work more effectively to meet the needs of people with personality based difficulties.

People with Antisocial Personality Disorder may also exhibit traits of impulsivity, high negative emotionality and a wide range of interpersonal and social disturbance. However, they are less inclined to seek help from the health or social care sectors. Often, by virtue of their behaviour, they are held and treated within the criminal justice sector (NICE 2010). This care pathway also provides advice and guidance relevant for staff working in various criminal justice agencies and forensic mental health services.

Throughout this document the use of "if appropriate" in conjunction with family carers assumes that family carers will be consulted and involved unless there are specific reasons not to do so; namely an explicit refusal of consent on the part of the patient; or specific risk factors that render family carer involvement inappropriate.

2.0 Context and Purpose

It is recognised that there are many diagnostic variations of personality disorder. However, at this stage, only two have associated clinical guidance for their treatment and management; Borderline Personality Disorder (NICE 2009); and Antisocial Personality Disorder (NICE 2010). This Care Pathway will focus on services associated with these two disorders.

People with Borderline Personality Disorder (BPD) typically experience a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity beginning by early adulthood and presenting in a variety of contexts. This is indicated by the presence of five or more of the following:

- Frantic efforts to avoid real or imagined abandonment;
- A pattern of unstable and intense interpersonal relationships characterised by alternating extremes of idealisation and devaluation;
- Identity disturbance: markedly and persistently unstable self-image or sense of self;
- Impulsivity in at least two areas that are potentially self-damaging (for example spending, sex, substance abuse, reckless driving, binge eating);
- Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour;
- Affective instability due to marked reactivity of mood (for example intense episodic dysphoria, irritability, or anxiety,

usually lasting a few hours and only rarely more than a few days);

- Chronic feelings of emptiness;
- Inappropriate, intense anger or difficulty controlling anger;
- Transient, stress related paranoid ideation or severe dissociative symptoms. (NICE 2009, p 18)

People with Antisocial Personality Disorder (ASPD) typically experience a pervasive pattern of disregard for and violation of the rights of others that has been occurring in the person since the age of 15 years. This is indicated by the presence of three or more of the following:

- A failure to conform to social norms;
- Irresponsibility;
- Deceitfulness;
- Indifference to the welfare of others;
- Recklessness;
- A failure to plan ahead;
- Irritability and aggressiveness. (NICE 2010, p 17)

The pathway explains how an adult with a Personality Disorder diagnosis, or personality based difficulties, can access appropriate mental health care, in a timely manner, according to their needs. It also describes the standards of care they can expect from professional staff, and the steps in care from the point of referral, through to when they no longer require care. The Pathway has been modelled to reflect best practice as described in NICE (2009)

and NICE (2010) and other relevant standards for mental health services in Northern Ireland

The Pathway recognises that mental health care should receive parity of esteem with physical health care services in terms of priority and resources. Whilst aspects of this pathway may be challenging to implement immediately due to the finite nature of resources it commits health and social care services to make better use of existing resource and to secure additional resources to address gaps in service provision.

3.0 The Care Pathway for Personality Disorders

The main gateway to secondary mental health care for people with personality disorder will be through the normal GP referral route. Hospital Emergency Departments may also refer to mental health services. Referrals through either of these routes will be triaged using the normal criteria for all mental health problems and receive an initial assessment of mental health needs.

People with Personality Disorders are most likely to seek help for comorbid conditions such as depression, anxiety or substance misuse. Therefore most will be treated in mainstream mental health services, or specialist services such as Addictions or Forensic services. When treatment in any of these services identifies personality disorder as a component part of the difficulties a patient is experiencing the team can access support from the Personality Disorder service. Depending on the complexities of the person's needs, and clinical priorities identified at that particular time, the Personality Disorder service input can take three main forms:

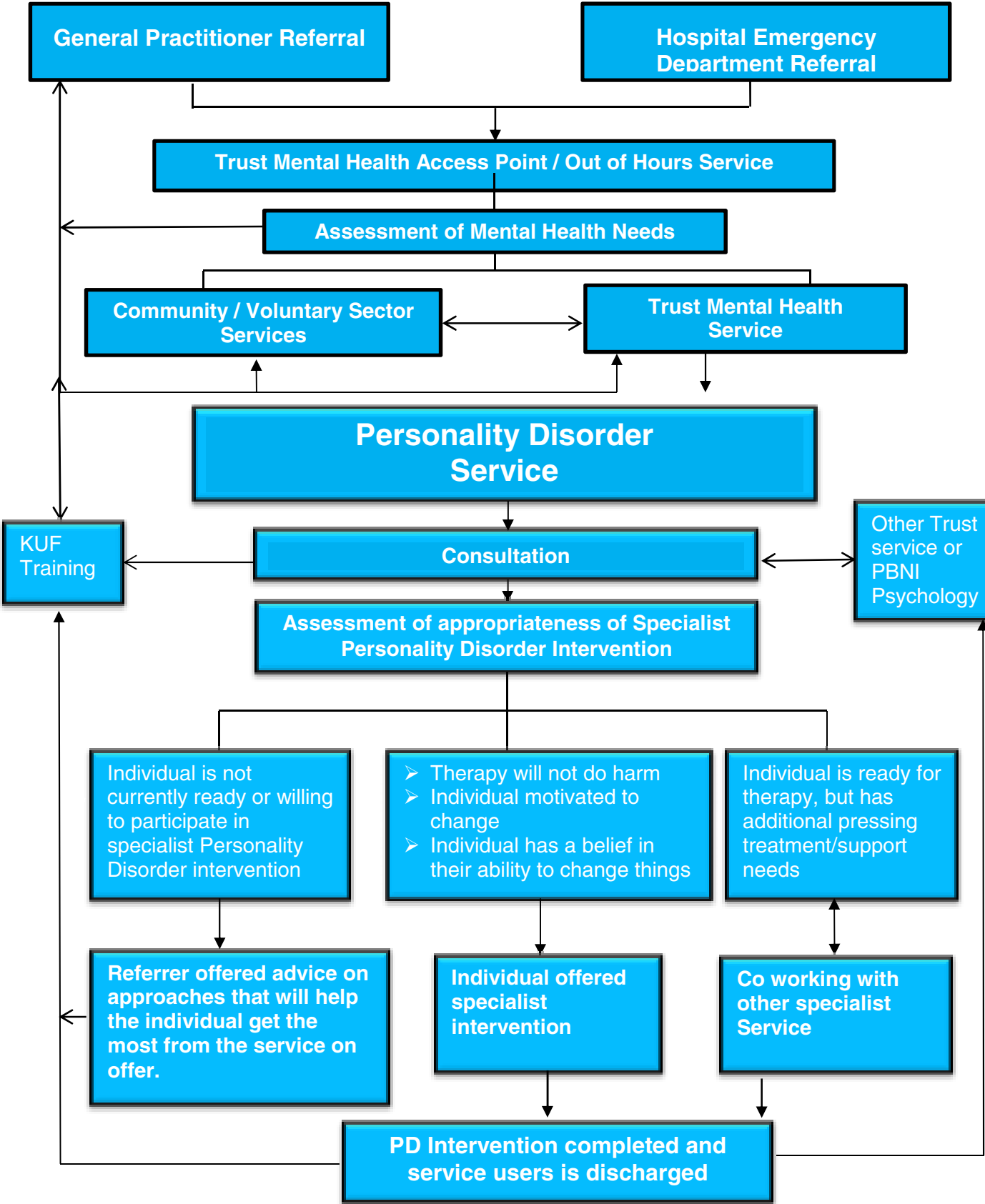
- Provide advice and guidance to other professionals to enhance the effectiveness of the care and treatment they are providing;
- Co-working with the other service to address more than one issue in a coordinated way;
- Directly provide a specialist intervention or therapy to the patient. This is most likely to occur when other problems

have been resolved, and the patient is ready and motivated to learn to manage their personality disorder symptoms.

The Personality Disorder service will provide similar arrangements for consultation to other services including: Probation Board Northern Ireland (PBNI); Prison Health Care service; Family and Children's Services, and Disability Services. Co-working or transfer arrangement can be considered based on an up to date mental health assessment by a suitably qualified professional.

The Knowledge and Understanding Framework (KUF) provides awareness and skills training for staff, service users and carers (www.personalitydisorderkuf.org.uk). KUF Level 1 awareness training will be available and is recommended for a broad range of Health, Social Care and Criminal Justice staff who frequently work with people with personality based difficulties.

Diagram 1: Care Pathway at a Glance



4.0 Recovery in Personality Disorder Services

Throughout this Pathway the term Recovery is used to explain the core aim behind the delivery of Personality Disorder services in Northern Ireland. In this context Recovery means more than just the relief of symptoms.

Recovering from mental health and emotional problems is highly personal; however with the right support many people recover completely or are able to manage their feelings and behaviour in a way which reduces the impact on their lives. Services will work in partnership with the service user to inspire hope and help them towards achieving a satisfying and fulfilling life as defined by them, in the presence or absence of symptoms. Services will also work with those close to the individual so that they too can have hope for the future and provide support in the Recovery process.

In the context of Personality Disorder, Recovery is likely to focus on motivating the individual to positively engage with supports, and to change any harmful behaviours. It will also include supporting the individual in developing their autonomy and independence, and planning towards a future when they no longer need services.

Diagram 2: The Principles of Recovery

Promoting Hope, and Self Determination

Services will be supportive and optimistic about the opportunities for recovery. Services will promote personal decision-making and help the individual build their capacity to manage their own mental health and wellbeing.

Personalised Whole Person Centred Care

Services will provide care which is known to work. The service user's personal preferences, ambitions and goals will be incorporated into a Recovery plan. This will include addressing their physical, emotional, occupational and social needs.

Encouraging Participation and Making Connection

Services will encourage the individual to direct their own care and help them to strengthen family, social and community networks. The service will also encourage individuals to access meaningful social, educational, and occupational/vocational opportunities as part of their personal recovery plan.

Focus on Strengths

Services will value the individual as a person and help them develop a positive and solution focused approach to the management of their needs. Services will work to enable the individual to maximise their personal strengths, resources and talents.

5.0 Stepped Care Model

Stepped care can be defined as having the right service, in the right place, at the right time, delivered by the right person. When a person is referred, the stepped care approach is used to match their needs with the right level of support; the individual only ‘steps up’ to intensive/specialist services as their needs require. Similarly people can be “stepped down” when specialist intervention has been completed but the individual needs some on-going post treatment support.

The level of support offered is determined by the personal needs of the individual, and by treatment and interventions that are known to help recovery for these conditions. The ‘stepped care’ approach helps ensure that the person is referred to the right service and to professionals with the right skills to help them meet their specific needs at that time.

The stepped care approach means that care can be stepped up or stepped down as needs change. A ‘step up’ usually means a more intensive specialist care is required to help recovery. A ‘step down’ usually means that recovery is at a stage where the specialist or intensive support is no longer required.

If an individual’s needs change and a different level of support is required then the professionals working with them will ensure they understand the reasons and the benefits of the change. They will also give information and an opportunity to discuss the new treatment and to consider the options.

Diagram 3: Stepped Care for Personality Disorders

Needs	Service Response
Step 1: Personality based difficulties that are impacting on general health, well-being and social functioning.	Difficulties may be resolved through making lifestyle adjustments and learning new problem solving and coping strategies. Health improvement and well-being programmes from Community and Voluntary organisations targeting stress, emotional problems and lifestyle issues.
Step 2: Personality based difficulties that are interfering with normal psychological and social functioning, and the individual's ability to benefit from services.	KUF Awareness Training for Health and Social Care, or Criminal Justice staff. Treatment in mainstream mental health, other health and social care or criminal justice services with advice and guidance from Personality Disorder Service on approaches and management that improve the effectiveness of the intervention.
Step 3: Specific personality disorder diagnosis that is causing a high level of psychological and emotional distress.	Treatment in mainstream mental health, other health and social care services with advice and guidance from Personality Disorder Service on approaches and management that improve the effectiveness of the intervention. Where the individual is psychologically ready and motivated, and the therapy will cause no further harm, specialist treatment delivered by a community based Personality Disorder service. With some specific comorbid conditions Personality Disorder services may co-work with other services.
Step 4: Complex mental health needs with comorbid personality disorder that is compromising a person's safety or the safety of other	Crisis Resolution and Home Treatment services, where appropriate with advice from Personality Disorder Service. High intensity specialist inpatient services appropriate for treating the comorbid condition. This may include secure hospital or care in a criminal justice setting.

6.0 Quality Indicators for Personality Disorder Services

6.1 The patient can expect to:

- Be treated as a partner in the delivery of the service and supported to work collaboratively towards agreed goals.
- Be given the names and roles of everyone involved in their treatment;
- Be listened to, given time to discuss their views and perspectives, and have their lived experience respected.
- Have involvement in all decisions about their care and, where appropriate, have family/friends/nominated carers views included in these decisions;
- Be responded to with compassion in a process of mutual respect;
- Have the outcome and implications of all needs assessments and care and treatment plans explained to them;
- Be informed as to what treatments and interventions are available, what they are for and the benefits and possible side effects;
- Be involved in developing their care and treatment plan. This plan will recognise their skills, strengths and abilities; and will match their needs with interventions which promote recovery;
- Have care and treatment delivered at a pace that is suitable for the individual;
- Be given contact details for urgent or crisis support;

- Be involved in deciding when they no longer require treatment, and once treatment has been concluded, given information how to re-engage with health and social care services should they require;
- Be given every opportunity to express any concerns about their care, including independent support if required.

6.2 Family / Carers can expect to:

- Be listened to as someone who has knowledge about their family member;
- Have their own lived experience respected;
- Be given information about how best they can help their family member;
- Be given information on treatments available and any likely consequences of that treatment;
- With the consent of the service user be given an opportunity to discuss the care/treatment and safety plans, particularly when they are included as part of the plan;
- With the consent of the service user, be given feedback about progress;
- Be given emergency contact details;
- Those providing regular and substantial care will be offered an assessment of their own needs which is reviewed regularly;

- Child protection or Adult Safeguarding concerns will be discussed with any individual with parental or caring responsibilities when appropriate.

7.0 Standards in Personality Disorder Services

7.1 Referral Standards

Personality Disorder Services will:

- Put in place arrangements to enable consultation;
- Publish details of how to make a referral for assessment and treatment.

All Referral Agents will:

- Seek a consultation in the first instance;
- Complete an appropriate referral;
- Obtain consent from those being referred and explain referral process.

People Referred will be provided with:

- A copy of the referral information;
- Feedback on the outcome of any assessment of suitability of a PD service;
- On-going support from the referral agent unless and until transfer is agreed;
- Be involved in any decisions about transfer.

7.2 Triage

Triage is a 'Person Centred' process which helps identify the most appropriate and timely response to need. Referrals to Personality Disorder Services will be acknowledged and triaged within five working days, and referrers offered a consultation to determine the most useful input from the Personality Disorder Service.

If it is agreed that the individual is likely to benefit from a specialist intervention then the individual will be offered a service in line with the access target for psychological therapies.

7.3 Appointment Standards

Service providers will –

- Offer an appointment in accordance with timescale identified at triage;
- Offer an appointment by making direct contact with the person which will be followed up in writing;
- Confirm appointment in writing within 5 days of arranging the appointment and copy of this appointment will be sent to their referral agent and nominated carer where the patient has given consent;

Provide the name of the practitioner who will be undertaking the assessment.

7.4 Assessment Standards

When carrying out an assessment Personality Disorder Services will:

- Engage the individual in a structured conversation which aims to identify their immediate needs, and to consider options;
- Ensure that relevant information from family carers, and relevant other services who have worked with the individual are discussed with the individual, and used appropriately to inform the assessment;
- Ensure there is enough time for discussion of problems and for summarising the next steps of care;
- Explain the use/meaning of any clinical terms;
- Give information in a way which can be easily understood about any diagnosis given and explain what it means;
- Give information about different intervention options;
- Work to promote personal safety and explain fully any risks associated with presenting needs and recommended action which required to protect the individual;
- Address the safety of others. If child protection or adult safeguarding risks are identified the individual and any person with parental or caring responsibilities will be informed about how these risks need to be managed by a referral to the service with safeguarding responsibilities;

- Offer support after the assessment, particularly if sensitive issues have been discussed;
- Ensure any wait before an assessment is no longer than 20 minutes after the agreed appointment time.

7.5 Formulation and Diagnosis

Formulation is the process by which professionals draw together all the information available in order to identify the individual's needs and possible reasons why these needs have arisen. This may include opinion from a range of professionals (the multi-disciplinary team), and will take into account the report of the individual, their family members, and the referrer. Information available from other health and social care services that have had contact with the individual will also be considered if it is relevant.

Discussion of the formulation can help the individual (and family/carers where appropriate) understand their needs and help identify areas of their lives which may need to change. The assessor will explain the outcome of all assessments, and if a diagnosis is made, they will explain what it means.

A formal diagnosis of Personality Disorder is complex and not without contention. It should only be made by a Consultant Psychiatrist or a Consultant Psychologist in consultation with the multi-disciplinary team.

If a formal diagnosis is being made the clinician should take considerable time and effort to explain the diagnosis to the individual and their family, and what it might mean for them.

7.6 Recovery Planning

Care and treatment options will be discussed with the individual, (and their family/carers where appropriate), and a care plan developed in partnership with them. This plan will take account of the individual's skills, strengths, abilities and aspirations as well as their mental health needs.

Care Plans will include:-

- Activities that promote social inclusion and physical wellbeing;
- Talking therapies which help address psychological needs;
- Behavioural therapies that support the individual to develop more healthy lifestyles;
- Details of any medication;
- Strategies for keeping safe.

The service user will be given an up-to-date written copy of the care plan, and a suitable time will be agreed to review it.

7.7 Safety Planning

Risk of harm is often elevated with people experiencing Personality Disorder. A significant element of the Personality Disorder service intervention will focus on supporting the individual to make positive choices and take personal responsibility for ensuring their own safety and where relevant the safety of others. Staff from Personality Disorder services teams will always openly discuss any issues which may have a significant impact on safety. This will involve supporting the individual to think through risks for them personally and for family and/or relevant other people. The individual will be supported to develop an agreed personal safety plan detailing arrangements for managing identified risks or crisis. The plan will also detail arrangements for regular review, and will be adjusted as circumstances change.

The personal safety plan will include agreed arrangements for following up with the individual if they do not turn up for an appointment, or otherwise disengage before their treatment has concluded. This will include arrangements for contacting a nominated friend or relative if this is appropriate, and advising the referrer.

It should be noted that for some therapeutic interventions (such as Dialectical Behavioural Therapy) a contract of engagement will be agreed with the patient that may include no proactive follow up from staff if an individual does not attend an agreed appointment.

7.8 Disengagement

When an individual is receiving treatment from Personality Disorder Services it is important that they keep all appointments, and if they cannot attend to let the service know with as much advance notice as possible. If the individual does not attend appointments, regularly cancels appointments, or otherwise disengages from the service:

- They will not be automatically discharged;
- A team member will attempt to contact the individual when they unexpectedly do not attend, and if this fails, will contact their nominated person, unless otherwise stipulated in the contract of engagement for a specific psychological therapy;
- A member of staff will contact the referrer to discuss and jointly agree the most appropriate follow up action;
- This discussion will consider the safety of the individual and any potential risks to others;
- If risks to children or vulnerable adults are identified as a result of the individual's disengagement, the relevant protection service will be informed.

7.9 Equality of Access

People with Personality Disorder will not be excluded from any health or social care service because of their diagnosis or because they have self-harmed.

People from Black Minority Ethnic groups should have access to culturally appropriate Personality Disorder Services based on their clinical need.

When language is a barrier to accessing or engaging with services people should be provided with:

- Information in their preferred language;
- Independent interpreters.

8.0 Treatment Options for Personality Disorders

The following section summarises the main needs indicators along with management and clinical practice advice for services working with someone with a personality disorder. For fuller guidance please consult the relevant NICE guideline

8.1 Borderline Personality Disorder

Service Area	Needs Indicators	Practice Recommendations
General Approaches for all Service Areas	Research evidence would suggest that the manner in which services are delivered to people with Borderline Personality Disorder (BPD) is a significant determinant of success (NICE 2009, p324 - 325).	Training and Awareness The Knowledge and Understanding Framework (KUF) awareness training is recommended for staff who regularly deliver services to people with Personality Disorders. This includes services for families and children; addictions and substance misuse, secondary mental health; emergency and crisis response services (medical and mental health); and criminal justice services.
	People with BPD find it hard to cope and may look to others to take responsibility for their needs. However if others do this it can inadvertently undermine the person's capacity to care for themselves.	Active participation Ensure that a person with BPD is supported to remain actively involved in finding solutions to their problems, even during times of crisis. Encourage them to consider the different options and life choices available, and the consequences of the choices they make.
	Many people with BPD will have experienced rejection, abuse and	Develop an optimistic and trusting relationship When working with people with BPD explore

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	trauma, and will have encountered stigma often associated with self-harm and other behaviours associated with BPD.	treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable. Build a trusting relationship by working in an open, engaging and non-judgemental manner, and be consistent and reliable.
	People with BPD can find it difficult to trust and engage with others. They can find it difficult to cope with unexpected changes.	Be Consistent and Reliable Build a trusting therapeutic relationship, including doing what you say, and not making false promises. Cancelling appointments, or changing key worker or services should be avoided if possible, and if unavoidable the individual should be given as much notice as possible.
	Many people with BPD tend to see people as extremes, “splitting” them into categories of wholly good or wholly bad.	Teamwork and Communication Consistency, good communication, and team working is essential when more than one professional or service is involved.
	People with BPD tend to experience gradual rather than sudden improvement in symptoms.	Realistic expectations Accept a realistic rate of change and encourage the individual to set realistic short term goals (as well as long term) to help them see that progress is possible.

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	Many people with BPD experience frequent emotional, interpersonal and social crises.	Managing Crisis Develop a crisis plan with the individual in advance and when a person with BPD presents in crisis: • Maintain a calm and non-threatening attitude; • Try to understand the crisis from the person's point of view; • Explore the reasons for the distress; • Use empathetic open questioning, including validating statements, to identify the onset and the course of the current crisis; • 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; • Facilitate the person to identify appropriate solutions and management strategies, and support them to follow up if required; • Offer appropriate follow –up with an agreed timeframe. After the crisis has subsided or resolved, ensure the crisis plan and the overall treatment plan are
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		updated in the light of the episode. This should be done in conjunction with the individual and their family carers (if appropriate).
	People with BPD can find endings and transitions very difficult, and these may evoke strong emotions and reactions. If not appropriately managed these can trigger emotional crisis and set back recovery.	Managing endings and supporting transitions Discuss any planned changes or transitions carefully beforehand with the person and with family carers if appropriate. Structure and phase transitions carefully. Ensure effective communication and collaboration with other care providers during the time of transition or ending, including the opportunity to access services in times of crisis. When referring a person for assessment in other services (including referral for psychological treatment) ensure they are supported during the referral period, and that arrangements for support are agreed with them beforehand. When managing a transition for CAMHS to adult services, time the transfer to suit the young person (even if it takes place after they have reached the age of 18). Continue treatment in CAMHS if there

8.1 Borderline Personality Disorder

		is a realistic possibility that it may avoid the need for referral to adult services.
Service Area	Needs Indicators	Practice Recommendations
Families and Carers	Family carers can be critical in providing on-going safety and support for someone with BPD. Effective engagement of family carers can support the delivery of treatment and risk management. Failure to engage family carers appropriately can risk undermining progress; particularly if the dynamics and responses within the family are contrary to the patient's goals; or facilitate unhelpful strategies and responses on the part of the service user. Family support is important for the long term wellbeing of the person with BPD and their maintenance in recovery. It is therefore important to support the resilience of family	Involving families and carers Ask the person with BPD directly for permission to involve their family members in their care, explaining the benefits, and exploring any issues in respect of confidentiality. Consent should be regularly reviewed. 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 or lack of services. Family or friends should be signposted to any family and carer support resources available, including KUF Awareness training. Those providing regular and substantial care should be offered independent carers needs

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	carers and support the maintenance of family relationships	assessment.
Service Area	Needs Indicators	Practice Recommendations
Community and Voluntary Services	People with BPD can have low resilience to dealing with the normal problems associated with daily living. This can cause emotional crisis. Part of treatment and recovery is to support the individual to address these practical problems in a positive way, developing their own strategies and support networks for the future.	Social Support People with BPD should be encouraged to proactively use community and voluntary sector services to help them address specific social problems that that may be impacting on their mental wellbeing including: advice agencies; addressing debt; housing problems; parenting support; physical health and wellbeing; training and employment opportunities.
	People with BPD can misuse substances as a maladaptive coping strategy. Serious substance misuse can impede their ability to engage or benefits from management and treatment strategies.	Lifestyle Support People with BPD should be supported to use specialist services to address personal risk behaviours, such as substance misuse, that might be impeding their ability to use clinical interventions to best effect. Where appropriate there should be communication and co-ordination between commissioned

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		community and voluntary services and statutory services as part of the shared care plan.
	People with BPD in recovery	Peer Support and Personal Development People with BPD in recovery need opportunities to gain confidence and consolidate progress through developing and using interpersonal and other skills. They should be supported and encouraged to participate in self-help, peer support and advocacy activities; providing training and education for others; and raising general awareness of BPD.
Service Area	Needs Indicators	Practice Recommendations
Primary Care	People presenting with fluctuating emotional distress, recurrent psychosocial crisis, long standing suicidal ideation, repeated self-harm, marked interpersonal problems with reduced social functioning. (<i>The fluctuating nature of mental distress can help distinguish this condition from other mental disorders.</i>)	Prescribing Avoid poly-pharmacy. Many people with BPD suffer from impulsivity, sensitivity to criticism and dependence on others. These factors can lead to unnecessary and sometimes risky drugs prescribing.

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	When assessing risk it is important to include a specific enquiry about self-harm and suicidal ideation. Risk posed to others is less frequent, but impulse aggression and violence can sometimes occur. The welfare of dependent children should also be considered.	Managing Risk People with BPD often present in crisis, and social problems may play a central role in maintaining the person’s distress. Assess the current level of risk to self and others. Ask about previous episodes and effective management strategies used in the past. Help them manage their anxiety by enhancing coping skills helping them focus on the current problems. Encourage them to identify manageable changes that will enable them to deal with the current problem (direction to practical advice such as CAB, debt advice agencies etc. may be helpful). Offer a follow up appointment at an agreed time. Most people with BPD can be managed within primary care. Isolated crisis do not in themselves indicate a need for referral to secondary mental health services. People with BPD often already have contact with numerous agencies and consideration should be given to the support already available
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		Referral for Secondary Care Referral to secondary care should be made if there is an uncertainty about diagnosis. Specific indicators include repeated self-harm, persistent risk taking, and marked emotional instability. Trust dedicated personality disorder services can provide advice and support for those in primary care working with people with BPD.
Service Area	Needs Indicators	Practice Recommendations
Emergency Medicine (including mental health emergency response services)	People who repeatedly present to emergency medicine following self-injury and other forms of self-harm are likely to have BPD. An assessment based on history and mental state examination should include assessment of comorbid mental health disorders and substance misuse. Assessment should include where possible information from family members or significant others.	Self-Harm Follow the regionally agreed care pathway for self-harm and NICE Clinical Guideline 16 for Self Harm for treatment and interventions. People presenting with three or more self-harm episodes should be referred to secondary mental health services for assessment if they are not already actively involved in services.

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Service Area	Needs Indicators	Practice Recommendations
Secondary Mental Health Care	The presence of suicidal ideation and / or repeated self-harm; tendency to form intense unstable relationships; fear of abandonment; emotional lability; poor sense of self; impulsiveness; emptiness and boredom; problems coping with crisis. For people with lower levels of disturbance and higher levels of social functioning, developing a better understanding of the steps they can take to resolve their problems without prolonged input from services may be preferable to treatment.	Community Mental Health Services Community mental health services should be responsible for the routine assessment, treatment and management of people with BPD, providing psychologically informed management, working with the person and family carers to design and implement an appropriate care plan. Assessment It is important to involve the person actively in the assessment and management of their BPD. When assessing BPD it is important to take a full history, which may need to include an assessment of co-morbid mental disorders such as substance misuse or eating disorders. • 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

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		rehabilitation or development; • The needs of any dependent children. Risk Management Risk assessment should take place in the context of a full assessment of the person’s needs; differentiate between long-term and more immediate risks; identify the risk to self and others, in particular the risks to dependent children, vulnerable adults, and other family members. The risks being assessed should be explicitly discussed with the person with BPD, and a collaborative a risk management plan developed. Risks should be managed by the whole multidisciplinary team, with good support and supervision for the key worker. Psychologically –informed management Develop a comprehensive multidisciplinary care plan in collaboration with the service users (and with family carers unless there is a specific reason not to do so): • Identify clear roles and responsibilities; • Identify manageable short term treatment
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		goals, and agree the specific steps the person might take to achieve these goals; • Identify long term goals, including those related to employment and occupation that the person would like to achieve. Goals should be realistic and linked to short term treatment aims; • Agree a crisis plan, identifying potential triggers, specific self-management strategies, and how to access services if self-management is not enough; • Care plans should be shared with the service user, family members (with consent), and the GP. Where indicated, facilitate a referral to specialist PBD services or psychological therapies service, and augment the work of such services by providing additional support at times of crisis. The assessment process can be distressing for many, so agree and arrange for support during this period in advance of any referral for specialist or psychological treatment.
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	Psychiatric symptoms show particular characteristics when they are linked to BPD. Compared with how they are expressed independent of BPD. They tend to be short –lived, fluctuate rapidly, and are likely to occur primarily in the context of interpersonal stress and respond to environmental modification. Consideration should be given to referral for psychological treatment for all people with BPD, but not all people with BPD should be referred. Psychological therapies may be appropriate when: • The service user has some understanding of the nature of their problems; • a desire to engage in psychological treatment; • an ability to formulate what	Comorbid Conditions The diagnosis of both BPD and a comorbid disorder should be reviewed before treatment is initiated, particularly if the diagnosis was made during an emergency situation. Any psychiatric symptoms that are integral to the BPD should be treated as part of that disorder. For example comorbid depressions, post-traumatic stress disorder or anxiety should be treated within a well-structured BPD treatment programme. People with BPD who also have major psychosis; dependence on substances; or severe eating disorder should be treated primarily for the comorbid condition, following the relevant NICE guideline for that illness or disorder, with additional specific treatment for BPD when this becomes appropriate. If a dual diagnosis is made with other Axis I disorders the person should receive treatment for both disorders. In some circumstances this may require additional expertise. In these

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	they would want to achieve with the help of treatment; and • Psychological therapy is not likely to cause further harm.	circumstances there should be arrangements for co-working and co-ordinated care. There should also be agreement on respective roles and responsibilities, and good communication between clinicians; service users and family members.
Service Area	Needs Indicators	Practice Recommendations
Acute Mental Health Services	Inpatient services should only be used when there is diagnostic uncertainty associated with a marked affective component or evidence of psychotic symptoms suggests there may be an Axis I disorder in need of treatment. While inpatient treatment is not suitable for the treatment of chronic risk associated with BPD, it may be appropriate to manage short term acute risk that cannot be safely managed in another context. The Mental Health (NI) Order 1986	Inpatient Treatment Inpatient treatment for people with BPD should be avoided where possible. Consider Crisis Resolution and Home Treatment services before considering an in-patient admission. Only consider admission for the management of crisis involving significant risk to self or others that cannot be managed within other services. Ensure that the decision to admit is based on an explicit, joint understanding with the patient of the potential benefits and potential harm that may arise from the inpatient admission. Agree the purpose and the length of admission in advance.

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	specifically excludes detained admissions by reason only of personality disorder. Therefore an admission for assessment using the powers of the Order can only be considered for co-morbid mental illness or disorders that meet the criteria outlined in the legislation.	Risk management Arrange a PQC Comprehensive risk assessment and risk management plan for anyone with BPD who has been admitted twice or more in the previous 6 months.
Service Area	Needs Indicators	Practice Recommendations
Specialist Personality Disorder Services	People with BPD resulting in complex health and social care needs.	Personality Disorder Service Specialist Personality Disorder services are intended to improve and support the management and treatment of people with BPD across a range of health and social care settings, as well as directly providing specialist interventions, and co-working with other services where appropriate. Trusts should provide multidisciplinary specialist services that have specific expertise in the diagnosis management and treatment of BPD. • Provide consultation and advice to primary, secondary and other care services; • Offer diagnostic advice when general

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		psychiatric services are in doubt about the diagnosis and / or management of BPD; • Develop systems of communication and protocols for information sharing and collaboration among different services, including those in forensic settings, social care, criminal justice and relevant voluntary sector services; • Provide and / or advise on social and psychological interventions, including access to peer support, advice on the safe use of drug treatment in crisis and for comorbidities and insomnia; • Work with CAMHS to develop local protocols for the transition of young people to adult services; • Ensure that clear lines of communication with primary and secondary care are established and maintained; • Support, lead and participate in the local and national development of treatments for people with BPD, including multi-centre research; • Oversee the implementation of the NICE Guideline for BPD;
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		• Lead the development and delivery of training programmes on awareness and management of BPD; • Monitor the provision of services for minority and ethnic groups to ensure equality of service delivery. Specialist teams should develop and provide training programmes in partnership with service users and carers. Specialist teams should involve service users and family carers in planning service delivery and information about services.
Service Area	Needs Indicators	Practice Recommendations
Child and Adolescent Mental Health Services	Young people with a diagnosis of borderline personality disorder, or symptoms and behaviour that suggest the disorder.	Children and Adolescents Should have access to the same range of treatment and services recommended in NICE 78, but delivered within CAMHS.
Service Area	Needs Indicators	Practice Recommendations
Learning Disability Services	People with a mild learning disability and behaviour that	Mild Learning Disability The individual should be assessed in conjunction

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	suggests BPD.	with the specialist Learning Disability service, and offered direct service, co-working or consultation support to their LD key worker in line with their assessed needs.
	People with moderate or severe learning disability showing behaviour and symptoms similar to borderline personality disorder.	Moderate or Severe Learning Disability People with moderate or severe learning disability should not normally be diagnosed with Borderline Personality Disorder and should be assessed and treated by Learning Disability services in line with their behavioural needs.
Service Area	Needs Indicators	Practice Recommendations
Psychological Therapies	When considering psychological treatment 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 a motivation to change • The person's ability to remain	Psychological Treatments Provide written material about the psychological treatment being considered, with alternative means of presenting the information, such as DVD for those with reading difficulties. There should be an opportunity for them to discuss the information so that the person can make an informed choice. Clarify the roles of different professionals and services providing treatment and support,

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	within the boundaries of a therapeutic relationship • That the therapy in and of itself, will not do further harm.	particularly if there is a co-working arrangement or there is significant involvement from a social care service. When providing psychological treatment for BPD, monitor the effectiveness on a broad range of outcomes including; personal functioning; drug and alcohol use; self-harm; depression; and other symptoms of the BPD. When providing psychological treatment for people with BPD the following service characteristics should be in place: • An explicit and integrated theoretical approach across the multidisciplinary team which is shared with the service user; • Structured care in accordance with NICE 78 Guideline; • Provision of supervision and support for the therapist; • Clarity of roles and responsibilities of all individuals and services. Do not use a brief psychological intervention (of less than 3 months duration).
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Service Area	Needs Indicators	Practice Recommendations
Drug Treatment	Drug treatment is not recommended for BPD, but may be considered in the overall treatment of comorbid conditions.	Drug Therapies Drug treatment should not be used specifically for BPD or for the individual symptoms or behaviour associated with the disorder. Antipsychotic drugs should not be used for the medium or long term treatment of BPD. Short term use of sedative medication may be considered cautiously for the management of crisis in the context of an overall treatment plan. The duration should not be longer than one week. Review the treatment of people with BPD who are currently being prescribed drugs, with the aim of reducing and stopping unnecessary drug treatment.

8.2 Anti-Social Personality Disorder: Care and Management Options

People with Anti-Social Personality Disorder (ASPD) tend to externalise their difficulties and rarely present in healthcare settings requesting help to deal directly with problems arising from their personality. Nor can they be compelled to assessment or treatment under current mental health legislation in Northern Ireland. However they may seek treatment for comorbid conditions. More frequently some of the behaviours associated with this disorder result in individuals presenting in the criminal justice system where they may be directed to interventions designed to reduce offending or anti-social behaviours.

The care and management options described here are intended to support services across health, social care and criminal justice providing interventions to treat a co-morbid condition or address specific offending behaviours.

There is some evidence to suggest a link between ASPD and conduct disorder in childhood. While not every child with a conduct disorder goes on to develop ASPD, early intervention has the potential to substantially reduce ASPD occurrence and / or severity. Consequently there is advice and guidance on childhood interventions which may prevent the development of the disorder.

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Service Area	Needs Indicators	Practice Recommendations
All Service Areas	People with ASPD should not be excluded from any health or social care service because of their diagnosis or history of antisocial or offending behaviour.	Training and Awareness The Knowledge and Understanding Framework (KUF) awareness training is recommended for staff who regularly delivers services to people with Personality Disorders. This includes services for families and children; addictions and substance misuse, secondary mental health; emergency and crisis response services (medical and mental health); and criminal justice services. Staff regularly providing services to people with ASPD should have support and supervision appropriate to the type and intensity of their service.
	When people with ASPD do present it is often for the treatment of a co-morbid condition, and / or they have been coerced into	Autonomy and Choice Work in partnership with people with ASPD to develop autonomy and promote choice by: • Ensuring they remain actively involved in

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	treatment by a relative or some external authority in a crisis.	finding solutions to their problems, including during crisis; • Encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make.
	People with ASPD are vulnerable to premature withdrawal from treatment and supportive interventions.	Engagement and Motivation A collaborative approach to motivating people with ASPD to engage positively starting from the point of referral and assessment continued throughout the course of the intervention, is more likely to have a positive outcome
	People with ASPD often exhibit traits of impulsivity, high negative emotionality and low conscientiousness. This means that the condition is often associated with a wide range of interpersonal and social disturbance	Continuity of Care Seek to minimise disruption to therapeutic interventions by ensuring that the initial planning and delivery of treatment and transfers from institutional to community settings take into account the need to continue treatment.
	People with ASPD often exhibit a	Optimistic and Trusting Relationship

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	high dropout rate of treatment. Coercion into treatment can prove counter-productive.	Positive and rewarding approaches are more likely to be successful than a punitive approach when engaging and retaining people with ASPD in treatment. 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.
	Carers for people with ASPD often bear the burden of care. The nature of antisocial and offending behaviour often associated with the disorder may mean that carers are treated unsympathetically, although they themselves may have considerable needs as a result of the behaviour of their family member. Families of people with ASPD have the same right to support as other families caring for someone with a significant mental disorder	Involving families and carers Ask the person with ASPD directly for permission to involve their family members, explaining the benefits of support from their families, and the limits of confidentiality. 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 or lack of services. Consider the needs of families and carers of people with ASPD and pay particular attention to

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	in accordance with Carers Guidance.	• The impact of antisocial and offending behaviours on the family • Consequence of significant drug and alcohol misuse • Needs and risks to any children in the family and the safeguarding of their interests. Family or friends providing regular and substantial care should be offered an independent carers needs assessment (irrespective of the consent of the service user). They should also be signposted to any family and carer support resources available.
	ASPD is a very broad diagnostic category encompassing people who never commit offences as well as a minority who commit the most serious offences, with a broad spread in between. Risk assessment and management therefore needs to be case specific.	Risk Management There is no evidence at present that treatment for ASPD is effective in reducing risk. Initial risk management should be directed at crisis resolution and ameliorating any acute aggravating factors.

	Current violence or threat that suggests immediate risk or disruption to the operation of the service A history of serious violence, including predatory offending or targeting of children or other vulnerable people.	Forensic Support Consider consultation with forensic services for specialist risk assessment and advice regarding an appropriate risk management plan.
	Professional obligations for Child Protection and Adult Safeguarding apply and override patient confidentiality.	Protecting Vulnerable Adults and Children Refer to appropriate children's or adult social services if there is a concern about risk to specific children or vulnerable adults.
	People with ASPD and comorbid mental disorders. There is evidence of higher than normal rates of poor concordance; high attrition; misuse of prescribed medication; and risks associated	Drug treatments should not routinely be used to treat ASPD or associated behaviours of impulsivity, anger or aggression. Pharmacological interventions for comorbid conditions should follow the relevant NICE Guideline.

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	for people with ASPD.	If using drug therapies for anxiety or depression pay particular attention to issues of adherence, and the risk of misuse or overdose. Clinicians should also be mindful of risks associated with drug interactions, including alcohol and illicit drugs.
Service Area	Needs Indicators	Practice Recommendations
Community and Voluntary Services	People with ASPD behaviours underlying social difficulties.	Social Support People with ASPD should be encouraged to use services appropriately to help them address specific lifestyle or social problems that that may be impacting on their mental wellbeing. This includes advice agencies, physical health and wellbeing programmes or training and employment opportunities. The referrer should ensure communication and co-ordination between commissioned community and voluntary services and statutory services as part of the shared care plan, including a shared risk management plan.

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	People with ASPD and comorbid mental or physical health problems.	Lifestyle Support People with ASPD should be supported to use voluntary and community services appropriately to address personal and social needs, and / or personal risk behaviours, such as substance misuse, that might be impacting on their health and well-being. The referrer should ensure communication and co-ordination between commissioned community and voluntary services and statutory services as part of the shared care plan, including a shared risk management plan.
	People with ASPD in or exiting the criminal justice system.	Addressing Offending Behaviours Refer to specialist voluntary and community services aimed at assisting offenders address their social care needs and reduce offending. The referrer should ensure communication and co-ordination between commissioned community and voluntary services and statutory services as part of the shared care plan, including a shared risk management plan.

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Service Area	Needs Indicators	Practice Recommendations
Primary Care	Interpersonal and social disturbance related to impulsivity, high negative emotionality and low conscientiousness.	Drug Therapy Pharmacological interventions should not be routinely used for the treatment of Antisocial Personality Disorder or associated behaviours of aggression, anger and impulsivity.
	People with ASPD who present in primary care are more likely to seek help with comorbid common mental health problems.	Comorbid Disorders Treat in line with the relevant NICE Guideline for the comorbid disorder. Be aware of the potential and possible impact of: • Poor concordance; • High attrition; • Misuse of prescribed medication; • Drug interactions (including with alcohol and illicit drugs). Ensure the full disclosure of relevant risks if referred on. Risk Management Attention should be given to the general principles for engaging someone with ASPD,

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		and risk assessment and management advice above.
	Drug and alcohol misuse may exacerbate antisocial behaviour.	Substance Misuse Treat in line with the relevant NICE Guideline for Advice for substance misuse. Ensure the full disclosure of relevant risks if referred on.
	Where there is significant risk and / or a history of serious violence, including predatory offending or targeting children or other vulnerable people	Offending Behaviour Refer to appropriate children’s or adult social services if there is a concern about risk to specific children or vulnerable adults. Professional obligations for Child Protection and Adult Safeguarding apply and override patient confidentiality.

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Service Area	Needs Indicators	Practice Recommendations
Criminal Justice Agencies	There is evidence that the prevalence of ASPD is greater in Criminal Justice populations. Traits of ASPD, such as a disregard for the welfare of others, often increase the likelihood of behaviour that is disruptive and may be harmful to other people. Programmes and interventions provided by the Northern Ireland Prison Service and the Probation Board for Northern Ireland are intended to reduce reoffending by, for example, targeting deficits in problem-solving and consequential thinking, as well as seeking to enhance client offenders' self-efficacy and victim empathy.	Risk Management Risk management, informed by an adequate assessment of risk and need, should be directed at crisis resolution and ameliorating any acute aggravating factors, such as substance misuse. Cognitive Behavioural Programmes Group based cognitive and behavioural interventions to address problems such as impulsivity, interpersonal difficulties and propensity to aggression and violence. Group based cognitive behavioural programmes aimed at reducing specific offending behaviours, which are often associated with antisocial personality traits.

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Service Area	Needs Indicators	Practice Recommendations
Family and Children's Health and Social Services	Prevention Identify children at risk of developing ASPD through child in need assessment systems. Focus on: • Parents with other mental health problems, or with significant drug or alcohol problems; • Mothers younger than 18, particularly those with a history of maltreatment in childhood; • Parents with a history of residential care • Parents with significant previous or current contact with the criminal justice system.	Parenting Support Refer to appropriate family / parenting support programmes. Take care not to intensify any stigma associated with labelling as antisocial or problematic. Appropriate interventions include: • Non maternal care for children younger than 1 year; • Interventions to improve poor parenting skills for the parents of children younger than 3 years. Early interventions should usually be provided over a period of 6-12 months and consist of well structured, manualised programmes that are closely adhered to; and target multiple risk factors such as parenting, school behaviour and parental health and employment. Risk Management Attention should be given to the general

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		principles for engaging someone with ASPD, and risk assessment and management advice above.
Service Area	Needs Indicators	Practice Recommendations
Child and Adolescent Mental Health Services	Parents of children with conduct disorders.	Conduct Disorders Group based parent training/education programmes of proven effectiveness. Generally structured with curriculum informed by principles of social learning theory; include relationship enhancing strategies; with an optimum of 8 – 12 sessions. Individual based parent training / education programmes only where there are particular difficulties engaging with the parents or a family's needs are too complex to be met by group based parenting programmes
	For children 8 years or older where the parents decline parenting groups or are hard to	Cognitive Problem Solving Cognitive problem solving skills training with the child.

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	engage, or where additional factors such as callous and unemotional traits in the child may reduce the likelihood of the child benefiting from parent training programmes alone.	
	For young people aged between 12 and 17 years with severe conduct problems, a history of offending, and who are at risk of being excluded from the family.	Multi-systemic Therapy Consider multi-systemic therapy focusing specifically on problem solving approaches with the family, and involve and use the resource of peer groups, schools and the wider community.
Service Area	Needs Indicators	Practice Recommendations
Community Mental Health Services	Mental health problems exacerbated by Interpersonal and social disturbance related to the impulsivity, high negative emotionality and low conscientiousness associated with ASPD	Drug Therapy Pharmacological interventions should not be routinely used for the treatment of ASPD or associated behaviours. Comorbid Disorders Treatment for comorbid disorders in line with the relevant NICE guideline, with particular attention to issues of adherence and the risk of misuse or

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		overdose when starting and reviewing medication. Risk Management Attention should be given to the general principles for engaging someone with ASPD, and risk assessment and management advice above.
Service Area	Needs Indicators	Practice Recommendations
Addictions Services	Substance misuse, including alcohol, exacerbated by interpersonal and social disturbance related to impulsivity, high negative emotionality and low conscientiousness.	Substance Misuse Offer psychological and pharmacological interventions in line with national guidance for the treatment and management of the relevant substance misuse. Attention should be given to the general principles for engaging someone with ASPD, and risk assessment and management advice above.

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Service Area	Needs Indicators	Practice Recommendations
Specialist Personality Disorder Services	People with Borderline Personality Disorder and comorbid ASPD.	Borderline PD Offer consultation or co-working in line with NICE guideline for Borderline Personality Disorder. Risk Management Attention should be given to the general principles for engaging someone with ASPD, and risk assessment and management advice above.
Service Area	Needs Indicators	Practice Recommendations
Psychological Therapy Services	There is no evidence to indicate that psychological therapies are effective in the treatment of ASPD. However there are some indicators that psychological interventions are more effective in the treatment of comorbid disorders than drug therapies.	Comorbid Disorders Offer the relevant NICE recommended psychological therapy for the specific comorbid disorder. There may be a need to lengthen the duration of any psychological therapy, or increase its intensity for someone with comorbid ASPD.

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		Risk Management Attention should be given to the general principles for engaging someone with ASPD, and risk assessment and management advice above.
Service Area	Needs Indicators	Practice Recommendations
Forensic Mental Health Services	People with serious mental disorder; a forensic history associated with this disorder, and comorbid ASPD.	Comorbid Disorders Treatment in line with NICE Guideline for the relevant mental disorder. Risk Management Attention should be given to the general principles for engaging someone with ASPD, and risk assessment and management advice above. Use structured assessment methods to increase the validity of the assessment. The use of measures such as PCL-R or PCL-SV to assess the severity of ASPD should be part of the routine assessment process.

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Service Area	Needs Indicators	Practice Recommendations
Inpatient Services	The Mental Health (NI) Order 1986 specifically excludes detained admissions by reason only of personality disorder. Therefore an admission for assessment using the powers of the Order can only be considered for comorbid mental illness or disorders that meet the criteria outlined in the legislation.	Inpatient care Normally only consider admitting people with ASPD to inpatient services for crisis management and the treatment of comorbid disorders. Admission should be brief, where possible set out in a previously agreed crisis plan and have a defined purpose and end point. Admission to inpatient services solely for the treatment of ASPD is not recommended. Risk Management If a patient with ASPD is receiving inpatient treatment for a comorbid mental health problem attention should be given to the general principles for engaging someone with ASPD, and risk assessment and management advice above.

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<http://www.hscboard.hscni.net/our-work/social-care-and-children/mental-health/>