Pharmacological Therapy - Practice Guidance Note
Prescribing Medicines and the Personality Disorder Pathway V01

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1 Introduction

1.1 There is no evidence that any drug reduces overall severity of problems for people who are diagnosed with Emotionally Unstable Personality Disorder (EUPD).

1.2 NICE guidelines for people diagnosed with Borderline Personality Disorder (or EUPD) published in 2009, set out that drug treatment should not be used specifically for EUPD or its associated symptoms.

1.3 The Prescribing Observatory for Mental Health - UK Quality Improvement Project on prescribing for personality disorder found that out of a baseline national cohort of 2500 patients just over half were prescribed at least one antipsychotic (without co-morbid mental illness).

1.4 There is a clear discrepancy between clinical practice and how the evidence supports prescribers to practise.

1.5 This paper intends to prompt some thinking and changes to current practice about the nature of prescribing in Personality Disorder in the hope that prescribers come to make more balanced judgements about drug treatment in this population.

1.6 NICE recommends strongly that psychological treatments should be first line treatments of choice in Personality Disorder. NTW has a developed a clearly worked out care pathway for patients diagnosed or presenting with personality disorder, and the main document comprehensively sets this out alongside the prescribing guidance summarised in the appendix.

2 Why do we prescribe in Personality Disorder?

2.1 We live in a society that holds medical intervention in high esteem. If we have a health problem that brings us difficulty it is reasonable to go to the doctor’s to seek a remedy.

2.2 Patients diagnosed with personality disorder have often encountered negative attitudes about the nature of their difficulties. A prescription can validate their suffering. Ongoing provision of the drug over years could be linked with this phenomenon alongside initial placebo effect.

2.3 Therapeutic engagement can often result in degrees of attachment, which is maintained by engaging the doctor in their special skillset of prescribing.

2.4 Distressed patients may stimulate anxieties in prescribers which can lead prescribers to act in a manner that may yield short-term relief for both parties at
a longer-term cost, through prescribing. The prescriber's time with a patient can be more difficult if the prescriber is felt to be not meeting perceived needs.

2.5 There are inconsistencies in published guidance. The American Psychiatric Association (2010) provides some support for symptom targeted pharmacotherapy secondary to psychotherapy. Yet NICE (2009) were unable to consider trials showing large effect sizes due to lack of transparency in funding arrangements.

3 What are the risks of prescribing medication when it is not recommended or indicated for the patient?

3.1 Prescribers are familiar with the harms from each class of medication.

3.2 Polypharmacy is widely described. There is no support in the literature for combination therapy, and indeed all the major guidelines recommend against this. Polypharmacy could indicate that treatment failures are not readily accepted as such.

3.3 Over-investment in medical strategies can lead to greater helplessness in the face of adversity, less self-responsibility and lower confidence in patients' own abilities to solve life problems related to personality difficulties. If medications are being used to help manage emotions, then by prescribing we may inadvertently reinforce an avoidance of learning and practicing the skills to solve such problems. This can render the evidence based psychosocial treatments less effective.

4 Comorbidity

4.1 It is recognised that co-occurring conditions are prevalent in people diagnosed with EUPD, but that comorbidity could be an artefact of overlapping symptom sets used to define co-occurring disorders. It is also recognised that a prescriber may justify prescribing by maintaining that the symptoms for which they are prescribing are those of a co-morbid disorder when they are more readily associated with the personality disorder.

4.2 The debate over the overlapping nature of EUPD with primarily affective disorders, and to a lesser extent, psychotic phenomena reflects the uncertainty to which prescribers are accustomed. Prescribers may move closer to certainty further down the line in a patient’s care episode, but this will require being open as to the hypothetical nature upon which intentions to invoke a treatment strategy are based.

4.3 NICE (2009) sets out that before starting a treatment for a comorbid condition in people diagnosed with EUPD, the diagnoses should be reviewed,
especially if either diagnosis had been made during a crisis presentation. It is also necessary to review the effectiveness and tolerability of previous and current treatments, alongside discontinuing ineffective treatments.

4.4 Treatment for comorbid conditions should take place within the structured psychological treatment for personality disorder.

5 Prescribing during a crisis

5.1 A thoughtful, joint, safety and crisis plan should help people diagnosed with a personality disorder, as well as carers and the clinical team, manage during difficult times. This safety and crisis plan should be easily accessible, shared and make specific mention of whether or not medication is indicated at such times, and if so, what medication.

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

5.1.2 If antipsychotic medication is used, make it clear to the patient that this will be for short-term use.

6 General Considerations

6.1 The treatment strategies for patients diagnosed with EUPD will come to be organised into a psychological approach called **Structured Clinical Management (SCM)**. SCM is an evidence-based approach to care and treatment for people diagnosed or presenting with personality difficulties. Such difficulties may include problems with thinking clearly and reasonably or staying aware of present reality, managing emotions, managing impulsive urges and behaviour and in fostering secure and healthy relationships. This approach is the core first lien treatment for all people diagnosed or presenting with personality difficulties. As part of this approach, 12 weekly medical reviews are recommended where pharmacotherapy is a feature of the care package.

6.2 The role of a prescriber in the Multidisciplinary Team (MDT) caring for patients diagnosed with EUPD remains an important one as we are well placed to navigate the diagnostic uncertainties and consider the cost/benefit analysis to medications with our patients. Prescribers should look to work with the MDT, rather than in isolation when it comes to decision making around prescribing.

6.3 The Trust’s Physical Health Policy should be adhered to alongside the Practice Guidance notes for individual medication classes. This includes explicit agreements with general practice regarding prescription provision and physical health monitoring.
6.4 Psychiatrists have experience in using hypnotics, benzodiazepines and antipsychotics for unlicensed applications and guidance exists from the Royal College of Psychiatrists for such practice.

6.5 The following vignettes have been developed around common themes of presentations to aid decision making in prescribing. They could do not intend to capture the individual circumstances of patients or circumvent a professional’s autonomy or responsibility.

6.5.1 **Vignette 1 (New Presentation)**

20 year old female. First presentation to CMHT. Close family members think she has Bipolar, her moods fluctuate markedly often within hours. No clear link with affective syndrome upon screening. Possible diagnosis of emotionally unstable personality disorder, seems more likely. A careful and ‘light touch’ to diagnosis due to age. Seeks mood stabilisation strategy.

- Share the hypothesis that both a diagnosis of EUPD and Bipolar are possibilities, but a diagnosis of EUPD seems more likely. And that both are difficult problems to learn to manage.
- Offer something other than medication such as a follow-up appointment, to further inform the chronology of the difficulties and further psychoeducation on non-pharmacological strategies. Discuss in MDT psychologically-informed approaches, such as SCM or DBT.
- With the best efforts in empathy and psychoeducation, no prescription may yield dissatisfaction in a patient and/or carer.
- If it is agreed that a trial in medication is a worthy endeavour, then a clear timeframe for reviewing the effectiveness should be stated alongside the rationale to share with the patient

6.5.2 **Vignette 2 (Crisis presentation)**

Young person diagnosed or presenting with EUPD presents in crisis. Suicidal ideas. On an SSRI.

- Unless a person diagnosed or presenting with EUPD has a co-morbid diagnosis of depression, their feelings of sadness and despair are unlikely to respond to SSRI therapy. Such a presentation could indicate a failed trial of SSRI. Part of the plan in crisis could be to stop the SSRI when the patient emerges from crisis
- There is support for using medications on a short-term basis in crises. Sedating antihistamines are favoured in NICE (2009) guidance. Clinical experience can take us beyond this class of medication. The choice of medication should be discussed with the patient.
• It should be explicit that the time frame of provision is short (NICE Guidance suggests one week) and communication of this to all parties, including GP to ensure that it doesn’t erroneously become a maintenance strategy.
• Discuss psychological approach with MDT, such as SCM or trauma stabilisation work.

6.5.3 **Vignette 3 (Crisis + Polypharmacy)**

Young person diagnosed or presenting with EUPD presents in crisis. Derogatory voices. Commands to kill self. Not felt to exist as part of co-morbid psychosis. Current therapy olanzapine 20mg nocte, mirtazapine 45mg, Diazepam 10mg total daily (iatrogenic dependence). Patient seeks additional medication/revision.

• Dopaminergic antagonism has unlikely been effective in this case.
• Sedation may be contributing to inability to problem solve through difficulties
• There is an opportunity to introduce the idea of rationalisation of medications, one change at a time.
• Could begin by switching antipsychotic, and introducing a much lower %BNF (e.g. quetiapine 100mg nocte)
• Alternate strategy could be to add temazepam 10mg nocte for 7 days, upon explicit communicated plan to convert this to diazepam and begin a total slow reduction regimen.
• Discuss psychological approach with MDT, such as SCM or trauma stabilisation work.

6.5.4 **Vignette 4 (Iatrogenic harm)**

40 year old person diagnosed or presenting with EUPD. Regular presentations to psychiatrist and GP over many years. Currently prescribed olanzapine 20mg nocte, sodium valproate 1.2g total daily, gabapentin 2.7g total daily, codeine 60mg four time a day, naproxen 1g total daily, temazepam 10mg nocte, zopiclone 7.5mg nocte, sertraline 200mg daily, alongside many medications for metabolic problems. Continues to present with dysphoria alongside chronic pain.

• Complex pain management strategies may represent the same process by which complex psychopharmacological strategies have been implemented.
• Reflection on prescriber-patient interactions, and with these shared with the GP may assist in decreasing overall burden of pharmacotherapy
• Strategies could be devised to reduce the medication in a slow and careful way, one agent at a time in an incremental reduction on a monthly basis. Benefit from reduction could outweigh the costs/potential for exacerbations.
• Discuss psychological approach with MDT, such as SCM, DBT or trauma stabilisation work.

7 A summary of evidence across classes of medication

7.1 Antidepressants

7.1.1 Prescribing of anti-depressants has been linked with an increase in suicidal thoughts and acts, with young people being at most risk. It is not known if people with pre-existing impulse control problems, such as those diagnosed with EUPD, are more vulnerable.

7.1.2 A recent study suggested that the rates of suicide and attempted suicide were highest in the first 28 days after initiation of treatment with an anti-depressant and the 28 days following discontinuing the treatment – with Venlafaxine, Mirtazapine and Trazodone being associated with the highest risk. With this in mind, if an anti-depressant is prescribed, consideration should be given to the choice of medication, especially if a co-morbid diagnosis of depression is not made.

7.1.3 There is no evidence to support the view that SSRI’s (Selective Serotonin Reuptake Inhibitors) are effective for common difficulties, such as experiences of emptiness, loneliness, boredom or chronic dysphoria.

7.1.4 There is no conclusive evidence that anti-depressants reduce impulsiveness, aggressive, or self-harming behaviour.

7.1.5 Amitriptyline has been studied and found to be effective (in small studies) in treating some depressive symptoms of EUPD; however, the anti-cholinergic side effects make it sometimes intolerable, plus it is cardio toxic in overdose so should be avoided in this patient group.

7.2 Mood Stabilisers

7.2.1 Instability of mood is a core symptom of a diagnosis of EUPD, which can often lead to a co-morbid diagnosis of Bipolar Disorder, nevertheless, the degree of overlap between the two conditions, is small once the effects of mood lability are accounted for; in addition some of this association may represent a mis-diagnosis.
7.2.2 Lithium has been shown in a very small trial\textsuperscript{12} to markedly reduce aggression in prisoners with personality disorder; although, it should be noted that Lithium is toxic in overdose and requires regular monitoring.

7.3 Antipsychotics

7.3.1 Haloperidol, there are some studies that suggest that at a low dose, levels of hostility, depression and impulsivity can be reduced.

7.3.2 There have been contradictory findings relating to the use of Olanzapine, in that some studies have reported a decrease in affective instability, anger, psychotic paranoid symptoms and anxiety; however, others have reported little or no benefit with an increase in self harm and higher levels of adverse effects and metabolic disturbance\textsuperscript{5}.

7.4 Other

7.4.1 There are no RCTs of benzodiazepines, clozapine or ECT.

8 References

1. Prescribing for people with personality disorder. POMH-UK. 2012
2. NICE Clinical Guideline: Borderline Personality Disorder (CG 78). NICE. January 2009
14. DOH. ‘Meeting the Challenge, Making a Difference’ – Working Effectively to Support people with Personality Disorder in the Community. 2014

Additional papers to consider including:

Agius, M. (2014) Bipolar disorder comorbid with borderline personality disorder and treatment with mood stabilisers. British Medical Journal;349:g6798


