Personality Disorder Services: Rapid Review

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Personality Disorder Services
Rapid Review

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Contents

List of Abbreviations

AAA	Animal-Assisted Activities
AAT	Animal-Assisted Therapy
ASPD	Antisocial Personality Disorder
BPD	Borderline Personality Disorder
BN	Bulimia Nervosa
BSD	Bulimia Spectrum Disorder
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behaviour Therapy
DBT	Dialectical Behaviour Therapy
DDP	Dynamic Deconstructive Psychotherapy
DFST	Dual-Focused Schema Therapy
EFT	Equine-Facilitated Therapy
ERGT	Emotion Regulation Group Therapy
HYPE	Helping Young People Early Programme
MBT	Mentalisation-Based Therapy
MBT-A	Mentalisation-Based Therapy-Adolescent
PD	Personality Disorder
PE	Prolonged Exposure
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Controlled Trial
SSRIs	Selective Serotonin Reuptake Inhibitors
STEPPS	Short-Term Psychodynamic Psychotherapy
ST	Schema Therapy

Executive Summary

This is a rapid review of the literature and evidence-base to help inform the development of Personality Disorder Services in Northern Ireland.

Scope of the Review

- What are the main definitions and estimated prevalence of personality disorder?
- What are the ongoing debates about personality disorder?
- What is the strategic context (law, policy, guidance and services) in NI?
- What is the international evidence for Personality Disorder Services, including specific interventions, service user and carer perspectives and service structures?
- What is the economic evidence for personality disorder treatments?
- What are the possible implications of the current evidence for the Mental Health Strategy and the development of services in Northern Ireland?

Methods

Relevant policy documents and systematic reviews published between 2010-20 were identified by searching key databases and grey literature sources. A total of 1,751 papers were identified, of which 645 were included in the final review.

Definitions & Prevalence

Personality Disorder is a contested, controversial and evolving concept however there are some key themes in defining characteristics and behaviours common in PDs. A PD can affect how an individual copes with life, emotions and connections with other people. People with PDs may find that their beliefs and attitudes are different from others. People may find their behaviour unusual, unexpected or even offensive at times and this can impact on making or keeping friendships, connecting with friends/family/work, managing and controlling emotions and impulses and coping with life. People diagnosed with PDs are at higher risk of suicide, problematic alcohol and drug use.

Personality Disorders types are often categorised into three groups or clusters bearing similar characteristics:

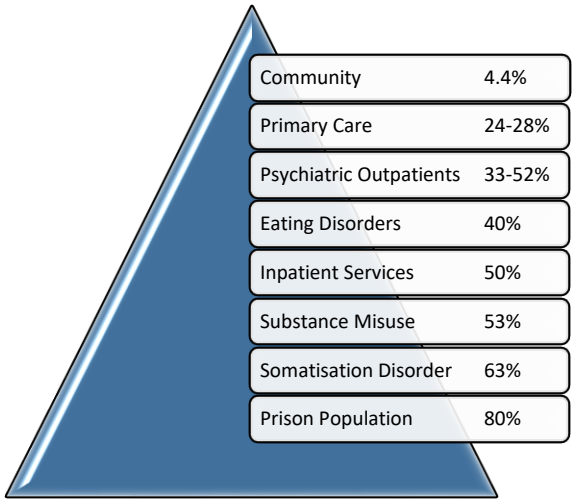
Cluster A – 'Odd or eccentric' (paranoid, schizoid, schizotypal)

Cluster B – 'Dramatic, emotional or erratic' (borderline or emotionally unstable, histrionic, narcissistic, anti-social)

Cluster C – 'Anxious and fearful' (obsessive/compulsive, dependent, avoidant)

Cluster C is the most common in community and primary care settings.

Figure 1: Estimated prevalence rates based on a systematic review of published data (Evans, 2017)



Ongoing Debates

Although the 'PD' diagnostic label is contested, being given a diagnosis can help people access the care they need. It is complex condition that may evolve and change at key developmental periods, and, across the life course. Professional organisations including the Royal College of Nursing, British Association of Social Workers, Royal College of GPs and the British Psychological Society have considered the difficulties related to the language of PD and have acknowledged the stigma and harm the label can convey. Understanding the impact of trauma in the development and treatment of PDs has also been highlighted as an important area of research and practice.

Strategic Context (Law, Policy, Guidance & Services)

The Mental Health (Northern Ireland) Order 1986 provides the current legal framework for compulsory intervention. In Article 3(2) it outlines a number of exclusions from the criteria for compulsory intervention: "No person shall be treated under this Order as suffering from mental disorder, or from any form of mental disorder, by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."

Since the 2005 Bamford Review, a number of policy initiatives has helped to shape the framework of a specialist regional personality disorder service (such as the Northern Ireland PD Strategy, *Personality Disorder: A diagnosis for inclusion* and *You in Mind: Regional Care Pathway for Personality Disorders)* alongside recommendations in the Bamford Action Plans that have led to the establishment of the Personality Disorder Network Group, tiered service provision, joint regional training and a Care Pathway for PDs.

International Evidence for Personality Disorder Services

Prevention & Early Intervention

Most PDs are rooted in childhood and begin to present in adolescence. PD services should address the life course and provide continuity of care during adolescence into adulthood. PDs such as Borderline PD (BPD) can be diagnosed and treated at an early stage and delays in diagnosis can lead to much poorer long-term outcomes. The mental health workforce requires

better training and assessment tools to recognise, intervene early, and reduce the stigma associated with disordered personality traits. Families and friends should be involved at the earliest opportunity. Universal school-based interventions have been used effectively to help students and staff deal with some of the risks attached to PD behaviours.

Crisis Interventions

The evidence for the effectiveness of crisis interventions is lacking and more research is required. Brief psychotherapeutic interventions based on effective long-term treatment models (such as DBT) may be useful and brief inpatient admissions can help support recovery and offer treatment during times of crisis.

Psychological Interventions

The most commonly used types of psychotherapy (DBT, MBT, CAT, CBT) are more effective than treatment as usual (TAU) for personality disorders and these interventions have few adverse effects. The evidence suggests that the type of therapy is less important than the quality of the therapeutic relationship in treatment and recovery. Clinicians may consider developing expertise in more than one psychotherapeutic approach. Generalist approaches and shorter adjunct therapies may also be beneficial. DBT is the most researched psychotherapy for PDs but more and better research is required. Group therapy can be a cost-effective approach and evidence of its use is growing.

Biological Interventions

There is little research evidence for the effectiveness of biological approaches such as ECT and transcranial magnetic stimulation but some small scale studies have been undertaken.

Pharmacological Interventions

Pharmacotherapy is frequently prescribed as an adjunct therapy but the evidence base is sparse and the international guidance on the use of drug treatment is conflicting. In the UK, drug treatment is recommended for short-term brief interventions to help avert crisis. Pharmacotherapy may help reduce some symptoms but no medications produce remission. There needs to be a balance between the potential long-term burden of adverse effects with short-term benefits of drug treatment.

Family Interventions

Many psychological interventions do not typically intervene at an environmental level and unstable family relationships can be a significant obstacle in recovery. Interventions targeted at family members and significant others can help equip carers with a better understanding of PDs, gain new skills to cope and reduce carer burden and ultimately improve relationships.

Peer Support

There is some evidence that peer support can help family members and carers but more research is needed. There are different models of peer support within PD treatment and these need to be considered before implementing the role. Pre-planning, organisational training and additional support is required to integrate peer support workers as part of mental health teams. Having a number of peer support workers can offer service users the options to choose someone they want to work with.

Acceptability

Understanding the factors that influence treatment engagement and adherence are important. Young people, for example, may drop in and out of treatment and this should not be always a sign of treatment refusal. An individualised approach with more treatment choice may help engagement.

Physical Health

The physical health of people with serious mental health problems has been under-researched and is an often neglected component of care. Personality disorder is a strong predictor of all-cause mortality and cause-specific mortality including suicide, malignant neoplasms, chronic lower respiratory disease and human immunodeficiency virus infection (Krasnova, Eaton, & Samuels, 2019). This mortality gap is a public health and human rights issue and integrated and holistic, outcomes-based physical and mental health care should be a priority for patients with PD.

Stakeholder Perspectives

Service Users

Greater understanding of PD is required within mental health services, giving a person a diagnosis of PD can be traumatising and more work needs to be done to improve the assessment, diagnostic process and access to services and psychological therapy. The stigma associated with PDs is significant and compassionate and consistent care is paramount.

Caregivers

Carers want to be involved in early assessment and intervention, including at times of crisis. By developing a better understanding of PD, mental health professionals will be able to support carers more effectively. Family members want greater access and improved quality of services.

Workforce

PD is a complex area of work and professionals need ongoing training and research into effective treatments. The patient/clinician relationship is key to delivering care and at times this can be challenging when trying to meet expectations and provide support within the constraints of available services. Clinicians want the recovery approach to be acknowledged and reinforced within PD and the associated stigma of PD challenged within the workplace.

Economic Evidence for Personality Disorder Treatment

Evidence-based psychological treatment is less expensive and more effective than treatment as usual. While treating PDs effectively will be less costly for the health service, the associated economic costs relating to employment, education and related disability are considerable. The social gradient in mental health inequalities need to be considered and ways to improve people's employment prospects and stability. Reducing workplace stigma and increasing knowledge and understanding of PDs within social and employment settings could help improve outcomes for people.

Implications for Northern Ireland

- Need for the full implementation of a consistent and comprehensive service model for Northern Ireland
- Consideration of the terminology used, specifically personality disorder
- Trans-diagnostic and alternative approaches to identifying needs to be explored
- Co-production in the design, development and delivery of the services
- Peer led services, peer support workers
- Trauma-informed care
- General training for GP and other health and social care professional-led early identification, diagnosis and treatment
- Key indicators for non-therapeutic environments e.g. schools
- Prevention and early intervention to be further developed across sectors including the use of appropriate screening tools
- Access to the relevant evidence based interventions across all levels of need, complexity and risk. The research evidence does not provide definitive clarity on what works for whom but it does provide sufficient support for specific psychological approaches to be provided
- Need for the appropriate resources at all levels for good, ongoing communication and cooperation across the tiers
- Building an evidence base for Positive Action Planning and other local approaches
- Routine data on quality measures and service user outcomes
- Research recommendations

Next Steps

PDs can be successfully treated using evidence-based psychotherapeutic approaches. The stigma attached to a PD diagnosis needs to be challenged within both mental health services and wider civil society. Efforts to support the prevention and early identification, diagnosis and treatment within a life course approach will be beneficial. Next steps in the development of a NI service could involve:

- Mapping and evaluating current services;
- A Delphi study on alternative terminology to personality disorder;
- Stakeholder consultation to further inform the Mental Health Strategy;
- An economic evaluation of alternative approaches;
- The development of proposals for specific service developments;
- The development of a research and outcomes framework.

Introduction

The main aim of this project is to identify and summarise the literature relevant to the development of Personality Disorder Services in Northern Ireland. It is intended that this rapid review will be used, by the Health and Social Care Board's Personality Disorder Network, to help inform the Department of Health's 10 Year Mental Health Strategy, and the business case/s needed for any associated service developments.

Given the relatively short timeframe for the project, we have focused the review questions and scope to enable us to provide an efficient review of the literature, without requiring the time or resources needed to undertake a full systematic review. We have also identified possible gaps in the evidence and suggest where further research, especially in the Northern Ireland context, could be useful.

Rapid Review Questions

- What are the main definitions and estimated prevalence of personality disorder?
- What are the ongoing debates about personality disorder?
- What is the strategic context (law, policy, guidance and services) in NI?
- What is the international evidence for Personality Disorder Services, including specific interventions, service user and carer perspectives and service structures?
- What is the economic evidence for personality disorder treatments?
- What are the possible implications of the current evidence for the Mental Health Strategy and the development of services in Northern Ireland?

Methodology

Ten databases were searched for personality disorder systematic reviews published from 2010: CINAHL Plus; Cochrane Library of Systematic Reviews; EMBASE; International Bibliography of the Social Sciences; MEDLINE (OvidSP); OpenGrey; PsycINFO; PubMed; SCIE; Social Sciences Citation Index; and EconLit (full details of the search strategy and results are included in Appendix 1). The year 2010 was selected to focus on the most up-to-date literature and also because that is when the Northern Ireland Personality Disorder Strategy was published by the Department of Health, Social Services and Public Safety (now the Department of Health). Seminal research published prior to 2010 was included and a hand search of the grey literature was also conducted. 1,751 articles were retrieved, 605 duplicates were removed. Title and abstracts of 1,146 papers were screened, of which 645 were included for full text assessment.

Definitions & Prevalence

From the beginning of this rapid review it should be acknowledged that personality disorder is a contested, controversial and evolving concept. There are a range of relevant debates that focus on issues such as theoretical perspectives, classification, the most effective responses and issues of stigma. These debates will be further explored in the next section but first some of the main definitions will be outlined. Most of the research on the prevalence of personality disorder and the effectiveness of interventions is organised using the traditional psychiatric classification systems so, regardless of the different perspectives on those approaches, it is therefore important to outline how personality disorder is presented in the International

Classification of Diseases (ICD), which is the main approach used in the UK, and the Diagnostic Statistical Manual (DSM) which is the main approach used in the US.

Personality disorder has been defined in a variety of ways but there do tend to be some key common themes across definitions. In the Foreword of the Northern Ireland Personality Disorder Strategy it states that "Generally a person is felt to have a personality disorder if their personal characteristics cause regular and long-term problems in the way they cope with life, interact with people and respond emotionally. Personality disorders are common, present in one person in twenty of the population, and for those people severely affected cause significant distress to the sufferer, their family and friends. Such distress may be evidenced by self-harm, substance misuse, depression, eating disorders or other mental disorders, as well as childcare and social problems." (Department of Health, Social Services and Public Safety, 2010, p. 2)

The Mental Health Foundation (2020) also provides a useful, general introduction to the concept. It suggests that "personality describes the characteristic patterns of thinking, feeling and behaviour that make up who we are and how we feel about ourselves. For most people this remains fairly consistent across situations and time. For some individuals, however, they may experience difficulties in how they think and feel about themselves and others. For someone experiencing a personality disorder (PD) these difficulties are ongoing and problematic, negatively affecting their well-being, mental health and relationships with others…

A PD affects how an individual copes with life, how they manage emotions and connect with other people. People with a PD may find that their beliefs and attitudes are different from most people who may find their behaviour unusual, unexpected or even offensive at times. As a result, individuals with PD's may have difficulties with:

- making or maintaining relationships
- connecting with other people, including friends, family or work colleagues
- managing and controlling their emotions
- coping with life and difficult feelings
- controlling their behaviours and impulses." (p. 1)

People who are diagnosed with personality disorders are also at higher risk of suicide, problematic alcohol and drug use, and other forms of mental health problems (Mental Health Foundation, 2020). So, regardless of how these forms of distress are labelled and communicated, they represent complex and important needs for many people and society.
Crocq (2013) traces the exploration of personality to the ancient Greeks and Chinese who both developed physiological and psychological theories for variation and problems associated with personality. Tyrer et al. (2015) suggest that the concept of personality disorder though did not really emerge until the 19th century and initially it tended to be viewed as a neurodegenerative disorder. In 1837, a book by James Cowles Prichard promoted the concept of 'moral insanity' which was characterised by major behavioural problems but with no identifiable illness. The issue of whether personality disorder should be viewed as an illness or as a character or moral issue continues to be debated. Tyrer et al. (2015) identified the beginning of the formal classification of personality disorder with the work of Kurt Schneider, who in 1923, described

a range of personality disorder types with the main theme that "those with personality disorders suffer because of their disorders and also cause society to suffer." (p. 717)

The NI Strategy (2010, p. 5) provided a good summary of the main, traditional psychiatric approaches to classification:

> "A definition of personality disorder is given in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) as: An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early childhood, is stable over time and leads to distress or impairment.
>
> The World Health Organisation (1992) in their Classification of Mental and Behavioural Disorders describe personality disorders as follows: These types of condition comprise deeply engrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in the giving culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance.
>
> A useful way to consider the different types of personality disorder is to place them into 3 groups or clusters which bear similar characteristics.
>
> Cluster A – 'Odd or eccentric' types (paranoid, schizoid, schizotypal)
> Cluster B – 'dramatic, emotional or erratic' types (borderline or emotionally unstable, histrionic, narcissistic, anti-social)
> Cluster C – 'anxious and fearful' types (obsessive/compulsive, dependent, avoidant)
> Cluster C are the commonest in the community and primary care setting.
>
> However it is Cluster B, in particular Anti-Social Personality Disorder (callous, irresponsible, low frustration tolerance, lack of remorse) and Borderline Personality Disorder (unstable and intense emotional relationships, impulsivity, identity crisis, suicidal thinking and self-harm, transient psychotic symptoms) that provide the greatest challenge within Health and Social Care and Criminal Justice settings because of the stress these disorders cause to the person, their family and society."

In the most commonly used, current classification system in Northern Ireland, the ICD-10, defines personality disorder as "a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption. Personality disorder tends to appear in late childhood or adolescence and continues to be manifest into adulthood. It is therefore unlikely that the diagnosis of personality disorder will be appropriate before the age of 16 or 17 years." (World Health Organisation, 1992, p. 157). The diagnostic guidelines

then specify that these are "Conditions not directly attributable to gross brain damage or disease, or to another psychiatric disorder, meeting the following criteria:

(a) markedly disharmonious attitudes and behaviour, involving usually several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;
(b) the abnormal behaviour pattern is enduring, of long standing, and not limited to episodes of mental illness;
(c) the abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
(d) the above manifestations always appear during childhood or adolescence and continue into adulthood;
(e) the disorder leads to considerable personal distress but this may only become apparent late in its course;
(f) the disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

For different cultures it may be necessary to develop specific sets of criteria with regard to social norms, rules and obligations. For diagnosing most of the subtypes listed below, clear evidence is usually required of the presence of at least three of the traits or behaviours given in the clinical description." (pp. 157-158). It then identifies the characteristics of a range of specific personality disorders including: paranoid personality disorder; schizoid personality disorder; dissocial personality disorder; emotionally unstable personality disorder (impulsive type and borderline type); histrionic personality disorder; anankastic personality disorder; anxious [avoidant] personality disorder; dependent personality disorder; and other specific personality disorders [that fits none of the other types and includes: eccentric, "haltlose" type, immature, narcissistic, passive-aggressive, and psychoneurotic personality (disorder)].

The DSM IV and V have a similar approach to ICD-10 with lists of specific personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent and obsessive-compulsive personality disorder. This approach to the classification of personality disorders has been criticised based on research which suggests it involves "arbitrary diagnostic thresholds, extensive overlap among categories, lack of evidence for 10 distinct categories, and insufficient clinical utility." (Bach and First, 2018, p. 351) The DSM V, although it retained the traditional categories, did include an alternative model which used the severity of impairment and five broad areas of pathological personality traits (American Psychiatric Association, 2013).

The ICD-11 was published in December 2018 but will not be used until the start of 2022. It states that "Personality disorder is characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more). The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles). The patterns of

behaviour characterizing the disturbance are not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict. The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning." (WHO, 2020, 6D10). It then organises personality disorder into mild, moderate and severe based on the impact on functioning which may address some of the criticism of the ICD-10 and DSM approaches although in additional to the level you can still specify one or more types of trait (negative affectivity, detachment, disinhibition, dissociality and anankastia) and a borderline pattern qualifier.

In ICD-11, therefore, the concept of borderline personality disorder has been retained. This will be returned to in the discussion but it is important to specify what this involves. In ICD-11 it states: "The Borderline pattern descriptor may be applied to individuals whose pattern of personality disturbance is characterised by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by many of the following: Frantic efforts to avoid real or imagined abandonment; A pattern of unstable and intense interpersonal relationships; Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self; A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours; Recurrent episodes of self-harm; Emotional instability due to marked reactivity of mood; Chronic feelings of emptiness; Inappropriate intense anger or difficulty controlling anger; Transient dissociative symptoms or psychotic-like features in situations of high affective arousal." (WHO, 2018, 6D11).

Most prevalence studies tend to be based on the ICD or DSM approaches to classification. Winsper et al. (2020) focused on the prevalence of personality disorders in the community and reviewed 46 studies from 21 countries. They reported a global average prevalence of 7.8% (95% CI 6.1-9.5) with higher rates in High Income Countries (9.6%, 95% CI 7.7-11.3%) compared with Low or Middle Income Countries (4.3%, 95% CI 2.6-6.1%) although they did caution there were high levels of heterogeneity between the studies.

Tyrer et al. (2015) also reported general community prevalence findings in North America to range from 4-15%, with higher rates amongst those in contact with health care services, with approximately 25% of service users in primary care and 50% of those in psychiatric outpatient settings meeting the diagnostic criteria. Most alarmingly, they report that about two-thirds of prisoners meet the criteria. The NI Strategy (DHSSPS, 2010) also included broad prevalence rates:

Population Studied	Prevalence of Personality Disorder
Community	5-11%
Primary Care Attenders	10-30%
Psychiatric Outpatients	30-40%
Psychiatric Inpatients	36-67%
Prisoners	60-80%

The Royal College of Psychiatrists (2020) in the position paper, *Services for people diagnosable with personality disorder*, refer to prevalence findings from the literature review completed by Evans et al. (2017) which reported:

- 4.4% community prevalence
- 24% to 28% of primary care attendees
- 33% to 52% in psychiatric outpatients
- 40% in eating disorders, 53% in substance misuse
- 63% in somatisation disorder (medically unexplained symptoms)
- 50% in inpatient services
- Up to 80% prison population

These high rates of prevalence may not fully communicate the complexity of issues that may be involved. For example, Quirk et al. (2016) found that there were associations between personality disorder, some physical health problems and high use of health care services. Guy et al. (2018), based on their systematic review of 20 studies of alcohol use disorders amongst those with a diagnosis of personality disorder found that the majority of people with personality disorder experience problematic alcohol use at some time in their life. This varied to some extend by personality disorder type, "people with antisocial PD had the highest lifetime AUD prevalence, at 76.7%, followed by those with borderline PD at 52.2%, while those with other forms of PD, or undifferentiated PD, had a prevalence of 38.9%. Lifetime AUD prevalence was not significantly higher in clinical compared with population samples." (p. 216). Newton-Howes et al. (2020), based on data from New Zealand found that people with a diagnosis of personality disorder were high users of services, especially in-patient services, and that there was a social gradient in prevalence, so there was an association between deprivation and personality disorder. The Royal College of Psychiatrists (2020, p. 27) also highlighted that: "9–10% of people with personality disorder will die by suicide (Paris, 2002) [and] between 45 and 77% of people who die by suicide have personality disorders (Cheng et al, 2000). A further aspect of the complexity, which will be explored further in the next section, is the association between trauma and personality disorder. For example, Ferreira et al. (2018) conducted a systematic review of the research on borderline personality disorder and sexual abuse. They included forty articles and concluded "Sexual abuse plays a major role in borderline personality disorder, particularly in women. Childhood sexual abuse is an important risk factor for BPD. ASA rates are significantly higher in borderline personality disorder patients compared with other personality disorders. Sexual abuse predicts more severe clinical presentation and poorer prognosis of borderline personality disorder. Suicidality has the most consistent evidence, followed by self-mutilation, Post-Traumatic Stress Disorder, dissociation and chronicity of borderline personality disorder." (p. 75)

Flynn et al. (2020, e29) have summarised some of these complex issues: "The presence of personality disorder can increase the risk of certain adverse behaviours including violence and self-harm. In a study examining mortality by suicide or undetermined cause, personality disorder was found to be the diagnostic category with the highest risk in women, an increase of over 20-fold. The evidence suggests that patients with borderline personality disorder are high users of mental health services compared with other patients. This can lead to difficulties in relationships between staff and patient, particularly if patients exhibit challenging behaviour. The high use of services has been linked to the psychopathology of borderline personality disorder, but also attributable to comorbid diagnoses, particularly substance misuse, which is a recognised criterion for excluding patients from specialist services."

The Royal College of Psychiatrists (2020, p.28) have also reinforced the potential intergenerational implications of personality disorder with maternal personality disorder being associated with "Twice the risk of postnatal depression (Hudson et al, 2017); Three times the risk of postnatal anxiety (Hudson et al, 2017); 2.27 times the risk of depression and self-harming behaviours in young people (Pearson et al, 2018); 50% of children with conduct disorder have a parent with personality disorder (Bonin et al, 2011); Interventions for their parents produced savings in a ratio of 8:1 (Bonin et al, 2011); and 24% of care proceedings are repeat proceedings where the prevalence of personality disorder among the parents is very high (Broadhurst et al, 2015; Broadhurst et al, 2017)."

The Centre for Mental Health et al. (2020), in the *Consensus Statement* which will be discussed further in the next section, reported:

> "About 1 in 16 worldwide have at some point been given a diagnosis of personality disorder and it is a diagnosis which is particularly common among patients attending general and psychiatric hospitals. Many are regular attenders in general practice. In the prison population, it is estimated that between 60 and 70% have met the diagnostic criteria of a personality disorder. They often find themselves living a precarious and isolated existence and over time, they are much more vulnerable to developing other health problems, such as anxiety and depression, as well as problems with their use of alcohol and drugs. They are also more likely to have physical health problems such as cardiovascular disease and obesity. Collectively, these problems exact a very heavy toll: compared to people who have not been given a diagnosis of personality disorder, men and women with this label live considerably shortened lives (18 years shorter for men and 19 years shorter for women). The shockingly elevated death rate appears to be due to those given this diagnostic label having a raised risk of 'unnatural deaths' (suicide, homicide and accidents) as well as 'natural' causes of death (such as infections, or cardiovascular disease). The NHS has not adequately met the complex needs of people given a diagnostic label of personality disorder." (p. 5)

It is also important to note that in the recent Mental Health Action Plan (Department of Health, 2020), one of the actions was to scope a prevalence survey of the mental health of adults in Northern Ireland which could provide a more specific estimate of prevalence, and the complexities of issues involved, in this context.

Ongoing Debates about Personality Disorder

There are a number of ongoing debates about personality disorder which can be broadly organised into: perspectives on the concept itself; concerns about the impact of the label, in terms of the labelled person but also issues of stigma and discrimination; and what are the most effective ways to respond to the complexity of the issues involved. The focus of this section is on the first two, about the concept itself and its impact. The evidence for the range of possible interventions is reviewed later in this report.

A very recent report which considered the concept itself, was the 2020 *Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality*

Disorder which was produced by a range of organisations including the Centre for Mental Health, the Royal College of Nursing, the British Association of Social Workers, the Royal College of General Practitioners and the British Psychological Society. It stated that:

> "This diagnostic label should be helpful because it can act as a gateway for individuals to access the care they need. Unfortunately all too often it can be used as a reason to reject individuals from services. Most of us would rather not use the term at all. In writing this document, it has been hardest of all for us to get consensus on what words we should use to talk about the problems and difficulties people with this diagnostic label experience. We would like to abandon the term 'personality disorder' entirely. The label is controversial for good reasons: it is misleading, stigmatizing and masks the nature of the problem it is supposed to address, adding to the challenges which people experience. However, it has its advocates, not least among those for whom it has been the only passport to effective help. Currently, the label is used to allocate services and resources within the health and care system, so until an agreed alternative emerges we continue to advocate for an alternative way of defining this group of people." (p. 4)

The Royal College of Psychiatrists (2020) Position Paper on *Services for people diagnosable with personality disorder* expressed similar concerns about how the concept has been used and highlighted some of the benefits of diagnosis:

> "Our conclusions acknowledge the argument that there is the potential for a diagnosis to cause harm, particularly if this is done in a way that lacks appropriate dialogue. However, on balance, we believe that the diagnosis has brought benefits of better describing the impact of such difficulties on people's health and social outcomes, not least the almost two decades of life lost through physical and mental health comorbidities. Another clear benefit has been to challenge the myth of untreatability whilst supporting the development of services and interventions which are both clinically and cost effective. The diagnostic framework has also supported the development of training and education for patients, carers and staff and for some has been a simple signpost enabling access to the right services and information." (p. 2)

In response to the Royal College's Position Paper, Harding (2020) has made the reasonable point that there are two main aspects to the diagnosis, the construct itself and the terminology used to describe it. He acknowledges that developing an alternative construct or constructs would be difficult, but suggests that changing the term personality disorder to a less stigmatising alternative could be done tomorrow.

Livesley (2020) has tried to identify why an evidence-based classification of personality disorder has been so elusive. He suggests that there are four main issues: "First, the phenomenological and aetiological complexity of personality disorder (PD) poses a challenge to traditional taxonomic methods and point to the need for new approaches. Second, current classifications incorporate assumptions that conflict with empirical evidence. Most notable are the adoption of a version of medical model that is too stringent to accommodate some common general medical conditions let alone mental disorders and the related adoption of

an essentialist philosophy. Third, a viable alternative to categorical diagnosis is not available. Although trait models are widely advocated as evidence-based alternatives, they have not gained widespread clinical acceptance due to substantial conceptual limitations that compromise their clinical utility. Finally, the processes used to revise official classifications are problematic – they are biased toward conservative revisions and difficult to shield from non-scientific influences. These diverse issues raise difficult to resolve problems that cannot continue to be neglected and serious questions about whether a general monolithic classification of PD that meets all needs is actually feasible." (pp 1-2)

Newton-Howes et al. (2015) make the important point that personality develops from birth and continues to change and develop throughout the lifecourse. Research, especially over the past 30 years, has established that personality can change and that personality disorder is treatable but there is still much to be considered. They suggest that "Further research is needed to improve classification, assessment, and diagnosis of personality disorder across the lifespan; to understand the complex interplay between changes in personality traits and clinical presentation over time; and to promote more effective intervention at the earliest possible stage of the disorder than is done at present. Recognition of how personality disorder relates to age and developmental stage can improve care of all patients." (p. 727)

In addition to the debates about the language used and the relevant construct/s there are also concerns about the impact of the personality disorder label on the person and on responses of others. Sheehan et al. (2016) reviewed the literature on stigma and personality disorders and found that: people tend to have less knowledge about personality disorders than other mental health problems; public responses can involve fear, frustration and the belief that people are being difficult or behaving badly rather than experiencing difficulties and distress. A particularly concerning aspect of the research on stigma and personality disorder involves the negative attitudes and behaviours of some health and social care workers. As Sheehan et al. (2016, p. 4) highlight "Ultimately, negative provider attitudes can lead to differential treatment of people with personality disorders. Stigma may reduce the amount of services available, reduce the quality of those services, and discourage people from seeking and continuing treatment… Perceived discrimination is a common occurrence for patients with personality disorders when they are seeking hospital admission in times of crisis. Suicide attempts among this group are even, at times, viewed as attention-seeking rather than a sign of illness." Self-stigma is also a concerning issue, when people accept the negative views of others and the misleading stereotypes, and experience further difficulties with self-esteem, depression, anxiety and shame. Sheehan et al. also explore structural stigma, which can lead to discrimination through the with-holding of services or the under-funding of research and development in this area. In terms of effectively addressing stigma, a range of ongoing interventions across all the relevant groups and the public seem to be needed, along with the greater involvement of people with personality disorder in those educational processes and in the planning, development and delivery of services.

The developments in research and understanding of the role of trauma, especially in childhood, on a wide range of outcomes is also highly relevant to the debates about personality disorder and how services should respond. The Consensus Statement (Centre for Mental Health et al., 2020, p. 8) argues that "The critical importance of childhood and adolescence in setting the course for a healthy adult life make it essential that early signs are

recognised and effectively addressed. The good news is that if we ask people routinely about adverse childhood experiences as part of an assessment or care review process, people tell us about their childhood experiences and then start to make sense of their current difficulties in the context of their childhood adversity. A history of trauma is so common that we have placed special emphasis on it, but it is important to recognise that some people may have similar difficulties without this." Porter et al. (2020) in their systematic review and meta-analysis of childhood adversity and borderline personality disorder reported that "Patients with BPD were over 13 times more likely to report childhood adversity than non-clinical controls. They were also more likely to report childhood adversity then other clinical populations. Emotional abuse and neglect were particularly elevated in BPD samples relative to controls." (p. 6) A review of the evidence on implementing trauma informed care found that, although it was important to consider context specific issues, the literature repeatedly identifies the need to address the key domains of workforce development, trauma-focused services and the process of organisational change (Bunting et al., 2018).

An alternative approach to diagnosis, which aims to provide a co-produced way of considering all the relevant social, psychological, biological and contextual factors, is the Power Threat Meaning Framework (Johnstone and Boyle, 2018). It is based on four inter-related aspects:

"1. The operation of **POWER** (biological/embodied; coercive; legal; economic/material; ideological; social/cultural; and interpersonal).
2. The **THREAT** that the negative operation of power may pose to the person, the group and the community, with particular reference to emotional distress, and the ways in which this is mediated by our biology.
3. The central role of **MEANING** (as produced within social and cultural discourses, and primed by evolved and acquired bodily responses) in shaping the operation, experience and expression of power, threat, and our responses to threat.
4. As a reaction to all the above, the learned and evolved **THREAT RESPONSES** that a person, or family, group or community, may need to draw upon in order to ensure emotional, physical, relational and social survival. These range from largely automatic physiological reactions to linguistically-based or consciously selected actions and responses." (p. 9)

In terms of what they means for services, the "PTM Framework for the origins and maintenance of distress replaces the question at the heart of medicalisation, 'What is wrong with you?' with four others:

- 'What has happened to you?' (How has Power operated in your life?)
- 'How did it affect you?' (What kind of Threats does this pose?)
- 'What sense did you make of it?' (What is the Meaning of these situations and experiences to you?)
- 'What did you have to do to survive?' (What kinds of Threat Response are you using?)

Translated into practice with an individual, family or group, two additional questions need to be asked:

- 'What are your strengths?' (What access to Power resources do you have?)
- ...and to integrate all the above: 'What is your story?'" (p. 10)

There are already some examples of this Framework being used to work with people with a diagnosis of personality disorder (Reis et al., 2019) and it may be worth exploring how it could be used to inform interventions and service development as part of a more holistic, integrated, systemic approach to providing evidence-based, co-produced services focused on meaningful and important outcomes for service users and their families.

Strategic Context in Northern Ireland

This section provides a summary of the relevant law, policy and services context in Northern Ireland.

Law

The Mental Health (Northern Ireland) Order 1986 provides the current legal framework for compulsory intervention. In Article 3(2) it outlines a number of exclusions from the criteria for compulsory intervention:

"No person shall be treated under this Order as suffering from mental disorder, or from any form of mental disorder, by reason only of **personality disorder**, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."

These exclusions were positively intended to provide a boundary on the use of compulsion. It is important to note that the exclusions are 'by reason only of' so people may be experiencing these difficulties along with forms of mental health problems which would come under the scope of the Order. The Code of Practice (1992, para. 1.10) highlights that "the exclusions in Article 3(2) mean that a person cannot be compulsorily admitted to hospital under the terms of the Order by reason only of personality disorder…but that does not mean that someone with personality disorder may not be offered hospital admission for assessment and treatment on a voluntary basis."

There has been some discussion about the exclusions, especially personality disorder. The Fenton Report (1995, p. 182) on the Brian Doherty Inquiry, stated that "the specific exclusion of personality disorder unless accompanied by other forms of mental disorder means that it is difficult to obtain assessment and treatment for people with severe personality disorder accompanied by potentially violent and irresponsible behaviour" and it recommended that "severe personality disorder should be introduced as "an additional category of mental disorder". That approach wasn't implemented in Northern Ireland but there has also been the concern that the exclusion of personality disorder from the mental disorder criterion for compulsory intervention has, at times, been misinterpreted or misused to exclude people who want to voluntarily access services.

The Mental Capacity Act (Northern Ireland) 2016 does not have any such specific exclusions but it is capacity based and so compulsory intervention would only come under the scope of the new Act if a person's capacity to make the relevant decision was sufficiently impaired, including if this impairment was caused by personality disorder. This then raises further questions about the assessment of the relationship between personality disorder and mental

capacity, and, if relevant, what interventions might be in the person's best interests. These could be important areas to explore before full implementation of the Act.

Policy

The Bamford Review's first report in 2005, *A Strategic Framework for Adult Mental Health Services* highlighted the need for services for people with a diagnosis of personality disorder. It stated that "People with personality disorders appear to achieve and maintain better outcomes in treatment in specialist services dedicated to care. The process of rejection and failure to identify the pathology itself affects the treatability of the condition, so that each negative encounter makes the condition worse. Some evidence exists that where specialist therapy is offered and completed, the costs are offset by the subsequent reduction of service usage by people with personality disorder." (p. 194). It also suggested that "It is likely that the incidence of personality disorder in Northern Ireland is as high, if not higher, than throughout the rest of the UK. Risk factors are increased by the impact of 35 years of trauma, low socio-economic status and increasing numbers of single parent families." (p. 196). It recommended a regional tiered strategy for people with personality disorder.

A strategy for personality disorder services was then issues for consultation in December 2008 and the Bamford Action Plan for 2009-2011 (DHSSPS, 2009) reinforced the need for an agreed strategy with an implementation plan to provide a range of accessible services to address the varying needs of people with personality disorders and to support their carers.

The Northern Ireland Personality Disorder Strategy, *Personality Disorder: A diagnosis for inclusion*, was published in June 2010 and represents significant progress in the development of services. From the beginning it acknowledged the complexities of the issues involved and impact of not effectively responding to the associated needs. "It is generally acknowledged that personality disorders are caused by a combination and interaction of genetic vulnerability and adverse early experiences, such as abuse and neglect. People with personality disorders are already heavy users of our health, social care and Criminal Justice services but currently are often not satisfied with how the traditional model of care provision addresses their needs and, in the absence of dedicated provision, may not receive the optimal care. There is however established evidence that personality disorders can be effectively managed, increasing the person's quality of life and decreasing their use of health and criminal justice services" (p. 1). Amongst the strategy's 17 recommendations were that:

- "An interagency Personality Disorder Network Group should be established by the Health and Social Care Board and Public Health Agency to support implementation of the Personality Disorder Strategy.
- Initially services should be developed across tiers 0-3, working alongside and linking with existing health and social care and criminal justice services, and involving housing, employment and leisure agencies.
- A specific prioritised role for those working in tier 3 services would be to minimise the need for transfer of people outside of Northern Ireland for treatment.
- The options for a residential unit targeting adults with a personality disorder (particularly Clusters B and C), and with links to local mental health services, should be explored by the HSCB and PHA.

- A dedicated Criminal Justice Residential Unit should be established to support the work of the new arrangements, Public Protection Teams, the Criminal Justice Order (NI) 2008 and sentencing framework. This would be the 'cornerstone' of a comprehensive new Outreach Service for offenders whose emotional and behavioural difficulties emanate primarily from personality based deficits and deficiencies.
- The HSCB and PHA should, through the balance of investment in service development, ensure equality of access to specialist services is maximised. Specialist personality disorder services should work alongside and link with generic and other specialist mental health services including forensic mental health services and psychological therapy services" (pp. 2-4).

It also highlighted the need for: research priorities and expected outcomes to be identified; a joint regional training strategy using the Knowledge and Understanding Framework; meaningful user and carer involvement; clear protocols and care pathways; and ongoing links with the other mental health service developments.

As part of the Bamford Review process, a rapid review of the evidence on personality disorders was commissioned by the Health and Social Care Research and Development Division of the Public Health Agency and completed by Brady et al. in 2011. It made a number of recommendations that are still very relevant:

- "Research into prevalence rates and existing treatment pathways for personality disorder in Northern Ireland should be undertaken.
- A full economic evaluation of costs of personality disorder, or evaluation of service use by individuals with personality disorder across health and social care, housing, policing and other agencies would provide baseline figures to establish and evaluate targets and potential intervention strategies taking into account the economic impact of introducing specialist services.
- Training, awareness and support should be provided to staff in mental health services and other services/agencies to ensure that communication with clients is appropriate and this should include before and after measures of awareness and attitudes for the purpose of evaluation.
- Integrated pathways for care should be agreed and developed for health, forensic and prison settings, and implemented from an early stage in service delivery. A range of therapeutic interventions should be developed and made available as part of individual treatment planning, and universal and patient-specific outcome measurements should be included in treatment planning and assessments for evaluation purposes." (pp. 1-2)

In October 2014, *You in Mind: Regional Care Pathway for Personality Disorders* was published by the Health and Social Care Board. It outlined the care pathway for personality disorders and detailed the stepped care approach based on the relevant available NICE guidance. Ensuring that services are based on the more recent NICE guidance is a central aspect of providing interventions that are as evidence-based and as effective as possible. The relevant NICE guidance will be further explored in the specific interventions section of this report. The *Regional Care Pathway for Personality Disorders* also stated 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." (p. 9)

The next Bamford Action Plan, for 2012-2015 (DHSSPS, 2014) confirmed that some progress had been made with "Community based Personality Disorder services are operational in all 5 Trusts and Prison Health. A regional clinical network to share services, skills and expertise, including PBNI and Prison Health is in place and continues to take forward work in this area. A Care Pathway for Personality Disorders was launched on the 10th October 2014." (p. 33)

In 2020, the Department of Health's Mental Health Action Plan specified that the personality disorder strategy, which had been intended to have a five-year scope, should be evaluated and closed by February 2021 with the ongoing need for strategic direction and service development to be included in the planned new 10 Year Mental Health Strategy for Northern Ireland which is currently being drafted.

Prevention & Early Intervention

Key Messages

- Most PDs are rooted in childhood and start to present during adolescence
- A Personality Disorder service should span adolescence into adulthood
- BPD can be reliably diagnosed and treated at an early stage
- Delays in diagnosis and treatment lead to extremely unfavourable outcomes both for the progression of the disorder and the individual social and economic costs
- Prevention and early intervention is a much more effective and economic option and is a fundamental human rights issue
- The mental health workforce requires better training and assessment tools to recognise disordered personality traits, to improve early intervention, promote better understanding of PDs and help tackle the associated stigma within and outside the profession
- Families and friends should be involved at the earliest opportunity
- Much more research evidence is required to identify the risk factors for developing severe problems and improve treatment outcomes including greater access to cost-effective and acceptable treatments
- School-based universal interventions can help teachers and schools to develop the knowledge and skills to help and support students experiencing PD and self-harm behaviours

The individual and societal costs associated with PD are considerable. People with BPD are less likely to complete their education, achieve fewer qualifications, have disproportionately higher levels of unemployment (Chanen, 2015), and persistent functional disability (Gunderson et al., 2011). BPD is a stronger predictor of being on disability support than either depressive or anxiety disorders (Østby et al., 2014). The family and carer burden is high (Bailey & Grenyer, 2013), as are both the costs of direct and indirect healthcare. High rates of suicide and comorbid physical health problems all contribute to much higher rates of premature mortality than the general population. Health, social and economic inequalities associated with mental

health problems is a human rights issue. The prevention and provision of early support for people with disordered personality symptoms is crucial (Chanen, McCutcheon, & Kerr, 2014). BDP usually has its onset in puberty/emerging adulthood and can be reliably diagnosed and treated in young people. Despite this, delays in diagnosis and treatment are commonplace and often specific treatments are offered late in the course of the disorder, to relatively few individuals and often in the form of inaccessible, highly specialised and expensive services (Chanen, 2015).

The Global Alliance for Prevention and Early Intervention for BPD calls for action through a set of policy recommendations (Chanen, Sharp, & Hoffman, 2017):

Clinical priorities:

a) Early intervention
b) Prioritising the training of mental health professional in evidence-based early intervention
c) Indicated prevention to developing a comprehensive prevention strategy – targeting individuals with sub-threshold features to prevent on the onset of new 'cases'
d) Early identification through workforce development strategies to increase knowledge and understanding of BPD in young people disseminated among trainees and clinicians in child and youth mental health professions including tackling stigma and discrimination associated with the condition
e) Diagnosis of BPD should not be delayed to afford individuals the opportunity to access treatment
f) Discourage the use of misleading terms or intentional use of substitute diagnoses
g) Families and friends should be actively involved as collaborators in prevention and early intervention

Research priorities:

a) Prevention and early intervention must be integrated with similar efforts for other severe mental disorders
b) Building a knowledge based to identify the risk factors for persistence or worsening of problems and treatment development based upon causal mechanisms that underlie risk
c) Novel, low-cost preventive, developmentally appropriate interventions that can be developed and evaluated and widely disseminated
d) Education and skill development programs for families with a young person with BPD
e) Research to quantify the educational, vocational and social outcomes for young people with BPD
f) Further development and validation of brief and user friendly assessment tools
g) Detailed health economic data
h) Research in how to improve access treatment and reduce dropout

Social and policy priorities:

a) BPD needs to be recognised as a severe mental disorder at all levels of the health system
b) Evidence-based policy is needed to address BPD from primary through to specialist care including young people and families as partners in the design of systems

c) Discriminatory practices in health care systems must be eliminated

School-Based Interventions

The school environment offers opportunities for early identification and intervention for young people with mental health problems including self-harm and complex problems such as BPD. However, teachers can feel they lack the knowledge and skills to understand and respond to these issues and can experience considerable stress when facing these challenges. Many teachers can experience difficulties understanding young people with PD and may resort to disciplinary approaches to deal with related behavioural issues which then lead to school suspension and expulsion. The Project Air Strategy for Schools is a manualised whole-school programme and aims to support all professionals working with young people including school counsellors, health staff, welfare workers, teachers and school administrators. There are five focus areas:

1. Understanding complex mental health problems
2. Identifying and assessing risk, responding to crisis and self-harm situations and responding effectively to challenging behaviours
3. Working to improve the school environment
4. Teacher wellbeing
5. Working with parents with a personality disorder

Townsend and colleagues (2018) implemented a pilot study of Project Air Strategy for Schools across 18 post-primary schools in Australia. The intervention was delivered in three stages:

- Stage 1 – Professional development provided to school counsellors (*n*=290)
- Stage 2 – Opt-in training that allows school counsellors to become accredited trainers (*n*=145)
- Stage 3 – Accredited school counsellor trainers provide training to their respective schools

Providing teachers with additional training on complex mental health issues and associated behaviours such as self-harm was valued, with teachers feeling more optimistic, confident and gained more knowledge and skills to support people with complex mental health needs following the intervention.

Helping Young People Early (HYPE) programme

HYPE a comprehensive indicated prevention and early intervention programme that includes both a service model and an individual therapy for 15-25 year olds, which incorporates the principles of CAT. It was established as part of the Orygen youth mental health service in Melbourne. The primary inclusion is having three or more DSM BPD criteria, recognising the dimensional nature of BPD, reducing discussions about treatment eligibility where there is a clear need for intervention which include suicidal behaviours, impulsivity and affective instability without meeting a clinical diagnosis.

A single practitioner (case manager) provides both psychotherapy and case management and all patients are jointly managed with a psychiatrist and reviewed weekly by the treatment team. Integrating therapy, case management and psychiatric care minimises the number of clinicians involved and a team-based approach provides a supportive environment for clinicians. Case management and therapy are clearly distinguished.

Typically, 16 CAT sessions (and case management) are offered to each patient with four post-therapy sessions offered at 1, 2, 4 and 6 months.

The key elements of the HYPE team-based, integrated early intervention for BPD are (Chanen et al., 2014):

- Assertive, 'psychologically informed' case management integrated with the delivery of individual psychotherapy
- Capacity for 'outreach' care in the community
- Flexible timing and location of intervention
- Active engagement and inclusion of families or carers
- Using a consistent, common and 'plain language' model across all aspects of care
- Psychoeducation for patients, families, carers, schools, and others involved in the with the young person using non-pejorative, non-blaming language
- Integration of general psychiatric care within the same team, with specific assessment and treatment of co-occurring psychiatric syndromes ('comorbidity'), including the use of pharmacotherapy, where indicated for such syndromes
- Crisis team and inpatient care, with a clear model of brief and goal-directed inpatient care
- Access to a psychosocial recovery program
- Individual and group supervision of staff
- A quality assurance programme

While many young people will no longer be living with their family and HYPE is primarily an individual therapy, usual practice is to involve family members or carers in assessment, treatment planning and psychoeducation. Where indicated, more formal family intervention sessions may be conducted by the team within the CAT model.

Crisis Interventions

Key Messages

- There is a lack of evidence of the effectiveness of crisis interventions
- Brief psychotherapeutic interventions based on effective long-term treatment models (e.g. DBT) may be useful for clinicians but more research is required
- Brief inpatient admissions may also play a clear role in supporting recovery and treatment during times of crisis
- Effective psychotherapy techniques are highly specialised and require specially trained therapists working in teams which can limit access to these interventions

Effectiveness of Crisis Interventions

Empirical research in the effectiveness of crisis interventions is lacking (Borschmann, Henderson, Hogg, Phillips, & Moran, 2012). A 2012 Cochrane systematic review concluded that there was inadequate evidence to reach any conclusions about the management of acute crises for people with BPD and further research is required (Borschmann et al., 2012). In January 2009, NICE published guidelines on the treatment and management of BPD including recommendations for the effective management of crises which focus on empowering the client and assess the level of risk to self and others, look to previous effective management

strategies and help the patient to manage anxiety by enhancing coping strategies and follow-up to monitor progress.

Brief DBT Intervention

While interventions such as DBT may be effective in long-term treatment for BPD where self-harm risk reduction is the primary goal, it is generally not considered suitable for acute management. Although, one uncontrolled study investigated the efficacy of a brief DBT intervention tailored for BPD patients in crisis who at follow-up had significant reductions in symptoms of depression and hopelessness (McQuillan et al., 2005). Psychotherapies, such as DBT, MBT and CAT (or their general principles) might be usefully applied during crises in this population but research is required to explore these possibilities further (Borschmann & Moran, 2011).

Brief Inpatient Psychiatric Hospital Admissions

The evidence base for brief inpatient hospital admissions is poor. No RCTs have been conducted to assess the effectiveness of this intervention but PhD research has systematically reviewed Brief Admissions concluding it can be effectively used to prevent self-harm and suicide in patients with BPD (Helleman, 2017). The review identified five key components of this intervention approach across the ten included studies:

1. Discussion of the goal of the Brief Admission with the patient in advance
2. Notation of the Brief Admission procedure in a written treatment or crisis plan
3. Clear understanding of admission procedure and duration of the Brief Admission
4. Description of the interventions used during the Brief Admission
5. Stipulation of conditions for premature (i.e. forced) discharge

Cape Cod Crisis Model

As a response to the mechanism in BPD patients using regressive methods to test other's fidelity to promises and expectations, the crisis intervention of the Cape Cod Model aims for quick resolution by offering immediate proof that trustworthiness can be tested, directly in the troubled relationship and cumulatively improves the patient's vulnerability in future relationships. Laddis (2010) describes the first phase of the intervention for BPD and PTSD which aims to reduce symptoms broadly within 8 to 24 hours from treatment initiation (n=32) compared to treatment as usual (n=26) patients admitted to crisis stabilisation units. Outcomes were measured using the Brief Psychiatric Rating Scale (BPRS) and a pilot client observation instrument designed to assess the circular behaviour targeted by the intervention. The treatment group scores improved in four of the five BPRS subscales. Results from the patient self-observation scale were mostly non-significant.

Green Card Clinic

Huxley and colleagues (2019) evaluated an adaptation of the 'Green Card Clinic' model (Wilhelm et al., 2007) as a brief intervention within a stepped care model. The intervention was a generalist, manualised psychotherapy to address the needs of individuals with personality disorders who presented to emergency care in crisis with high-risk and complex needs. The intervention consists of up to four weekly sessions of therapy and was developed in line with recommended best practice for personality disorder treatment and a relational model of care. The 'Green Card Clinic' model of treatment was adapted for personality disorder presentations

and to be applicable to different mental health care settings including youth and adult patients. The intervention is structured and combines care planning, skills-based intervention, and relational principles. It includes engagement with the individual's family, partner or carer in treatment and recovery planning as a specific planned part of the intervention.

Psychological Interventions

Key Messages

- Dialectical Behaviour Therapy (DBT) is the most researched psychotherapy for personality disorders
- There is evidence that the commonly used types of psychotherapy (DBT, MBT, CAT, CBT) are more effective than treatment as usual (TAU) for personality disorders and these interventions have few adverse effects
- MBT significantly reduces levels of anxiety and depression, and addresses some of their most common comorbid disorders and improvements in quality of life for BPD patients
- Clinicians may consider developing expertise in more than one psychotherapeutic approach
- More and better quality research evidence is needed
- Generalist approaches and shorter adjunct therapies may also be beneficial
- The therapeutic relationship is an important factor in treatment and recovery

Although DBT has been studied the most, a series of meta-analyses suggest little to no differences between any active specialty treatments for BPD and no differences between DBT and non-DBT treatments or between cognitive behaviour theory–based and psychodynamic theory–based treatments (Levy, McMain, Bateman, & Clouthier, 2018; Storebø et al., 2020). Levy and colleagues suggested that clinicians are justified in using any of these treatments and might consider developing expertise in more than one approach. Storebø and et al. (2020) reviewed 75 trials (*N*=4,507*)*, of mostly female participants (age range 14.8-45.7 years) including over 16 different psychological treatments. The authors, "found no unequivocal, high-quality evidence to support one BPD-specific therapy over another in the treatment of BPD". For DBT compared to TAU, significant effects were observed in BPD severity, self-harm and psychosocial functioning and for MBT vs. TAU, improvements were observed in self-harm, suicidality and depression (Storebø et al., 2020), however the quality of the evidence for these outcomes was low. There is a need for more high quality evidence in larger patient numbers. Day-to-day experiences of clinicians also suggest that there are some promising interventions that have early encouraging results, e.g. add-on therapies such as STEPPS and ERGT.

There is substantial variation in how beneficial psychotherapy is for people with BPD, a review of the factors predicting the outcome of treatment identified two consistent positive predictors of symptom change: pre-treatment symptom severity (higher pre-treatment symptoms may achieve greater symptom reduction); and patient-rated therapeutic alliance (Barnicot et al., 2012). In a systematic review of fourteen RCTs measuring quality of life for patients with BPD following psychotherapy, significant effect sizes for quality of life (Cohen's d = 0.32; 95% CI [0.17, 0.48]) and BPD pathology (d = 0.44; 95% CI [0.16, 0.71]) were observed (Chakhssi, Zoet, Oostendorp, Noordzij, & Sommers-Spijkerman, 2019). The intensity of therapy may also be less important, intensive therapies (≥100 hours over 12 months) may not be significantly

superior to less intensive therapies (≤100 hours over 12 months) for reducing symptoms of suicidality and depression (Links, Shah, & Eynan, 2017). Links et al. also found evidence for the effectiveness of shorter duration (e.g. 14 weeks), and more 'generalist' approaches, adjunctive therapies and group-based skills training all showing potential. Mungo and colleagues specifically looked at impulsivity in BPD in their 2020 review looking back at studies published between 1989-2019 and recommend psychotherapy in BPD, particularly schema therapy, dialectical behavioural therapy, psychoeducation, system training of emotional predictability and problem solving and psychotherapy using mentalisation (Mungo, Hein, Hubain, Loas, & Fontaine, 2020) in line with other research findings (Oud, Arntz, Hermens, Verhoef, & Kendall, 2018) including for patients with mixed features of personality disorders (Silva, Donato, & Madeira, 2018).

Cognitive Analytic Therapy (CAT)

CAT is a time-limited, integrative talking-based psychotherapy that takes a practical and collaborative approach and focuses on understanding the individual's self-management problems and interpersonal relationship patterns and the thoughts, feelings and behavioural responses that result from these patterns (Chanen et al., 2014). "The self is seen in CAT to be characterised by an 'internalised' repertoire of relationship patterns, acquired throughout early and subsequent development. When development is suboptimal (as in the development of personality disorders) and early caregiving interactions are less nurturing or even destructive, these relationship patterns will be internalised and used or re-enacted inappropriately and/or inflexibly." (Chanen et al., 2014, p. 366). One of the central features is the co-creation by the patient and therapist of a shared understanding of the patient's difficulties and their origins by developing plain-language written and diagrammatic 'reformulations'. These form the basis for understanding relationship problems both outside and within therapy and assist the individual to recognise and revise their self-management patterns. It has advantages for early intervention because of its integrative and 'trans-diagnostic' approach that tackles the many different co-occurring problems within an overall treatment model. Treatment typically lasts between 16-24 weeks with a focus on managing the end of therapy from the outset – this has practical implications of increasing throughput and improving access to therapy (Mulder & Chanen, 2013).

Effectiveness of CAT

A UK service-based RCT compared 24 sessions of CAT (n=38) with treatment as usual (TAU) (n=40) over 10 months for individuals with personality disorder (Clarke, Thomas, & James, 2013). Primary outcomes were psychological symptoms (SCID-II) and interpersonal difficulties (Inventory of Interpersonal Problems, IIP). Secondary outcomes included adjustment, service satisfaction, dissociation and the Symptom Checklist-90-Revised. Data linkage also measured the frequency and duration of all accident and emergency attendances and in-patient admissions including for general health problems. Post-therapy, 33% of CAT participants no longer met symptomatic criteria for any personality disorder, and 100% of TAU met criteria for at least one (p<.001, Fisher's exact test). CAT was also favoured compared to TAU for the second primary outcome measure, IIP ($F_{(1,69)}$ = 16.507, p<.001). Results provide preliminary evidence that CAT is more effective than TAU but further evidence is required.

Cognitive Behavioural Therapy (CBT)

Meta-analysis of CBT found that it was not superior to control conditions, although this result was based on only 5 trials and heterogeneity was low (Cristea et al., 2017). Combining the results of two complementary Cochrane reviews, Gibbon et al. (2011) psychological interventions that proved superior to the control condition included cognitive behaviour therapy (CBT) and contingency management in men with ASPD and cocaine dependency.

Dialectical Behaviour Therapy (DBT)

DBT is an evidence-based, intensive, cognitive-behavioural treatment for borderline personality disorder intended primarily to reduce rates of suicidality and self-harm (Little, Tickle, & das Nair, 2018). Based on a biosocial theory of BPD, DBT focuses on the relationship between two factors as the core difficulties of the diagnosis: the biological dysfunction of emotional regulation; and an invalidating environment that inhibits the use of positive behaviour skills and reinforces the use of less helpful ones (Feigenbaum, 2007; Linehan & Kehrer, 1993). It incorporates Cognitive Behaviour Therapy (CBT) with elements of mindfulness and acceptance from Zen Buddhist practice and emerged from Marsha Linehan's attempts to treat suicidal behaviour in 'revolving door' BPD patients. Dialectics places importance on finding the balance between natural tensions in order to bring about change (Ghadishah, 2018). DBT aims to teach clients new behavioural skills and supports the replacement of unhelpful behaviours with more adaptive ones.

The structured treatment typically conducted over a 12-month period consists of four concurrent components, each mapped to the essential functions:

- Weekly individual psychotherapy to improve motivational factors (average duration of 60 minutes)
- Weekly group skills training to enhance capabilities (average duration of 2.5 hour skills training involving teaching skills in 4 domains: mindfulness; distress tolerance; emotional regulation; and interpersonal effectiveness (Linehan, 1993))
- As-required phone consultation with an individual therapist to promote generalisation of skills to daily life, conduct brief skills coaching, especially when a service user is in acute distress
- Case management to help the patient structure their environment
- Weekly consultation team meetings for DBT therapists to ensure therapists have the knowledge, skills and motivation to maintain model fidelity and prevent therapist burnout (Linehan, 1993).

DBT has five key aims (Linehan, 1993; Linehan et al., 2015):

1. Increase motivation to change and use skills provided
2. Teach skills for more effective emotional and behavioural regulation
3. Support the individual to generalise these skills to the wider environment
4. Help shape an environment that reinforces the use of the skills
5. Increase the therapist's own skills and motivation to keep working with the client

A review of the literature (Rudge, Feigenbaum, & Fonagy, 2020) identified three broad categories of the mechanisms of change in DBT and CBT for BPD:

1. emotion regulation/self-control

2. skills use
3. therapeutic alliance/investment in treatment

However, as a complex intervention, there may be various mechanisms of change that may be associated with the unique aspects of DBT and the underpinning theory and requires further empirical testing (Lynch, Robins, Morse, & Krause, 2001).

Effectiveness of DBT

Randomised controlled trials of DBT have demonstrated it to be more effective than TAU however methodological limitations associated with typically small sample sizes are common (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Turner, 2000; Van den Bosch, Verheul, Schippers, & van den Brink, 2002; Verheul et al., 2003). Bendit (2014) challenges the assumption that DBT is the most effective treatment for BPD simply because it has been empirically tested more than any other treatment. He notes that there other psychological treatments that have been effectively tested using RCT methodologies such as mentalisation-based therapy, schema-focused therapy and dynamic deconstructive psychotherapy and encourages optimism for new effective treatments for the condition. Reaching a similar conclusion, Kliem and colleagues' (Kliem, Kroger, & Kosfelder, 2010) meta-analysis of 16 studies (8 RCTs and 8 not randomised or controlled) calculated post-intervention global effect sizes for suicidal and self-injury following DBT. The dropout rate was 27.3% pre- to post-treatment. A moderate global effect and a moderate effect size for suicidal and self-injurious behaviours were found, when including a moderator for RCTs with borderline-specific treatments. The authors recommend that future research should compare DBT with other active borderline-specific treatments that have also demonstrated their efficacy using several long-term follow-up assessment points. Another review concluded that DBT interventions with skills training were more effective than those without (Links et al., 2017).

Meta-analyses suggest little to no differences between any active specialty treatments between DBT and non-DBT treatments or between CBT and psychodynamic theory-based treatments (Levy et al., 2018). Evidence shows that any of these interventions could be efficacious treatment compared to waiting list or treatment as usual (Levy et al., 2018).

In a Danish single-centre, two-armed, parallel-group randomised controlled trial (Andreasson et al., 2016), participants were offered 16 weeks of DBT versus 16 weeks of collaborative assessment and management of suicidality (CAMS) treatment. The primary outcome measure was a new self-harm event at 28 weeks. No significant differences were observed in the number of non-suicidal self-injury (OR: 1.60; 95% CI: 0.70–3.90; p = .31) or suicide attempts (OR: 2.24; 95% CI: 0.80–7.50; p = .12). The authors conclude that DBT is not superior to CAMS for reducing self-injury or suicide attempts. One of the largest RCTs (N=101) compared standard DBT with community treatment by experts (CTBE) (Linehan et al., 2006). Although subjects in both conditions showed substantial improvements, the DBT group generally exhibited better treatment response, particularly on outcomes related to behaviours specifically targeted by treatment. Subjects assigned to DBT were half as likely to attempt suicide as those assigned to CTBE (23.1% with at least one suicide attempt in DBT versus 46% in CTBE; p = 0.01). DBT patients had significantly fewer crisis treatments (psychiatric emergency attendance [33.3% CTBE vs. 15.6% DTB] and inpatient admissions [35.6% CTBE vs. 9.8% DBT).

Linehan and colleagues (Gunderson, 2015; Linehan et al., 2015) conducted another RCT involving one year of treatment and one year of follow-up in *N*=99 women with BPD who had at least two suicide attempts and/or self-injury acts within the past five years. The study compared standard DBT (skills training), DBT-S (skills training + case management) and DBT-I (individual therapy + activities group). All treatment conditions resulted in similar improvements in the frequency and severity of suicide attempts, suicide ideation, use of crisis services due to suicidality, and reasons for living. Interventions that included skills training resulted in greater improvements in frequency of self-injury, suicide attempts and depression. Anxiety significantly improved in standard DBT and DBT-S. Standard DBT had lower dropout rates from treatment. The authors conclude that interventions that include DBT skills training are more effective than DBT without skills training, and standard DBT may be superior in some areas.

Intensive outpatient DBT has been reported to reduce suicidal ideation, self-injurious behaviours, the number of days of hospitalisation for psychiatric or suicidal reasons, number of emergency department visits and depressive symptoms and anxiety however results for reducing anger and violent behaviours have been mixed (Bloom, Woodward, Susmaras, & Pantalone, 2012).

Avoiding hospitalisation is an ongoing priority because of the:

- Costs
- Stigma
- Disruption of work, school
- Disruption to interpersonal relationships
- Concerns about contagion effects of suicide among inpatients (Hacker, Collins, Gross-Young, Almeida, & Burke, 2008; King et al., 1995; Taiminen, 1993) or reinforcing suicidal behaviours (Linehan, 2018)

DBT in Inpatient Settings

Kröger et al. (Kroger, Harbeck, Armbrust, & Kliem, 2013) investigated consecutive admissions to a psychosomatic care hospital in Germany to assess the effectiveness and dropout using DBT in an inpatient population (N=1423). The average length of stay was 63.9 days (SD = 19.65). 45% of participants responded to treatment, 11% deteriorated and 30.6% remained unchanged despite treatment. Participants with co-occurring substance use disorders showed a significantly higher risk of discontinuing treatment. Patients aged ≤20 years were particularly at risk.

Bloom and colleagues (2012) conducted a systematic review of 11 studies of DBT for borderline personality disorder in inpatient settings with patients in voluntary treatment (one study was excluded from the review because it was conducted in a forensic setting and indicated that it may not be suitable for forensic patients because of violent behaviour (Low, Jones, & Duggan, 2001)). Of the 11 studies, only two reported treatment components in the comparison group which weakens the quality of the evidence. The majority of the samples were women only, and DBT inpatient treatment reported improvement in at least one symptom or problematic behaviour compared to a comparison group including:

- self-harm behaviour (Barley et al., 1993; Bohus et al., 2004; Katz, Cox, Gunasekara, & Miller, 2004)

- depressive symptoms (Bohus et al., 2004; Roepke et al., 2011; Springer, Lohr, Buchtel, & Silk, 1996)
- dissociative experiences (Kleindienst et al., 2008)
- anxiety (Bohus et al., 2004)
- suicidal ideation (Springer et al., 1996)
- violent behaviour (Katz et al., 2004)
- interpersonal problems (Bohus et al., 2004)
- global adjustment (Bohus et al., 2004; Kleindienst et al., 2008; McDonell et al., 2010)

Many of these treatment gains were maintained after hospital discharge (Bohus et al., 2004; Bohus et al., 2000; Katz & Cox, 2002), up to almost two years post-discharge (Kleindienst et al., 2008). In a separate trial, Oostendorp and Chakhssi (2017) measured symptoms, coping, attachment style and quality of life using self-report questionnaires at the start of treatment, after 19 weeks and post-treatment in 64 patients with BPD. Treatment lasted on average 7.2 months and significant improvements were observed in all variables. Positive changes in secure and preoccupied attached style were a significant predictor of psychological wellbeing at the end of treatment. There is considerable variation in the configuration and duration of DBT implementation for inpatients and a need to standardise and systematically test inpatient DBT but it appears to have some benefits for inpatients (Bloom et al., 2012; Oostendorp & Chakhssi, 2017).

Modifications of DBT

Many patients do not have access to DBT and developing research has explored using immersive Virtual Reality technology to enhance skills elements of DBT skills training (Navarro-Haro, Perez-Hernandez, Serrat, & Gasol-Colomina, 2018). Case studies have had some encouraging results but controlled studies are needed to inform this evidence base.

Feliu-Soler et al. (2014) assessed the effects of 10 weeks of DBT-mindfulness (DBT-M) training added to general psychiatric management (GPM) to improve emotion regulation in BPD patients. No differences were observed in emotional response at post-treatment, however, the DBT-M showed greater improvement in clinical symptoms. Their preliminary results suggest that mindfulness training reduces some psychiatric symptoms but may not have a clear effect on how patients respond to emotional stimuli in an experimental setting.

DBT delivered in community mental health settings has also been effective but more research is needed to establish how generalisable these results are. Conrad and colleagues (2017) evaluated a 10-week group intervention in an Australian community mental health service with clients diagnosed with either Cluster B personality disorder or mood disorder. Participants had been active clients for an average of 58.3 weeks prior to treatment. Significant improvements in quality of life and self-control were observed from baseline to post-treatment as well as a reduction in hopelessness, cognitive instability and dependence on mental health services.

Panepinto et al. (Panepinto, Uschold, Olandese, & Linn, 2015) investigated the efficacy of a modified DBT programme in a college counselling centre. Participants were not limited to students diagnosed with BPD and reported reductions in obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, paranoia, somatisation, psychoticism and phobic anxiety and overall stress. The authors recommend further research to identify the critical

beneficial DBT components in a general population sample that may benefit mental health. Chugani, Ghali and Brunner (2013) conducted a similar study piloting an 11-week DBT skills training class aimed at increasing adaptive skill use and emotion regulation in college students with Cluster B personality disorders or traits at a student counselling centre. Compared to treatment as usual, dialectical behaviour therapy participants significantly improved increasing skills use and decreasing maladaptive coping skills; there was a trend for improvement in difficulty regulating emotions.

Non-randomised controlled studies have also found effectiveness for adapting DBT with suicidal adolescents with BPD symptoms in both outpatient (Rathus & Miller 2002) and inpatient settings (Katz et al., 2004), in adult inpatient settings (Barley et al., 1993; Bohus et al., 2000) and forensic settings (McCann, Ball, & Ivanoff, 2000; Trupin, Stewart, Beach, & Boesky, 2002). RCTs are needed to establish the evidence for their use in this settings (Lynch, Trost, Salsman, & Linehan, 2007).

Sandage et al. (2015) conducted an evaluation of a pilot manualised group forgiveness module. Outcome measures included of forgiveness, attachment and psychiatric symptoms, participants showed increases in all measures of forgiveness and decreases in attachment insecurity and psychiatric symptoms during the forgiveness module and maintained at 6-week follow-up.

Carmona i Farrés and colleagues (2019) evaluated the impact of the mindfulness element of DBT on emotion dysregulation and impulsivity. A clinical sample was randomised to DBT mindfulness skills training (DBT-M) or DBT interpersonal effectiveness training (DBT-IE). Impulsivity decreased in the DBT-M group but not in the DBT-IE group. BPD psychopathology and some aspects of ED (e.g., emotional clarity and emotional acceptance) improved in both groups.

DBT for Co-Morbid Conditions

DBT is recommended for substance use and BPD (Lee, Cameron, & Jenner, 2015). Current therapies that are extended for patients with BPD and PTSD are also demonstrating effectiveness with evidence to suggest that exposure-based interventions can be safely incorporated into standard DBT once self-injury and suicide behaviours are under control (Links et al., 2017).

Dynamic Deconstructive Psychotherapy (DDP)

DDT treatment helps patients connect with their experiences and create more satisfactory, authentic and healthier relationships with others by attempting to improve the three neuro-affective deficits responsible for the health processing of emotional experiences using four sets of techniques:

- association
- attribution
- alterity-ideal
- alterity-real techniques

Research has shown that different DDP techniques are effective for different aspects of BPD (Goldman & Gregory, 2010). Treatment is limited to 12 months and the therapy developed for more severe and intractable cases of BPD especially where there are comorbid complex

behaviour problems including problematic drug and alcohol use, self-harm, eating disorders and chronic suicide attempts (Majdara, Talepasand, Rahimian Boogar, & J Gregory, 2018). It has shown to reduce the risk of alcohol misuse, suicidal behaviours and institutional care (Gregory, Remen, Soderberg, & Ploutz-Snyder, 2009).

Group Psychotherapy

Evidence for the effectiveness of psychotherapy for individuals with PDs is increasing (Popolo et al., 2019) and beginning to challenge the belief that they are treatment resistant (Livesley, Dimaggio, & Clarkin, 2016). Group treatment can be more cost effective than individual therapies that can take considerable time with high attrition rates. A number of trials of group psychotherapy for BDP have been conducted. A meta-analysis of 24 studies (N=1595) reported a large effect on reduction of BPD symptoms (g = 0.72, 95% confidence interval [0.41, 1.04], p < .001) and a moderate effect on suicidality/parasuicidality symptoms (g = 0.46, 95% confidence interval [0.22, 0.71], p < .001) (McLaughlin, Barkowski, Burlingame, Strauss, & Rosendahl, 2019). There was a small to medium effect in favour of group treatments for secondary outcomes (i.e., anxiety, depression, and mental health) but there was considerable heterogeneity in included studies.

Metacognitive Interpersonal Therapy (MIT-G)

Metacognition is the capacity to identify, reflect upon, and master states of mind of the self and others to help understand how we and others feel, what drives us to act and form an integrated view of oneself and use this understanding to manipulate and master these mental states. Metacognition is impaired in a wide range of PDs and in successful treatments appears to improve. In a feasibility study, Popolo and colleagues (Popolo et al., 2019) investigated the acceptability and clinical effectiveness of MIT-G in a sample of young adults diagnosed with mixed PDs. The programme comprised 16 2-hour sessions with each session having a fixed structure, sessions were divided into blocks of 2 or 3 for each motivational system. During each session, each motivational system was described in simple language and participants are invited to narrate episodes related to these motives which are then role-played to promote metacognition. Participants were randomised to MIT-G (n = 10) or waiting list+TAU (n = 10). Dropout rate was low and session attendance high (92.2%). Participants in the MIT-G arm had symptomatic and functional improvements and an increased capacity to understand mental states and regulate social interactions using mentalistic knowledge. Results were sustained at follow-up. Further research of MIT-G in larger samples is required to further test its effectiveness in reducing PD-related symptoms and problematic social functioning.

Mentalisation-Based Therapy (MBT)

MBT is a manualised, structured treatment that integrates cognitive, psychodynamic and relational components of therapy, with a basis in attachment theory and a rigorous focus on improving mentalising (the ability to understand the mental states of oneself and others). It consisted of 18 months of weekly combined individual and group psychotherapy provided by two different therapists (Bateman & Fonagy, 2006).

Effectiveness of MBT

A systematic review of 14 studies (N=885) including three RCTs concluded that MBT achieved superior or equal reductions in BPD psychiatric symptoms when compared with other

treatments (supportive group therapy, TAU, structured clinical management and specialised clinical management (Vogt & Norman, 2019)). The studies included in the review (Bales et al., 2015; Bales et al., 2012; Bateman & Fonagy, 1999, 2001, 2008, 2009; Bo et al., 2017; Brüne, Dimaggio, & Edel, 2013; Edel, Raaff, Dimaggio, Buchheim, & Brüne, 2017; Jørgensen et al., 2014; Jørgensen et al., 2013; Kvarstein et al., 2015; Laurenssen et al., 2014; Rossouw & Fonagy, 2012) indicate that MBT can achieve significant reductions in BPD symptom severity, the severity of comorbid disorders, and the use of psychotropic medication. It can also improve general psychiatric well-being, interpersonal functioning, and social adjustment. The effect sizes for the reductions of psychiatric symptoms were consistently large for MBT patients and either superior or comparable to the comparison treatments. Borderline-specific features were also found to decrease over the course of treatment, including substantial reductions in parasuicidal behaviour. MBT was also found to significantly reduce levels of anxiety and depression, which provides further evidence that MBT is a successful treatment for BPD patients, as it addresses some of their most common comorbid disorders and improvements in quality of life for BPD patients following MBT. The use of psychotropic medications was considerably reduced in MBT groups is also an indicator of the success of the treatment. This reduction may help to improve patients' quality of life as the side effects and adverse consequences of psychotropic drugs are linked with lower quality of life (Hajji, Marrag, Soussia, Zarrouk, & Nasr, 2014). The positive effects of MBT were observed across various settings, including day hospitals as well as inpatient and outpatient clinics. It is also important to note that the quality of studies included in this review was variable, with typically small sample sizes, high attrition rates and the developers of the intervention were involved in five of the studies. Little is also known about the mechanisms of MBT and better quality trials are needed to investigate its efficacy in treating BPD. Preliminary results from another trial based in Italy of two small samples of patients undergoing MBT who were followed up 1 year post-treatment (Carrera, Pandolfi, Cappelletti, Padoani, & Salcuni, 2018) reported improvements in patient symptoms but also found a significant reduction in workload for health staff relating to a reduction in the number and frequency of urgent accesses, emergency admissions, psychiatric treatment and antipsychotic drug use.

Bateman and colleagues (2016) evaluated the effectiveness of MBT vs. structured clinical management for antisocial personality disorder (ASPD) in an RCT subsample of patients in treatment for suicidality, self-harm and borderline personality disorder. The study found benefits of MBT for ASPD-associated behaviours in patients with comorbid BPD and ASPD, including the reduction of anger, hostility, paranoia, and frequency of self-harm and suicide attempts, as well as the improvement of negative mood, general psychiatric symptoms, interpersonal problems, and social adjustment.

Day Hospital MBT & Intensive Outpatient MBT

A multisite RCT conducted in the Netherlands (Smits et al., 2020) compared two types of MBT: day hospital (MBT-DH; n=70) and intensive outpatient (MBT-IPO; n=44). Significant improvements were found on all outcome measures, with moderate to very large effect sizes for both groups. MBT-DH was not superior to MBT-IOP on the primary outcome measure, but MBT-DH showed a clear tendency towards superiority on secondary outcomes. Although MBT-DH was not superior to MBT-IOP on the primary outcome (symptom severity) despite its greater treatment intensity, MBT-DH showed a tendency to be more effective on secondary outcomes (borderline symptomatology, personality functioning, interpersonal functioning,

quality of life and self-harm), particularly in terms of relational functioning. The authors propose that patients in MBT-DH and MBT-IOP seem to follow different trajectories of change, which may have important implications for clinical decision-making.

Petersen and colleagues (2010) report findings from an all-female MBT outpatient group therapy programme following 5-month day hospital treatment (Petersen et al., 2008). Treatment consisted of 1.5 hour outpatient psychodynamic group therapy once a week. The long-term mentalisation-oriented therapy was associated with a reduction in acute symptoms and significant improvements in interpersonal problems and social adjustment. At 2-year follow-up, positive effects were improved and hospitalisations were almost reduced to zero. Vocational status also improved. The number of months unemployed decreased, on average, from 8.6 months in 1 year prior to entering day treatment to 5.5 months in the first year of group therapy, 3.3 months in the second year of group therapy and finally to 2.4 months in the first year of follow-up.

MBT + DBT in Inpatient Settings

Edel and colleagues (Edel et al., 2017) examined in a pilot study, the effectiveness of MBT given adjunct to DBT vs. DBT alone, in a German BPD inpatient sample. Both treatments were effective in reducing symptom severity and the combination of DBT and MBT was superior in reducing fearful attachment and in improving affective mentalising. Combination DBT and MBT reduced self-harm than DBT alone. The authors suggest that short-term combinations of evidence-based borderline treatments may improve psychiatric inpatient care but further research is required.

MBT for Children & Young People

Three studies used MBT-A, a mentalisation-based-therapy specifically adapted for adolescents (Bo et al., 2017; Laurenssen et al., 2014; Rossouw & Fonagy, 2012). Two studies conducted with adolescents (Bo et al., 2016; Rossouw & Fonagy, 2012) used the risk-taking and self-harm inventory (RTSHI), developed for the use in this age group with high validity and reliability (Vrouva, Fonagy, Fearon, & Roussow, 2010). One study reported significant differences in scores between the MBT-A and TAU groups for its subscale of 'self-harm' at 12 months with the MBT-A group engaging in significantly less self-harming behaviour; on the second subscale of 'risk taking', no group differences were found (Rossouw & Fonagy, 2012). The other study did not report significant differences in scores of their cohort between pre- and post-treatment (Bo et al., 2017).

Other Forms of Psychotherapy

Other psychotherapy techniques can be effective for BPD including transference-focused psychotherapy, systems training for emotional predictability and problem solving, and CBT (Biskin & Paris, 2012). Individuals with PD may benefit from different therapies depending on their interpersonal style and preferences (Haskayne, Hirschfeld, & Larkin, 2014) and targeting particular symptoms such as impulsivity (which may be a predictive factor in remission in BDP (Links, Heslegrave, & Reekum, 1999)) (Mungo et al., 2020). Therapies tend to lie on a continuum from supportive to interpretive/directive interventions, which seem to exist within and between therapeutic orientations (Leichsenring, 2005). Previous research has demonstrated that individuals with PD improve if they are matched appropriately to the

intervention (Blatt, Besser, & Ford, 2007). Among PDs, ASPD and BPD have been more researched that the remaining PDs and the current evidence is sparse, not allowing for distinct treatment recommendations (Lieb, Stoffers, & Vollm, 2011).

Psychodynamic therapies

A recent meta-analysis (Keefe et al., 2020) of psychodynamic treatments for BPD and Cluster C PDs based on the evidence from 16 trials found that psychodynamic therapies were superior to controls in improving PD symptoms (g = -0.63; 95% confidence interval [CI; 0.87, 0.41]), suicidality (g = -0.79, p .02; 95% CI [1.38, 0.20]), general psychiatric symptoms (g = -0.47; 95% CI [0.69, 0.25]), and functioning (g = -0.66; 95% CI [1.01, 0.32]), but not for interpersonal problems due to heterogeneity (g = -1.25; 95% CI [3.22, 0.71]). The improvements were sustained at post-treatment follow-up (average 14 months). Study quality was generally rated as adequate however under-researched areas include narcissistic PD, specific Cluster C disorders, and personality pathology.

Acceptance & Commitment Therapy (ACT)

ACT is designed to promote psychological flexibility (Hayes, 2004) and has been shown to be effective for PTSD symptoms and improving interpersonal relationships and quality of life in BPD, particularly when combined with strategies from DBT and Functional Analytic Psychotherapy (Tsai, Kohlenberg, Kanter, Holman, & Loudon, 2012). One study (Arango et al., 2019) examined facial emotion expression, valence and arousal during an ACT-based psychotherapeutic intervention for patients with BPD to ascertain whether ACT can help improve emotion regulation strategies to reduce the negative emotions frequently experienced by patients with BPD which lead to dysfunctional behaviours. Many studies rely on self-report instruments and this study promotes the idea that the analysis of facial expressions may be useful in assessing the relationship between emotions, physiological processes and instrumental behaviour through the psychotherapeutic process.

Cognitive Remediation Therapy + Guanfacine

Impaired cognition is characteristic of schizophrenia spectrum disorders including schizotypal personality disorder and is the best predictor of functional outcome (McClure et al., 2019). McClure and colleagues conducted an 8-week, randomized, double-blind, placebo-controlled trial of guanfacine plus cognitive remediation and social skills training (15 guanfacine, 13 placebo) in 28 patients with schizotypal personality disorder. A statistically significant pre- versus post-treatment effect was observed for speed of processing, verbal learning, and visual learning and performance-based skills assessment. Both guanfacine and cognitive remediation plus social skills training were well tolerated, with no side effects or dropouts. Participants treated with cognitive remediation, social skills training, and guanfacine demonstrated statistically significant improvements in reasoning and problem solving, as well as in functional capacity and possibly social cognition, compared with those treated with cognitive remediation, social skills training, and placebo. The authors conclude that cognitive remediation plus social skills training may be an appropriate intervention for individuals with schizotypal personality disorder, and guanfacine appears to be a promising pharmaceutical augmentation to this psychosocial intervention.

Iconic Therapy

Iconic Therapy is a comprehensive psychological intervention that integrates existing therapeutic principles proven to be effective in educating people who have difficulty regulating their emotions. It involves the use of images to help those affected by BPD understand the origins and mechanisms of their emotional instability, feel validated and acquire the necessary attitudes and skills for daily life during a 12-week intensive programme. These images (a total of 35) include pictures, drawings and coloured geometric figures of neutral emotional valence (such as a table, a sailboat or a tower of books) that symbolically represent therapeutic principles (e.g., acceptance, resilience or empathy). The group of participants visualise from 2 to 5 icons per session on a big screen as the therapist explains their therapeutic symbolism, which seemingly eases a better understanding and more rapid evocation of therapeutic clues in crisis moments. Iconic Therapy was created in 2004 by the psychologist Soledad Santiago (Santiago, 2013) and first trialled in a personality disorder unit at a psychiatric hospital in Málaga. A current trial is underway to assess the effectiveness of Iconic Therapy vs. Structured Support Therapy in a sample of suicidal youth (Hurtado-Santiago, Guzman-Parra, Bersabe, & Mayoral, 2018).

Metacognitive Interpersonal Therapy (MIT)

MIT was developed for the range of PDs (Dimaggio et al., 2007) and follows a series of formalised procedures that address a patient's needs (Dimaggio, Montano, Popolo, & Salvatore, 2015). These include work aimed at forming a shared understanding of functioning, where clients are helped to develop an understanding of what they think and feel and of how they are guided by maladaptive interpersonal schemas while striving to reach these goals. Patients are encouraged to take a critical distance from his/her maladaptive beliefs about the self and others, together with an emphasis on access to healthy self-parts (e.g., self as lovable, active, committed, motivated, safe, curious, trustful, able to explore psychological states). Clients are then invited to try new actions and to expand their meaning making repertoire and to pursue goals they feel that deeply belong to them to live a progressively more adapted and fulfilling life. MIT has been demonstrated to be effective in a single case series of patients with PD (Dimaggio et al., 2017), and results have been replicated in a multiple-baseline single case series (Gordon-King, Schweitzer, & Dimaggio, 2017, 2018).

Schema Therapy

Schema therapy (ST) combines aspects of cognitive, behavioural, psychodynamic, attachment, and gestalt models and integrates cognitive, behavioural, and experiential techniques and was originally developed by Young (J. Young, 1990) as an individual therapy focusing particularly on PDs and chronic life problems (Gulum, 2018). Although initially ST was designed as an individual psychotherapy approach, it has been modified for use in group therapy (Farrell, Shaw, & Webber, 2009). Both the individual and group forms of the ST approach show promising findings in their effectiveness (Bamelis, Evers, Spinhoven, & Arntz, 2014; Farrell et al., 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Schaap, Chakhssi, & Westerhof, 2016).

A small scale single group design study by Doomen (2018) assessed the effectiveness of schema focused drama therapy in the treatment of Cluster C PDs in a sample of eight people. Results were encouraging with positive effects found for emotion expression, reduction in destructive coping and an increase in healthy sides.

Short-term Psychodynamic Psychotherapy (STPP) for Comorbid PD & Depression

STPP has been shown to be effective in the treatment of PDs and depressive disorders. Abbass and colleagues (Abbass, Town, & Driessen, 2011) conducted a systematic review and meta-analysis of STPP for comorbid PD and depressive disorder. Of the eight studies included, pre- to post-treatment effects sizes were large (d = 1.00-1.27) and these gains were sustained at follow-up over 1.5 years. Patients with Cluster A/B and C PD were responsive to STPP, with the majority of all studied patients showing clinically significant change on self-report measures.

Transference-Focused Psychotherapy

A variation of psychodynamic psychotherapy, transference-focused psychotherapy is typically delivered twice weekly in individual therapy sessions for up to a year. The primary focus is on the emotions arising in the relationship with the therapist and the use of traditional psychodynamic techniques. Clear limits and a treatment contract are developed at the start of therapy. Biskin and Paris' systematic review of treatments for BPD included three trials that supported the effectiveness of its use (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Giesen-Bloo et al., 2006).

Systems Training for Emotional Predictability and Problem Solving (STEPPS)

STEPPS is a 20-week group therapy that incorporates elements of CBT, skills training and systems therapy and designed as an 'add-on' treatment for patients managed in the community. Two trials were identified by Biskin and Paris which found that STEPPS reduced BPD symptoms and quality of life but there were no reductions in self-harm, suicide attempts or number of days in hospital (Blum et al., 2008; Bos, van Wel, Appelo, & Verbraak, 2010).

Non-Specialised Psychotherapeutic Treatment

Many treatments require specialised programmes and training, where these are not available, referral to an experienced psychotherapist who can provide a structured treatment program may be the best option, but no specific type of psychotherapy is preferable to another in this context (Biskin & Paris, 2012). Therapy could combine multiple modalities with different therapists, working as a team to avoid conflicting treatment approaches.

Adjunct Therapies

Art Therapy

In a randomized controlled trial, 57 adult participants diagnosed with a PD cluster B/C (SCID-II) were randomly assigned to either weekly group art therapy (1.5 hours, 10 weeks) or a waiting list group. Outcome measures were assessed at baseline, at post-test (10 weeks after baseline), and at follow-up (5 weeks after post-test). The results show that art therapy reduced PD pathology and maladaptive modes but it also helped patients to develop adaptive, positive modes that indicate better mental health and self-regulation.

Animal-Assisted Interventions

A number of studies have examined the impact of animal-assisted interventions for a range of serious mental health problems including personality disorder but there is a lack of high quality evidence based on randomised controlled trials. Animal-assisted interventions can involve a range of animals such as horses, domestic pets and farm animals and commonly consists of two types of intervention: 'animal-assisted therapy' (AAT) which is a goal-directed intervention

using the animal as an integral part of the treatment process to achieve goals; and 'animal-assisted activities' (AAA) which is less structured and aims to achieve positive psychological outcomes within a positive setting (Maujean, Pepping & Kendall, 2015). Some research supports the use of AAT where treatment engagement or motivation is low (Beck, Serydaraian, & Hunter, 1986).

Canine-Assisted Therapy for BPD

An animal-assisted intervention is a "goal-oriented intervention that intentionally includes or incorporates animals in health, education and human service (e.g., social work) for the purpose of therapeutic gains in humans" (Jegatheesan et al., 2013). There is currently no data examining the impact of AAI with BPD but canine-assisted therapy in group therapy has been shown to be effective for adult inpatients endorsing similar symptoms as BPD (Barker & Dawson, 1998) and other studies have demonstrated benefits of the approach in severe mental illness, reducing symptoms of anxiety and depression, negative symptoms of psychosis, trauma symptoms (Dietz, Davis, & Pennings, 2012) and improvements in social interaction and quality of life (Barker & Dawson, 1998; Jasperson, 2010; Villalta-Gil et al., 2009) in both children and adults. Canine-assisted therapy incorporates similar principles of existing evidence-based treatments for BPD (Kim, 2020) emphasising the importance of establishing therapeutic rapport, improving social skills and increasing adaptive behavioural responses (Kruger & Serpell, 2010) but as yet the research evidence is not available to support its use to help treat PDs.

Equine-Facilitated Psychotherapy

Horses act as a therapeutic aide by creating the capacity for an individual to forge a bond of trust, affection, patience, assertiveness and responsibility (Ewing et al., 2007). The equine-human bond should work in tandem with the client-therapist relationship to facilitate the processing of emotions and experiences and developing a therapeutic partnership. EFP has been found to enhance self-esteem, trust, relationships, interpersonal effectiveness, and overall feelings of well-being in participants (Rothe et al., 2005). There is some evidence for the benefits of EFP, particularly with young people but the research base is limited (Brandt, 2013).

Farm Animal-Assisted Activities

An RCT led by Berget (2008; 2011) evaluated the effectiveness of a twice-weekly intervention with farm animals to decrease levels of depression and anxiety, improve levels of self-efficacy, coping abilities and quality of life. Ninety people with a psychiatric disorder (schizophrenia, mood disorder, PD, or anxiety disorder) were randomised to 12 weeks of AAA or TAU. Activities including patting, washing, and grooming animals, moving them and horse-riding. At 6-month follow-up, participants showed significant increases in self-efficacy and coping abilities but the effect on depression was unclear.

Emotion Regulation Group Therapy (ERGT)

ERGT has been successfully used as an adjunct treatment to reduce self-injury and suicidal behaviour in women with BPD (Gratz, Tull, & Levy, 2014) and promising results suggest that further research is required (Storebø et al., 2020). Gratz and colleagues' manualised therapy programme is based on ACT and DBT and emphasises the following themes:

a) the potentially paradoxical effects of emotional avoidance

b) the emotion-regulating consequences of emotional acceptance and willingness, and
c) the importance of controlling behaviours when emotions are present, rather than controlling the emotions themselves.

Groups meet weekly for 90 minutes over 14 weeks and are limited to 6 patients per group.

Smartphone Interventions

Ilagan et al. (Ilagan, Iliakis, Wilks, Vahia, & Choi-Kain, 2020) conducted a systematic review and meta-analysis of smartphone apps designed as treatment interventions for adults with symptoms of anger, suicidality or self-harm common in BPD. Twelve studies of 10 applications were included, reporting data from N=408 participants. Between-groups meta-analyses of RCTs revealed no significant effect of smartphone applications above and beyond in-person treatments or a waitlist on BPD symptoms (Hedges' g = − 0.066, 95% CI [−.257, .125]), nor on general psychopathology (Hedges' *g* = 0.305, 95% CI [− 0.14, 0.75]). Dropout rates ranged from 0 to 56.7% (M = 22.5, 95% CI [0.15, 0.46]). A majority of interventions studied targeted emotion dysregulation and behavioural dyscontrol symptoms. Half of the applications are commercially available. The authors conclude that the effects of smartphone interventions on symptoms of BPD are unclear and there is a lack of evidence for their effectiveness. More research is needed to investigate both positive and adverse effects of smartphone applications and identify the role these technologies may provide in expanding mental healthcare resources.

Biological Interventions

Electroconvulsive Therapy

Clinician responses (e.g. electroconvulsive therapy, ECT) to manage depressive symptoms in borderline personality disorder (BPD) may evoke specific transference/countertransference dynamics (Mohan, 2018) and withdrawal of such responses may precipitate an abandonment crisis (Rasmussen, 2015). ECT's symbolism as an external cure for a personality problem may further complicate future expectations by the patient placed on the treating team. Mohan states that ECT is a valuable intervention in BPD – provided the psychiatric formulation clearly identifies the proportion of psychopathology that is likely to be managed by a biological intervention. Mohan warns against the practice of ECT in personality disorders as a 'just in case', 'last resort', 'risk aversion' or 'rescue' type of intervention without a clear understanding of the intricate dynamics involved which may end lead to the psychiatrist taking on responsibility for the patient's behaviour.

Transcranial Magnetic Stimulation

A two-armed randomised uncontrolled study in Mexico explored the effectiveness of transcranial magnetic stimulation for reducing impulsivity in BPD, both conditions were randomised to different frequencies of stimulation and improvement was significant in both groups but they could conclude the area or frequency most likely to cause significant change. Further research is required (Reyes-López et al., 2018). A second review identified two RCTs and two case studies and found the treatment to be safe and potentially effective in the reduction symptoms (Rachid, 2019).

Pharmacological Interventions

Key Messages

- Psychotherapy is the recommended primary treatment for personality disorders
- Pharmacotherapy is frequently prescribed as an adjunct therapy but the evidence base is sparse
- International guidance on the use of pharmacological interventions for personality disorders is conflicting
- Pharmacotherapy may help reduce some symptoms but no medications produce remission
- There is a balance between the potential long-term burden of adverse effects with short-term benefits of drug treatment

Psychological interventions are the recommended primary treatment for BPD (NICE, 2009) and other personality disorders (Gabbard, 2007) but there is a rationale in the literature for pharmacological approaches in the treatment of PDs. Behavioural traits may be associated with abnormalities of the Central Nervous System (Mulder, 1992) but the empirical base is scarce (Siever & Davis, 1991; Soloff, 1998) and evidence quality poor (Duggan, Huband, Smailagic, Ferriter, & Adams, 2007). To further complicate pharmacological treatment options are the high levels of comorbidity; most individuals with one personality disorder have at least one axis I comorbid disorder (commonly depression, anxiety, alcohol and drug disorders) and most will meet the criteria for at least one other personality disorder (Lenzenweger, Lane, Loranger, & Kessler, 2007; Newton-Howes et al., 2014).

Bateman and colleagues (2015) outline some of the current developments in pharmacotherapy including the potential effect of targeting N-methyl-D-aspartate signalling and the effects on disinhibition, social cognition, and dissociative symptoms (Ripoll, 2012), use of opiods (Bandelow, Schmahl, Falkai, & Wedekind, 2010; Stanley & Siever, 2010) and oxytocin for prosocial behaviours/interpersonal symptoms (Bartz, Simeon, et al., 2011). However, no randomised controlled trials exist for any of these compounds at present. Case studies and small open trials have not been promising. Opioid agonists and antagonists have been ineffective and potentially detrimental in treating patients with borderline personality disorder (Bartz, Zaki, Bolger, & Ochsner, 2011). Patients with borderline personality disorder given intra-nasal oxytocin were less cooperative and had more attachment anxiety than normal controls (Bartz, Simeon, et al., 2011). There is a risk that some people may have paradoxical responses to some drugs such as oxytocin because of pharmacological activation of the attachment processes (Bertsch et al., 2013) that underlie some of the characteristics of personality disorder. In conclusion, the authors suggest that drug trials might have to take into account attachment patterns, to bring greater synthesis to pharmacological and psychological research, and, when combined with neurobiological investigation, might improve the chance of identifying more effective treatments.

Drug Treatment for BPD

The management of patients with BPD is often challenging, with substantial risks of inappropriate or insufficient treatment (Biskin & Paris, 2012). Methodological limitations associated with drug treatment trials for personality disorders include: the short length of trials; small sample sizes and high attrition rates; choice of outcome measures often relying on self-

report measures; exclusion criteria typically includes less severe cases, and; the lack of replication (Biskin & Paris, 2012). At best, these psychopharmacological strategies remain theoretical and require further research on safety and efficacy prior to drawing any conclusions (Ripoll, 2013). Despite the lack of an empirical base (Hancock-Johnson, Griffiths, & Picchioni, 2017), drugs are frequently prescribed for the treatment of BPD. A 2010 systematic review of pharmacotherapy for BPD (Stoffers et al., 2010) tested the use of antipsychotics, antidepressant and mood stabiliser treatment as well as omega-3 fatty acid dietary supplement which is supposed to have a mood stabilising effect. 28 studies and a total of 1,742 participants were included in the analysis. The findings suggest that there are marginal benefits of second-generation antipsychotics, mood stabilisers, and omega-3 fatty acids, but most effect estimates were based on a single study so more research is needed. This consensus is supported elsewhere in the literature (Ripoll, 2012). A second systematic review of pharmacotherapy for BPD (Bellino, Rinaldi, Bozzatello, & Bogetto, 2011) concluded that the evidence suggests that mood stabilisers (topiramate, valproate and lamotrigine), second generation antipsychotics (olanzapine and aripiprazole) and omega-3 fatty acids can be useful to treat affective symptoms and impulsive-behavioural dyscontrol in BPD patients. Antipsychotics were found to significantly improve cognitive symptoms in patients with BPD and SSRIs were found to be effective in decreasing severity of depressed mood, anxiety and anger, mainly in subjects with a concomitant affective disorder. The effects of antidepressants on impulsive behaviours were uncertain.

The long-term use of these drugs is unknown. The small amount of available information for individual comparisons indicated marginal effects for first-generation antipsychotics and antidepressants. The data also suggest that there may be an increase in self-harming behaviours in patients treated with olanzapine. Adverse effects may include weight gain, sedation and change of haemogram parameters with olanzapine and weight loss with topiramate.

A 2020 review (Bozzatello, Rocca, De Rosa, & Bellino, 2020) of current and emerging evidence for medication use examined clinical trials evidence of the main classes of drugs for BPD and concluded that an individualised, tailored pharmacotherapy for BPD that targets the main symptom clusters can improve some aspects of the condition particularly for those who respond slowly or not at all to monotherapy. There is still no medication to treat the global psychopathology of BPD. The evidence also recommends that polypharmacy should be avoided or strictly limited.

The risk of overdose and burden of adverse side effects of medication can be substantial (Biskin & Paris, 2012). Biskin and Paris suggest that the 'safest first step' may be to prescribe a SSRI for anger symptoms but the potential benefits are limited. Partial responses to medication are common and frequently lead to polypharmacy and treatment for longer than necessary (Zanarini, Frankenburg, Hennen, & Silk, 2004; Zanarini, Frankenburg, Khera, & Bleichmar, 2001).

The international guidance on the use of pharmacotherapy in BPD is conflicting. The APA guidelines state that symptom targeted pharmacotherapy is an important adjunctive treatment for BPD (based on Siever and Davis' (1991) psychobiological perspective using SSRIs or monoamine oxidase inhibitors for affective instability; SSRIs or mood stabilisers for

impulsive aggression; low dose psychotics for cognitive-perceptive disturbances). There is some controversy over their recommendations (Ingenhoven, Lafay, Rinne, Passchier, & Duivenvoorden, 2010). The World Federation of Societies of Biological Psychiatry guidelines (Herpertz et al., 2007) states that there is moderate evidence for antipsychotics effectiveness for cognitive–perceptual and impulsive–aggressive symptoms, that some evidence exists for SSRIs being effective for emotional dysregulation, and that some evidence exists for mood stabilisers being effective for emotional dysregulation and impulsive–aggressive symptoms. However, in the UK, NICE guidelines state that drug treatment should generally be avoided, except in crisis, and then given for no longer than a week. An evidence synthesis conducted for Australia's National Health and Medical Research Council (NHMRC, 2012) guidelines for BPD treatment concluded that "overall pharmacotherapy did not appear to be effective in altering the nature and course of the disorder. Evidence does not support the use of pharmacotherapy as first line or sole treatment for BPD [borderline personality disorder]".

Based on the NICE and NHMRC guidelines, Bateman, Gunderson and Fogarty (2015) outline the use of drugs in BPD:

- Drugs should not be used as primary therapy for borderline personality disorder
- The time-limited use of drugs can be considered as an adjunct to psychosocial treatment, to manage specific symptoms
- Cautious prescription of drugs that could be lethal in overdose or associated with substance misuse
- The use of drugs can be considered in acute crisis situations but should be withdrawn once the crisis is resolved
- Drugs might have a role when a patient has active comorbid disorders
- If patients have no comorbid illness, efforts should be made to reduce or stop the drug

There are no methodologically sound studies of pharmacotherapy for BPD in young people (Chanen et al., 2014).

Some BPD symptoms are more amenable to treatment than others (Ripoll, 2013). Interpersonal affective symptoms, such as intolerance of aloneness and conflicted feelings about dependency, are slowest to remit, while symptoms reflecting impulsive behaviour, self-injury, and aggression tend to resolve more quickly (Choi-Kain, Zanarini, Frankenburg, Fitzmaurice, & Reich, 2010; Gunderson et al., 2011; Zanarini et al., 2007).

Anti-Convulsants for BPD

There is some evidence that anticonvulsant agents such as topiramate, valproate, or lamotrigine, and atypical antipsychotics such as aripiprazole and olanzapine, may be effective in treating BPD. Consistent with their benefits on impulsivity, a recent review recommended anticonvulsants and atypical antipsychotics for decreasing alcohol craving and consumption in BPD patients with comorbid alcoholism.

Anti-Depressants for BPD

Ripoll's review of evidence for psychopharmalogical treatment of BPD suggests that of the antidepressants, MAOIs and fluvoxamine may offer greater therapeutic benefit, but effects of antidepressants on BPD symptoms are more modest. Antidepressant medications may

nevertheless be helpful to treat comorbid mood and anxiety disorders, and they may be more efficacious in treating male BPD patients with prominent impulsive aggression (Ripoll, 2013). Bozzatello and colleagues' (2020) reviewed the most up-to-date evidence for anti-depressant use and although they have been widely prescribed for BPD despite the lack of high quality evidence overall use has recently declined and they are now only recommended for comorbid affective disorder. The authors conclude that the evidence is outdated, with no placebo-controlled trials for the efficacy of antidepressants for BPD run since 2010. SSRIs may help depressed mood, anxiety, anger and impulsive behaviour but the overall evidence is weak. Controlled trials of SNRIs are lacking and there are no new studies of new antidepressants such as vortioxetine.

Anti-Psychotics for Auditory Verbal Hallucinations in BPD

The presence of auditory verbal hallucinations are present in around one quarter of BPD patients and it is associated with an increase of suicide plans and attempts, more frequent hospitalisation and higher prevalence of PTSD and emotional abuse (Slotema, Blom, Niemantsverdriet, & Sommer, 2018). Based on a review of 21 studies, typical and atypical antipsychotics can have positive effects on auditory verbal hallucinations in BPD (Slotema et al., 2018).

Drug Treatment for Antisocial Personality Disorder

The evidence for drug treatment for antisocial personality disorder is extremely limited and the most recent Cochrane review concluded that there is not enough evidence to determine whether or not medication is a helpful treatment for ASPD (Khalifa, Gibbon, Völlm, Cheung, & McCarthy, 2020). Gedeon and colleagues (Gedeon, Parry, & Vollm, 2019) reviewed the literature on the use of oxytocin in ASPD and drew similar conclusions to Khalifa et al. (2020). There were diversified effects with oxytocin showing some benefits in promoting positive effects on symptoms of ASPD, but there were also studies showing non-desirable effects such as increased violence towards partners. Summarising the results of two complementary Cochrane reviews, Gibbon et al. (2011) reported a small number of randomised controlled trials included (eight for pharmacological interventions). The majority of these studies did not focus solely on ASPD but selected participants for other conditions, most commonly substance misuse disorders. Most trials tested a different psychological or pharmacological intervention, so very few conclusions can be drawn. Among the pharmacological approaches tested, nortriptyline and bromocriptine had some effect in men with alcohol dependency. Both drugs reduced anxiety levels, nortriptyline also had a positive effect on substance use related outcomes. Phenytoin was reported as superior to placebo on frequency and intensity of aggressive acts in male prisoners.

Drug Treatment for Cluster C Personality Disorder

No randomised controlled trials have been published of drug treatment of patients satisfying the full criteria of any cluster C personality disorder. However the World Federation of Societies of Biological Psychiatry guidelines (Herpertz et al., 2007) suggest that studies in patients with social phobia, which consistently report that antidepressants are better than placebo, may be evidence that these drugs might be effective in patients with avoidant personality disorder (Bateman et al., 2015).

Drug Treatment for Schizotypal Personality Disorder

Jakobsen et al. identified four randomised, double-blind, placebo-controlled trials, on subjects with well-defined diagnoses (Jakobsen et al., 2017) and only amisulpride, risperidone and thiothixene have been studied at methodologically robust level. Further high quality studies of the effects of antipsychotic treatment of SPD are required.

Antipsychotics for PDs

Patients with schizotypal personality disorder have been studied in a few small studies using typical and atypical antipsychotics (Silk & Feurino III, 2012) and while patients showed some improvement in overall symptom severity but the risk to benefit ratio is unclear (Bateman et al., 2015). No randomised controlled trials for patients with schizoid or paranoid personality disorder have been conducted and therefore no robust evidence about the efficacy of drugs in these patients is available at present (Bateman et al., 2015). Bozzatello and colleagues' (2020) review concluded that first-generation antipsychotics can be administered to BPD patients during acute states with impulsive-aggressive behaviours and psychotic-like symptoms but there is little evidence for their effectiveness. They recommend that treatment should be prescribed in low doses and for short periods because of its side effects and elevated dropout rate. Among second-generation antipsychotics, there was evidence to support the therapeutic effect of olanzapine on cognitive symptoms, aggressiveness, outbursts of anger, and anxiety in BPD patients. Further controlled studies are needed to confirm the preliminary, promising data on aripiprazole and quetiapine. Data on the newest medications have not been collected yet. Ingenhoven and Duivenvoorden (2011) reviewed eleven placebo-controlled RCTs in a systematic review of anti-psychotics for BPD and concluded that antipsychotics can have significant effects on cognitive-perceptual symptoms, anger and mood lability but wide and long-term use remains controversial. Losses to follow-up ranged from 7% to 57%, most studies reporting more than 30% which is common in personality disorder trials. Rosenbluth and Sinyor (2012) suggest that given the high rate of comorbidity between personality disorders and axis I disorders, atypical antipsychotics are best used when these symptom domains are prominent and there is a comorbid axis I condition for which an atypical antipsychotic is indicated.

Other Psychotropic Agents

Mood Stabilisers

The 2020 review conducted by Bozzatello et al. (2020) concluded that more studies are required to evaluate the effectiveness of these types of drugs including large-scale double-blind placebo trials and drug-drug comparison trials. The currently available evidence suggests that valproate, topiramate, and lamotrigine are a therapeutic option in treating impulsivity, anger, and affective instability in BPD patients.

Other Agents (Opiate Antagonists, Clonidine, Oxytocin, Omega-3 Fatty Acids)

Oxytocin has shown some benefits as a treatment for emotion recognition deficit and hypervigilance towards social threats in BPD but further research is required (Servan, Brunelin, & Poulet, 2018).

Drug Treatment in Forensic Settings

Völlm et al. (Völlm, Chadwick, Abdelrazek, & Smith, 2012)surveyed prescribing for ASPD and BPD in a high and medium secure setting. They found that nearly 80% of the 161 personality disordered patients surveyed received some form of psychotropic medication, nearly two-thirds were prescribed two or more drugs. Sixty-five percent of patients were prescribed medication specifically for the management of their personality disorder. Second generation antipsychotics and mood stabilisers were the most commonly prescribed drugs. Symptoms most frequently reported as targets for psychotropic medication included emotional instability, paranoia, aggression and hostility.

Physical Health

Key Messages

- The physical health of people with serious mental health problems has been under-researched and is an often neglected component of care
- Personality disorder is a strong predictor of all-cause mortality and cause-specific mortality including suicide, malignant neoplasms, chronic lower respiratory disease and human immunodeficiency virus infection (Krasnova, Eaton, & Samuels, 2019)
- The mortality gap is a public health and human rights issue
- Integrated and holistic, outcomes-based physical and mental health care is a priority for patients with PDs

Opportunities to make every contact count are important. Research in this area has pointed to universal screening measures for key touchpoints with public services e.g. beyond healthcare including the police, education etc. and helping to create shared responsibility for promoting care.

Collaborative Care Models provide a framework to deliver holistic evidence-based care and can be effectively delivered in outpatient settings. Promising findings from a randomised controlled trial in community mental health patient programmes in Maryland (USA) reported significant reductions in overall cardiovascular risk, smoking reduction, and improved blood pressure and lipid risk score in patients with serious mental illness. Physical health improvements are likely to improve symptoms in a number of mental health conditions (Carlo, Barnett, & Unützer, 2020).

Cardiac Illness

Personality traits significantly predict poorer cardiac outcomes. A systematic review of seven studies indicated that patients with Type D personality had a 276% increase in the odds of a poor medical outcome compared to patients without (Reich & Schatzberg, 2010). However, a 2019 systematic review of RCTs (Hall, Barnicot, Crawford, & Moran, 2019) for adults with a primary diagnosis of personality disorder and primary outcome of cardiovascular health returned no results. A review of hypertension treatments for patients with BPD (Roininen et al., 2019) also concluded that despite the high prevalence of hypertension and considerable cardiovascular risk and therapeutic conflicts of psychotropic medication, the authors found no studies on harmful drug-drug and drug-disease interactions or treatment recommendations for co-occurring hypertension and BPD. Further research is required.

Chronic Illness

There is some evidence of higher comorbidity with long term chronic conditions such a fibromyalgia, chronic fatigue syndrome and BPD and more research is recommended to explore possible associations and prognostic implications and potential treatment challenges in these conditions (Penfold, St Denis, & Mazhar, 2016).

Diabetes

Sperry (Sperry, 2010) explores some of the difficulties for treatment adherence in diabetic patients when the patient or one or more family members have disordered personality behaviours that can interfere with or complicate treatment. The need for self-monitoring, self-discipline and consistency may be difficult at times and impulsive behaviour, substance, nicotine and caffeine use alongside relationship problems may lead to inattention or neglect of insulin regulation or self-neglect. He emphasises the importance of the therapeutic relationship which should be an essential component of a diabetic treatment plan. He recommends that a basic strategy for working with diabetic families with borderline pathology to achieve some measure of success with the general treatment targets before addressing the treatment targets specific to diabetes.

Obesity

Maclean and colleagues' analysis of the US National Epidemiological Survey of Alcohol and Related Conditions (NESARC) report that controlling for household characteristics and comorbidities, personality disorders lead to higher BMI and risk of obesity in women but not men (Maclean, Xu, French, & Ettner, 2014). Their model suggests that women with personality disorders are 12.5-21.9% more likely to be obese than women without PDs and paranoid, schizotypal and avoidant PDs demonstrate the strongest adverse impact on women's body weight. They propose a causal relationship from PDs to body weight that is consistent with the psychiatric understanding of PDs.

People with personality disorders are over-represented in bariatric surgery candidates. Bordignon and colleagues (Bordignon, Aparicio, Bertoletti, & Trentini, 2017) conducted a systematic review of 16 studies that examined personality characteristics and bariatric surgery outcomes. They reported that weight loss during the postoperative period was associated with externalising dysfunctions and characteristics of persistence present at preoperative assessment; while postoperative emotional or psychological disorders were associated with emotional or internalising dysfunctions. They found that following surgery, some patients' symptoms improved, they experienced easier social relations (increased extraversion scores), and greater emotional stability (reduction in scores for neuroticism). They recommend assessment of personality characteristics to help inform surgical prognosis and the development of interventions for this population.

Tinnitus

Most studies show a significant association between personality characteristics (such as neuroticism, psychasthenia and schizoid features) and tinnitus (Mucci, Geocze, Abranches, Antunez, & de Oliveira Penido, 2014). These characteristics may be associated with the perception and annoyance of tinnitus, and contribute to the difficulty of patients' adaptation to the chronic symptom. There is a need for further research using more comprehensive

personality assessment instruments that can contribute to a better understanding of this phenomenon.

Health Risk Behaviours

Sexually Transmitted Infections

Certain personality traits associated with compulsivity and sensation seeking may lead to an elevated risk of engaging in unprotected sex and interventions targeting these individuals could address both direct and indirect mechanisms through which these personality traits may influence risky sex decisions and significantly reduce the transmission of sexually transmitted diseases such as HIV (Shuper, Joharchi, & Rehm, 2014).

Smoking

Bespoke smoking cessation trials in England for serious mental health conditions have reported high rates of sustained abstention after 12 months (Gilbody et al., 2019) and the evidence base for successful, tailored lifestyle programmes is growing. More research for PD is needed.

Research Trials Underway

A number of research trials are underway and have not yet reported findings:
PRO*BPD Schema therapy vs DBT (Fassbinder et al., 2018)
Role of personality disorder in randomised controlled trials of pharmacological interventions for adults with mood disorders: a protocol for a systematic review and meta-analysis (Kavanagh et al., 2019)

Interventions for Co-Morbid Conditions

Key Messages

- The prevalence of co-occurring conditions reinforces the importance of ensuing personality disorder focused services are also addressing people's other needs, especially in relation to alcohol and drug use; trauma; and their physical health.
- There is some specific evidence to support the use of psychological interventions for personality disorder and co-occurring conditions and services should be assessing and responding to the full range of people's needs.

Substance Use & BPD

Lee and colleagues' (2015) review of interventions for co-occurring substance use and BPD included ten studies using DBT, dynamic deconstructive psychotherapy (DDP) and dual-focused schema therapy (DFST). Both DBT and DDP reported reductions in substance use, suicidal/self-harm behaviours and improved treatment retention. Improvements in global and social functioning was observed in DBT. DFST reduced substance use and DBT and DDP improved utilisation. The authors conclude that DBT is the preferred treatment option given the evidence-based for women in particular. The small sample sizes suggest that further research is required.

PTSD & BPD

In her PhD thesis, Ghadishah (2018) describes the use of a combined DBT and Prolonged Exposure (PE) treatment module for clients with a dual diagnosis of BPD and PTSD. PE involves imaginal exposure (revisiting the traumatic experience in one's imagination and describing it out loud in therapy sessions) and in vivo exposure (confronting avoided situations in real life) The 3-month treatment showed to be effective in reducing maladaptive symptoms, suicidal ideation and chronic suicide attempts and emotional vulnerability and increased effective emotional regulation faster than DBT alone.

Eating Disorders

McDonald (2019) reviewed the literature that explores the genetics and epigenetics of bulimia nervosa (BN) / bulimia spectrum disorder (BSD) and comorbid BPD. The results indicated that BN/BSD-BPD is significantly different than BN/BSD or healthy controls on many genetic and epigenetic variables, suggesting that it may be a unique condition. McDonald proposes a genetic/epigenetic aetiological model of this condition and outlines the variables that are currently believed to influence specific symptoms and behaviours of BN/BSD-BPD, highlighting the likely role of childhood abuse in these conditions. Obsessive-compulsive personality disorder traits have been observed in excessive exercisers with anorexia nervosa (S. Young, Rhodes, Touyz, & Hay, 2013) and excessive exercise is associated with poor treatment outcomes. Personality disorder traits may contribute to individual cases being more complex and resistant to treatment, therapeutic interventions that aim to alleviate emotional distress and address behavioural rigidity and perfectionism traits are supported such as the Loughborough Eating Disorders Active Programme (LEAP) (Taranis, Meyer, Touyz, Arcelus, & La Puma, 2011).

Acceptability

Key Messages

- Understanding the factors that influence treatment engagement and adherence are important
- Young people may drop in and out of treatment and this should not be always a sign of refusal of treatment
- An individualised approach with more treatment choice may help engagement

Dropout

Treatment adherence and dropout are common measures of the acceptability of treatment. Gülüm's (Gulum, 2018) review of schema therapy RCTs reported a weighted mean dropout rate of 23.3%, 95% CI (14.8-31.7%) suggesting that this type of therapy may be significantly lower than studies involving PD treatment.

Practical Issues

Transportation difficulties were the primary reason for drop out (Koons, 2001). Subjects receiving DBT were significantly less likely to change therapists or drop out of treatment compared to CTBE (Linehan et al., 2006).

Co-Morbidity

Using inpatient admission data for patients receiving DBT for BPD, Kröger et al. (2006) reported higher dropout rates for co-occurring substance use disorders and patients aged ≤20 years.

Young People

Clinical experience at Orygen suggests that young people will drop in and out of treatment and most prefer time-limited therapy contracts (Chanen et al., 2014). BPD can affect young people's capacity to assess and use treatment services, failure to attend appointments and other forms of non-communicative behaviour are expected and should not be immediately interpreted as refusal of treatment.

Family Interventions

Key Messages

- Many psychological interventions do not typically intervene at an environmental level
- Unstable family relationships can be a significant obstacle in recovery
- Interventions targeted at family members and significant others can help equip carers with a better understanding of PDs, gain new skills to cope and reduce carer burden and ultimately improve relationships

Many psychological interventions do not typically intervene at an environmental level which is significantly influenced by family members and other loved ones. For example, for women with BPD, unstable family relationships can be the main obstacle in their recovery (Larivière et al., 2015). Many caregivers want to feel empowered, know how to take care of themselves but also to learn skills to better support their family member (Kay, Poggenpoel, Myburgh, & Downing, 2018). There is also some risk that psychoeducation for families can increase burden and brief interventions may not be intensive enough to make significant changes.

CAT-Based Programmes for Families

In a recent pre–post assessment study of an intervention for families with young people with BPD facilitated by clinicians *Making Sense of BPD*, three 2-hour sessions, conducted over 3 consecutive weeks, were offered, covering the features of personality disorder, diagnosis, causes, treatment, interpersonal skills, relationship patterns, and self-care (Pearce et al., 2017). These topics were discussed within a youth developmental context, and a family member with lived experience contributed to the final session. Participants showed decreased subjective burden but increased objective burden and no change in distress. Knowledge of personality disorder increased. An RCT of MS-BPD led by Professor Andrew Chanen at Orygen is underway (Betts et al., 2018).

DBT-Based Programmes for Families

Dialectical Behaviour Therapy-Family Skills Training (DBT-FST) is a structured, behaviourally oriented family intervention that includes both acceptance and change strategies and skills (Fruzzetti, Santisteban, & Hoffman, 2007; Hoffman, Fruzzetti, & Swenson, 1999). Including the four elements of standard DBT it incorporates a fifth component, "structuring the environment" to give patients a setting to practice new skills with their family members in a real-life environment. It aims to provide family members with an understanding of borderline

behavioural patterns in a clear and non-judgemental way, enhance the contributions of all family members to a mutually validating environment and address emotion regulation and interpersonal skill deficits in all family members. The treatment is a 6-month (24-week) series that meets for an hour and a half on a weekly basis with a group of from 6 to 9 families.

Family Connections is an offshoot of the DBT-FST programme delivered by family members with support from professionals, offers psychoeducation, problem solving, family relationship skills, and a support network over 12 weekly sessions (Hoffman, Fruzzetti, & Buteau, 2007; Hoffman et al., 2005). This is a major commitment in terms of time for families trying to get on with their own lives. Improvements were noted in symptom distress, subjective sense of coping, and decreased burden. Three pre-post studies (Hoffman, Fruzzetti, & Buteau, 2007; Hoffman et al., 2005; Rajalin, Wickholm-Pethrus, Hursti, & Jokinen, 2009) have demonstrated statistically significant decreases in participants' subjective experience of burden, distress/depression, and grief, and statistically significant increases in participants' subjective experience of mastery/empowerment. These changes were either sustained or further improved at 3-month follow-up. Family Connections programmes have been running in more than 10 New Zealand cities since 2010 and in Australia since 2015. The programme has substantial waiting lists (Krawitz, Reeve, Hoffman, & Fruzzetti, 2016).

Martin et al. (2020) used a co-production approach to design a mixed-methods study to evaluate the impact of a peer-led education group (using Family Connections) for carers of individuals with BPD. Quantitative data was collected on perceptions of mastery, burden and prior to the intervention, participants felt little control over their lives and felt helpless to implement change. Carers both expressed feelings of personal distress and guilt and burden on their employment and leisure time as a result of providing care. These outcome measures were measured again immediately post-intervention and four months after. Family members showed initial improvement of perceived mastery which lowered slightly at 4 months. Total scores showed a statistically significant reduction in burden over time. Qualitative interviews also explored their relationship with their loved one, thoughts about the group intervention and specific coping skills/strategies they used.

Table 1 Evaluation of *Family Connections* – qualitative themes
(Martin, Holz, Woodward, & Cameron, 2020)

Area of focus	**Pre-group**	**Post-group**	**Follow-up**
Relationship with loved one	Hopelessness	Improved with lingering emotion dysregulation challenges	Hopeful
	Intense/volatile	Recognition of efforts by loved ones	Appreciative of improved connection
	Unpredictable		Less interpersonal conflict
Thoughts about the group intervention	*Hoped for characteristics:* Information	*Characteristics of group that did help:* Education/Information	*Suggestions for future groups:* Separate groups for families & romantic partners
	Skills	It worked, was beneficial	More sessions

	Support	Provided hope	Offered concurrent to DBT treatment of loved one
Support strategies used	Reading the mood	Validation	Continued use of the skills applied post-group
	Ending negative interactions	Communication	
	Avoidance/be passive	Mindfulness	
	Apply logic	Acceptance	
		Setting limits	

Staying Connected when Emotions Run High (Bailey, 2014), is a briefer intervention delivered by professionals offering five sessions on core principles of self-care, keeping calm in distress, setting boundaries, nondirective counselling skills, and safety planning. Again, families reported less burden, better sense of wellbeing, and improved quality of life.

MBT-Based Programmes for Families

Bateman and Fogarty (2019) conducted a trial of a supportive and skills-based programme for families/significant others living with or supporting people with a diagnosis of BPD. The Families and Carers Training Support (MBT-FACTS) consists of five 1.5-2-hour evening meetings delivered by trained family members. Primary outcomes were adverse incidents reported by a family member, secondary outcomes included self-reported family wellbeing, empowerment, burden and anxiety and depression symptoms. Families were randomised to treatment or wait-list control. The programme reported a reduction in adverse events, family functioning and wellbeing which were maintained at follow-up. Both treatment and wait-list control groups improved in measures of depression, total anxiety, and total burden. Further research is required to assess whether the intervention improves outcomes for individuals with BPD.

Group Psychoeducation for Carers

Grenyer and colleagues (2019) conducted an RCT of group psychoeducation for carers of people with BPD. Involving 6-8 carers per group, the intervention focused on improving relationship patterns between carers and relatives with BPD, psychoeducation about the disorder, peer support and self-care and skills to reduce burden. Carers were randomised into intervention (n=33) or waitlist (n=35). After 10 weeks, those in the intervention group reported improvements in dyadic adjustment with their relative, greater family empowerment, and reduced expressed emotion, which was sustained after 12 months. There were also improvements in carers' perceptions of being able to play a more active role, such as interacting with service providers. The authors conclude that providing structured group programs for carers can be an effective way of extending interventions to a group experiencing high burden.

Economic Costs

Key Messages

- Evidence-based psychological treatment is less expensive and more effective than treatment as usual
- Social gradient in mental health inequalities
- Improving employment prospects and stability is crucial
- Reducing workplace stigma and increasing knowledge and understanding of PDs within social and employment settings could help improve outcomes for people

Hospitalisations are costly, the mean annual cost of psychiatric inpatient services for someone with a diagnosis of borderline personality disorder already engaged in outpatient care was $7,948 (SD=$4,317) in 2003 (Bateman & Fonagy, 2003). A 2017 systematic review examined 30 economic evaluations providing cost data related to interventions for BPD across 134,136 patients (Meuldijk, McCarthy, Bourke, & Grenyer, 2017). The methodological quality of the included studies was good and the mean cost saving for treating BPD with evidence-based psychotherapy across studies was USD $2,987.82 per patient per year. A further mean weighted reduction of USD $1,551 per patient per year (range $83-$29,392) was found compared to treatment as usual. Evidence-based psychological treatment was less expensive *and* more effective, despite considerable differences in health cost arrangements between individual studies and countries. Where calculated, a significant difference in cost-savings between different types of evidence-based psychotherapies was found.

O'Sullivan et al. (O'Sullivan, Murphy, & Bourke, 2017) conducted a systematic review of the cost of DBT for BPD, the mean average cost per patient was reduced by 21-35% from pre-DBT to post-DBT treatment with the most significant cost savings reported for inpatient hospital days, shorter length of stay and reduced emergency department presentations.

Improving employment prospects and stability is also an important metric to consider. Petersen and colleagues (2010) report findings from an all-female MBT outpatient group therapy programme. Vocational status improved during the intervention with average months of unemployment decreasing from 8.6 months in year 1 to 2.4 months in the first year of follow-up.

Service User Perspectives

Key Messages

- Greater understanding of PD is required within mental health services
- Giving a person a diagnosis of PD can be traumatising and more work needs to be done to improve the assessment, diagnostic process and access to services and psychological therapy
- The stigma associated with PDs is significant
- Compassionate and consistent care is paramount

Very little research attention has focused on improving the functional outcomes for patients with BPD. Research is needed to understand how interventions can impact the patient's employment and interpersonal and family relationships (Links et al., 2017). The therapeutic

alliance was identified as a common factor predicting outcome in patients with BPD in a review of 33 studies involving a range of different psychotherapeutic approaches (Barnicot et al., 2012), and consistently predicts greater improvement in symptoms.

Barr and colleagues (Barr, Jewell, Townsend, & Grenyer, 2020) conducted qualitative interviews with consumers (*n*=8*)* and thematic analysis identified some of the difficulties faced by people accessing services that included:

- Challenges and successes finding a mental health professional that understands personality disorder
- The need to improve the assessment and diagnosis process
- The need to improve communication between mental health professionals to ensure continuity of care
- Increasing feelings of safety when consumers are experiencing a crisis

UK service user and clinical perspectives of PD patient pathways were explored by Flynn et al. (2019). Six focus groups were held with clinicians (*n*=45) and current and past service users were invited to complete an online survey (*n*=131). The main areas of concern raised by both staff and patients were the diagnosis of PD, the absence of a coherent care pathway, access to psychological treatment and staff training.

The results reflect some of the ongoing debates around PD including individual and structural factors:

- Diagnosing PD – the term is unhelpful and stigmatising and can change how they are perceived and what subsequent treatment is then available, impacting on care pathways. Individuals felt 'labelled' and the diagnosis process itself can be traumatising.
- Receiving compassionate and consistent care – service users perceived staff manner and behaviour as critically important. Clinician compassion, understanding and the ability to listen was valued highly but there was some evidence of conflicting or contradictory approaches by professionals, particularly consultant psychiatrists, within teams.
- Access to services is varied and often relies on a postcode lottery.
- Psychological therapies should be made more widely available and offered as a first line of treatment. The most effective treatments are not always readily available to all service users e.g. DBT
- Service users perceived a lack of understanding of the PD diagnosis among staff and felt that further knowledge and training would be beneficial.

DBT

Little and colleagues (Little et al., 2018) undertook a systematic review of the qualitative literature pertaining to service user perceptions of DBT for BPD and reported four constructs in people's experiences of DBT.

1. Life before DBT: a hopeless beginning

Individuals described experiences of hopelessness and distress often stemming from a lack of self-understanding and not being understood or supported by others. Hope for change was

limited because of the lack of choice in treatment options and the ineffectiveness of prior treatments.

2. Relationships that support change

Feeling valued, respected and listened to was important for many service users and described therapeutic relationships as one of "equality and companionship, where there is a degree of therapist disclosure helping individuals feeling validated and normalised" (Little et al., 2018, p. 290). Therapists having specialist knowledge was also valued and differentiated them from other mental health professionals outside of the DBT programme, particularly in terms of supporting the application of skills. Being part of group therapy was largely positive, again it helped to validate and normalise experiences but could be, at times, overwhelming.

3. Developing self-efficacy

Developing self-efficacy was highlighted as an outcome of the therapeutic process:

- Learning the skills to regulate emotions and tolerate stress and being able to cope with situations that may have been overwhelming prior to therapy. Several studies discussed that through practice and repetition that these skills became automatic or 'second nature' and confidence increases in managing difficult situations and emotions.
- Taking ownership and responsibility – the difficult and challenging nature of treatment was acknowledged and it was understood by participants that change must come from within and progress will only come when the individual takes responsibility. There was also some discussion about in the early stages of DBT that individuals found safety in passing responsibility to staff before they felt confident enough to take it back.
- Changes in relationships – there were mixed reports of the impact of new approaches to communication and assertiveness which could have both positive and negative responses with relatives and friends

4. A shift in perspectives

Insight and acceptance was identified in most studies. This helped to develop a greater understanding of the origins of difficulties and the processes leading to problematic behaviour enabling service users to reflect on their past. It was also considered important to accept that their difficulties had not been removed but they were being taught how to manage them better. Giving individuals hope for the future was also a strong theme across the studies and an important shift away from the sense of hopelessness many experienced before starting DBT.

The review also raises some questions about current outcome measures used for treatment effectiveness which may not capture the changes experienced by individuals undertaking DBT. The importance of the therapeutic alliance was also identified in qualitative research conducted in a German study (Meissner, Bischkopf, Stiglmayr, Fydrich, & Renneberg, 2016). The Qualitative Change Interview was conducted with N=47 patients following one year of treatment which focused on the helpful and hindering aspects of the therapy process.

Brief Admission

Helleman and colleagues (Helleman, Goossens, Kaasenbrood, & Achterberg, 2014) report findings from a qualitative study of interviews with N=17 patients with BPD subject to Brief Admission interventions. Patients highlighted the quality of the contact with a nurse as the most important aspect of the brief admission and the authors stress the importance of connecting with patients during this short admission, particularly in the context of the interpersonal hypersensitivity often present in BPD.

Caregiver Perspectives

Key Messages

- Carers want to be involved in early assessment and intervention, including times of crisis
- Mental health professionals should develop a better understanding of PD and how to support carers effectively
- Access to and quality of services need to be improved for their family member

Greer and Cohen (2018) conducted a systematic review of the experiences of romantic partners of adults with BDP and the interventions designed to support them. Thematic analysis revealed issues around the emotional challenges of dealing with their partner's condition, the dual role as partner and parental/therapeutic figure and lack of control. Nine papers in the review reported on available interventions which consisted of educational and skills-based programmes but these had limited data on their effectiveness and did not address all of the issues raised by caregivers. The authors conclude that more partner-oriented programmes should be developed using psychoeducation, peer support and individual-relationship based skills approaches.

Barr and colleagues (Barr, Jewell, et al., 2020) conducted qualitative interviews with carers (*n*=7*)* and thematic analysis identified some of the issues faced by carers supporting individuals with BPD that included:

- The importance of carer involvement in early assessment and intervention
- Improving responses and follow-up when people present in crisis
- Increasing mental health professionals' understanding of PDs and improving communication
- Improving accessibility and quality of services for consumers

Workforce

Key Messages

- PD is a complex area of work and the workforce need ongoing training and research into effective treatments
- The patient/clinician relationship is key to delivering care and at times this can be challenging when trying to meet expectations and provide support within the constraints of available services
- Clinicians want to reinforce the recovery approach to be acknowledged in PD

Experiences of Prescribing Medication

Martean and Evans (2014) conducted a qualitative study to explore the experiences of psychiatrists considering medication for patients with PD. Semi-structured interviews with consultants were thematically analysed and revealed feelings of helplessness and inadequacy as clinicians when unable to relieve symptoms using medication. Discontinuity in doctor-patient relationships compounded these issues. This research highlights the need for more effective treatment and services for patients with PDs and more support and training for psychiatrists in relational complexities of prescribing.

Clinical Guidelines

Völlm and colleagues explored the tension between the recommended guidance and clinical expertise in a survey in medium and high security forensic settings. Psychotropic interventions were seen as effective by prescribers but were contrary to the NICE guidance for ASPD and BPD. NICE's guidelines were considered restrictive, "The NICE Guidelines on PD are useful only to the extent that they demonstrate there is no robust evidence for therapeutic interventions. For practising clinicians they are practically useless." Another clinician responded, "Clinical practice and experience has demonstrated that some patients with ASPD/BPD benefit from medication. Do we want drug treatments to be forbidden when patients may benefit?"(Vollm et al., 2012). It is important to note that in accordance with the NICE guidance, no BPD has been licensed for use for BPD in the UK and therefore unusual for NICE to recommend the use of any unlicensed drug; the current quality and lack of evidence also informed NICE's decision-making for the use of pharmacotherapy (Kendall, Burbeck, & Bateman, 2010).

Patient Personality/Psychotherapist Reactions

In an interesting review by Stefana and colleagues (2020), the relationship between patient personality and psychotherapist reactions in individual therapy settings was explored, recognising that therapists' reactions toward patients could be a valuable source of diagnostic information. Although there is a caution raised over the small number of studies included and methodological variation in the review they found significant and consistent relationships between therapist reactions and specific personality traits and disorders. Eccentric patients evoked feelings of distance and disconnection; emotionally dysregulated patients, anxiety and incompetence, and anxious and withdrawn patients were associated with sympathy and concern. Staff highlighted the importance of managing expectations and avoiding re-traumatising service users in qualitative focus groups conducted by Flynn.

Recovery-Oriented Approach

Giving a BPD diagnosis should not overwhelm or give clinicians cause for therapeutic pessimism (Balaratnasingam & Janca, 2020). Targeted interventions, including meaningful psychoeducation, are helpful in promoting optimism and enhancing recovery-oriented treatments. Flynn et al. (2019) found that understanding recovery was an issue in focus groups with clinicians with a common misconception among colleagues that people could not recover from PD and did not know what recovery looks like in PD e.g. what is the measure of success. Common measures tend to focus on reduced readmission rates, reduced self-harm, however one clinician suggested that a measure of success is individually meaningful to each service user. They also acknowledged the cyclical nature of recovery and that one missed appointment does not indicate a failure.

Training

Flynn's focus groups with clinicians identified that although training is provided, it was considered basic, not easily accessible and not universal. Ongoing staff support, including supervision, peer support, organisational support of service and multi-agency working was considered important to effective working and collaborative decision-making.

Peer Support

Key Messages

- More research is needed in the effectiveness of peer support for PD
- Peer support can help family members and carers
- There are different models of peer support and these need to be considered before implementing the role
- Pre-planning, organisational training and additional support is required to integrate peer support workers as part of mental health teams
- Having a number of peer support workers can offer service users the options to choose someone they want to work with

Peer support is a recovery oriented approach that engages patients and carers with people with lived experience of the disorder who have recovered (Barr, Townsend, & Grenyer, 2020). Limited quantitative evidence suggests that patient outcomes may not differ when the same service is provided by peer workers or mental health professionals (Chinman et al., 2014; Pitt et al., 2013). Peer support provided to carers and families in a group setting also shows improved outcomes for carers including greater empowerment and lower anxiety. Models of peer support for BPD are not available in the literature and other mental health peer support models may not be suitable for individuals with BPD (Barr, Townsend, et al., 2020). A systematic review of 38 studies on consumer and carer perspectives of services for individuals with BPD found that consumers and carers had different foci, including carers not receiving appropriate recognition from health professionals, and consumers describing the importance of their relationship with a health professional (Lamont & Dickens, 2019). An earlier systematic review of peer support for serious mental illness concluded that there was little evidence from current trials about the effects of peer support but also highlighted that there are deficiencies in the conduct of and reporting of the evaluation of complex interventions (Lloyd-Evans et al., 2014).

Barr, Townsend and Grenyer's (2020) qualitative study of the perspectives of consumers, carers and clinicians of peer support workers identified two operational models of peer support workers.

Table 2 Two models of peer support for BPD

Model 1: Consumer peer workers integrated in the mental health team	Model 2: Consumer peer workers complementary to the mental health team
Consumer peer workers write notes & the notes are shared with other mental health team workers	Consumer peer workers may or may not write notes & notes are not shared with other mental health team members
Consumer peer workers read consumer medical records & the notes of other mental health team members	Consumer peer workers do not read consumer medical records or notes of other mental health team members
Formalised consultations may occur between consumer peer workers & the mental health team	Informal discussions may occur between consumer peer workers and the mental health team

They go further and make specific recommendations for services to support peer work for consumers with BPD and their carers.

Table 3 Recommendations for services to support peer work for consumers with BPD and their carers

1	Evaluate an organization's workplace stigma toward borderline personality disorder and consider altering if required before the introduction of consumer peer workers and carer peer workers.
2	Inform the development and delivery of peer support based on peer support principles and the values of consumer peer workers and carer peer workers. Ensure duty of care and confidentiality codes are in place to guide practice.
3	Clarify the consumer peer worker and carer peer worker role in collaboration with the peer worker, including whether consumer peer workers support carers and carer peer workers support consumers. Discuss the consumer peer worker and carer peer worker role with members of the mental health team, consumers, and carers.
4	Clarify whether a complementary or integrated model of peer support will be used. For either model, clarify the selection criteria for consumer peer workers and carer peer workers, and how consumer peer workers and carer peer workers will be trained and supervised.
5	Consider hiring multiple consumer peer workers to provide consumers with options to select a consumer peer worker.
6	Consider including peer support in treatment plans for consumers.
7	Consider offering support to consumers from both consumer peer workers and mental health professionals.
8	Consider increasing the accessibility of peer support, and make professionals aware of peer support options to inform referrals.
9	Consider organizing consultation and supervision between consumer peer workers, carer peer workers, and mental health professionals.

As part of the psychenet project (www.psychenet.de), Mahlke and colleagues (2017) conducted an RCT comparing one-to-one peer support with TAU. Peer support was delivered by trained peers to patients with serious mental illness including BPD. The primary outcome was self-

efficacy as measured on the General Self-Efficacy Scale at 6-month follow, secondary measures included quality of life, social functioning and hospitalisations. Patients in the intervention group (*n*=114) had significantly higher scores of self-efficacy at the six month follow up compared to the control group (*n*=102). There were no statistically significant differences on secondary outcomes in the intention to treat analyses.

Service Design

Key Messages

- Prevention and early intervention should be further developed.
- The tiered or stepped care model is the recommended approach to ensure the most effective balance between generic and specialist services.

Service Design Recommendations

The Consensus Statement (Centre for Mental Health et al., 2020) suggests that the core tenets of an effective service are:

- "developing a consistent therapeutic environment and network of services,
- a consistent and respectful therapeutic relationship in which a real sense of partnership can develop,
- psychologically informed practice,
- individual formulations,
- and a trained workforce" (p. 10)

The Royal College of Psychiatrists' (2020, pp. 21-25) Position Paper provides detailed recommendations for how the tiered or stepped care model should be further developed. Some of the key recommendations are:

"Mental health commissioners and providers should ensure a functioning pathway operating across all tiers…

4.1 Tier 1:
4.1.1 Primary care psychological interventions should not exclude service users with a diagnosis of personality disorder.
4.1.2 General practitioners should have access to support and supervision in working with people with personality disorder: both managing them within the practice and knowing when and how to refer onwards.
4.1.3 Recovery Colleges, providing psychological education, should offer a range of relevant personality disorder interventions.
4.1.4 Other voluntary and third sector organisations need to be encouraged to co-ordinate and cooperate with the statutory sector pathways, including using social prescribing.
4.1.5 Peer support and self-help groups need to be linked to the pathways and be suitably supported by statutory services

4.2 Tier 2:

4.2.1 A range of specific, evidence-based interventions for people with personality disorder should be available in all localities on an outpatient basis.
4.2.2 Services should be multi-disciplinary and 'multi-model', that is they should offer a range of biological, psychological and social interventions, in a relational context.
4.2.3 Structured management approaches such as Structured Clinical Management (Bateman & Krawitz, 2013), should be available in community mental health teams and overseen by local specialist services.
4.2.4 Where patients are not able to engage, consultation can be sought from Tier 2 teams. This can help them to support and manage complex patients without the risk of falling into patterns of engagement which are unhelpful and exacerbate risk.
4.2.5 Interventions should be embedded within core psychiatric services.
4.2.6 Services should adopt systems to identify patients with whom they are struggling to engage and promote engagement.
4.2.7 Services should facilitate engagement with preventative, primary and acute care to promote physical health and wellbeing.

4.3 Tier 3:
4.3.1 Each trust must ensure that there is a dedicated and specialist personality disorder service delivering a therapeutic milieu-based treatment approach.
4.3.2 The patient group should be defined through Tier 2 and core psychiatric services being unable to offer interventions which can establish and maintain engagement.
Tier 3 services might include 'partial day-hospitalisation', various individual and group psychotherapies and family interventions. They also need facilities and procedures to assertively engage those who are unable or unwilling to attend hospital or community clinics."

It also provides detailed recommendations for: Tier 4 (specialist residential therapeutic units for personality disorder); Secure hospital and community forensic provision (Tier 5 and 6); and for the transition from child and adolescent mental health services, and for perinatal and infant mental health services. The stepped care model aims to ensure people receive the type of care and support that they need, when they need it and this is based on the necessary resourcing of all aspects of services, and good communication and cooperation between the tiers.

Children & Young People

PDs are rooted in childhood and adolescence (American Psychiatric Association, 2013), and early intervention could be too important an opportunity to miss. Prevalence rates rise during puberty and diagnosis in adolescence is associated with high morbidity rates and poorer future outcomes. Young people diagnosed with BPD have an increased risk of developing other mental disorders, interpersonal problems, distress and reduced quality of life (Cohen, Crawford, Johnson, & Kasen, 2005; Crawford et al., 2008; Winograd, Cohen, & Chen, 2008). While BPD can be one of the most distressing and disabling disorders, it is often associated with help-seeking (Tyrer et al., 2011) and can respond to treatment (Chanen et al., 2008, 2009; Schuppert et al., 2009; Schuppert et al., 2012). It can also be reliably diagnosed in its early stages (Chanen et al., 2014). Data also suggests that adolescence is a key developmental period to intervene, where BPD traits may be more flexible and malleable (Lenzenweger & Castro, 2005).

The prevention, early intervention and treatment of children and young people is of great importance, particularly managing the continuity of care when often the transition between child and adolescent and adult mental health services can be difficult. The debate about how important a continuum of service provision is crucial especially when personality disorder traits often emerge in childhood and adolescence and learning how to cope and manage could have life changing outcomes for this age group who are at high risk of mortality. Learning from other countries would suggest that extending adolescent treatment well into emerging adulthood (e.g. 15-25 in Orygen, Australia) would seem a sensible approach.

Forensic Settings

The effectiveness evidence of interventions for personality disorder offenders in the community is limited. A feasibility pilot for an RCT of the 'Resettle' programme was conducted by Nathan and colleagues providing some support for evaluating a complex intervention for personality disordered offenders in a criminal justice setting.

Offender Personality Disorder (OPD) Pathway

The OPD pathway established in 2011 aims to provide a 'community-to-community' pathway to enable individuals to access psychologically informed services from sentencing, to release and community reintegration and offers a number of key pathway services including:

- Psychologically Informed Planned Environments (PIPEs)
- Specific personality disorder treatment interventions
- Community case management

With a focus on training and supervision, it aims to improve the confidence, competence and attitudes of staff working with complex offenders and to offer an efficient and cost-effective approach to reduce offending and improve the psychological health, wellbeing and relational skills of offenders with PD behaviours (Skett & Lewis, 2019). Qualitative interviews with the commissioners of the service have been positive about its potential effectiveness (Trebilcock et al., 2019).

The Offender Personality Disorder Pathway in Wales has piloted a transition and liaison service aimed at supporting women moving from prison to the community and men leaving approved premises to the community (O'Meara, Morgan, Godden, & Davies, 2019). Based on the Intensive Intervention and Risk Management Service (IIRMS) model and delivered by two full-time mental health nurses, it offers a transition service over a few months to help people access services and support as they transition back into the community.

Intellectual Disabilities

Interventions based on DBT principles including standalone DBT skills groups have been delivered successfully in a range of different settings for people with intellectual disabilities and a PD diagnosis, with at least half of participants with a forensic history for violent, sexual, property damage or arson offences. Some have argued that people with IDs may have difficulty understanding Linehan's model but it has been adapted to allow for meaningful engagement. Adaptions have included a focus on experiential exercise, teaching fewer skills per module and simplifying the language used. More creativity and variety has been introduced to sessions using role-play, props and interactive games. The adapted DBT programme described by Lew et al. (2006)(2006) was aimed at individuals with intellectual

disabilities, presenting with "problem behaviours" and underserved by community services. Incorporating weekly individual therapy, 69 group sessions, a consultation team, a telephone coaching service and involvement of allied services and family members to develop environments which could support the therapy. Morrissey and Ingamells (2011) have been trialling an adapted DBT programme for male offenders with intellectual disabilities at a high-secure intellectual disability service since 2004. The programme includes 60 group sessions, weekly individual therapy and coaching via "DBT-aware" inpatient staff.

Integrated Care Pathways

Flynn's study of service user and clinician perspectives identified a common theme with a description of a fragmented care pathway for PD and that while some specialist services can be accessed in crisis the provision in mainstream mental health is lacking (Flynn et al., 2019). Service users felt that better mainstream provision could be helpful when on the verge of crisis, providing an alternative place of safety that does not involve attending accident and emergency, "I would like to see the introduction of crisis cafes or drop-in centres…where ex-service users can call and/or walk into, to seek help and support when they feel they need it." (Flynn et al., 2019, p. 138). Service availability can also vary greatly by postcode, including long waiting times for psychological therapy.

Maternal & Infant Mental Health

While there is a significant body of literature about mothers as parents and developmental issues for infants, children and young people, there is a lack of research on women with BPD across the perinatal period, from preconception and postpartum (Blankley, Galbally, & Snellen, 2013). BPD carries specific risks for the mother and infant and there is a need for the development, implementation and evaluation of specific management guidelines.

Stepped Care Models

Relatively few studies have examined a stepped care approach to personality disorders. Huxley and colleagues (Huxley et al., 2019) assessed a brief, four session, psychological treatment intervention for PD within a whole of service stepped care model. The intervention stepped between acute emergency crisis mental health services and longer-term outpatient treatments. The provision of a brief intervention as part of a stepped model of care may allow services to make treatment more accessible for people with personality disorders and assist them to access treatment options which may in turn, reduce the frequency of their engagement with crisis services. The brief intervention was a generalist, manualised psychotherapy for PD for people presenting to emergency care in crisis with high-risk and complex needs informed by the 'Green Card Clinic' (Wilhelm et al., 2007). Two separate studies were evaluated – the first involved N=191 referred to the intervention at a single community health site in a metropolitan health service. The second involved N=67 referred across 4 different sites in metropolitan health services. Suicide risk and symptom severity reduced and quality of life improved, with only a small proportion of individuals requiring ongoing support from the health service following the intervention.

Considerations for a Northern Ireland Service Model

- Need for the full implementation of a consistent and comprehensive service model for Northern Ireland
- Consideration of the terminology used, specifically personality disorder
- Trans-diagnostic and alternative approaches to identifying needs to be explored
- Co-production in the design, development and delivery of the services
- Peer led services, peer support workers
- Trauma-informed care
- General training for GP and other health and social care professional-led early identification, diagnosis and treatment
- Key indicators for non-therapeutic environments e.g. schools
- Prevention and early intervention to be further developed across sectors including the use of appropriate screening tools
- Access to the relevant evidence based interventions across all levels of need, complexity and risk. The research evidence does not provide definitive clarity on what works for whom but it does provide sufficient support for specific psychological approaches to be provided
- Need for the appropriate resources at all levels for good, ongoing communication and cooperation across the tiers
- Building an evidence base for Positive Action Planning and other local approaches
- Routine data on quality measures and service user outcomes
- Research recommendations

Possible next steps include: map and evaluate current services; Delphi study on alternative terminology to personality disorder; stakeholder consultation to further inform the Mental Health Strategy; economic evaluation of alternative approaches; development of proposals for specific service developments; development of research and outcomes framework.

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Appendix 1 – Search Strategy & Results

Date of searches: 11/11/2020

Database	Search terms	Retrieved
CINAHL Plus	AB (personality disorder) AND AB (systematic review)	[102]
Cochrane Database	Personality disorder	[7]
EMBASE 2010 to 2020 Week 45	personality disorder.mp. or exp personality disorder/ AND "systematic review"	[770]
IBSS		[23]
MEDLINE 2010 to November, 09 2020	AB (personality disorder) AND AB (systematic review)	[190]
PsycINFO APA 2010 to November Week 1 2020	Personality disorder AND exp Treatment Effectiveness Evaluation/ OR exp "systematic review"/ OR exp intervention	[431]
PubMed	'personality disorder' AND 'systematic review'	[506]
SCIE	Personality disorder	[10]
SSCI	'personality disorder' AND 'systematic review'	[284]
EconLit	Personality disorder	[13]