Prescribing for people with a personality disorder

POMH-UK Topic 12b re-audit report
Prepared by the Prescribing Observatory for Mental Health

Kent and Medway NHS and Social Care Partnership Trust

Please use the following to cite this report:
Executive summary

Background

The Prescribing Observatory for Mental Health (POMH-UK) runs national audit-based Quality Improvement Programmes (QIPs) open to all specialist mental health services in the UK.

This report presents the re-audit findings for QIP 12b; prescribing for people with a personality disorder under the care of mental health services. The data presented at national, individual Trust and clinical team level refer to performance against practice standards derived from NICE guidelines and endorsed by an expert steering group.

Practice standards for audit

1. A clinician’s reasons for prescribing antipsychotic medication (i.e. target symptoms or behaviour) are documented in the clinical records.
2. There is a written crisis plan in the clinical records.
3. There is evidence that the patient’s views have been sought in the development of the crisis plan.

Treatment targets

1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.
   Derived from NICE CG078 recommendation 6.12.1.2: Antipsychotic drugs should not be used for the medium and long term treatment of borderline personality disorder; and 3.12.1.3: Drug treatment may be considered in the overall treatment of co-morbid conditions.
2. Z-hypnotics should not be prescribed for more than four consecutive weeks.
3. Benzodiazepines should not be prescribed for more than four consecutive weeks.
4. Medication prescribed for more than four consecutive weeks should be reviewed, and such a review should take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records.

Sample

Forty-one Trusts participated in the baseline audit of this quality improvement programme, submitting data for 2,600 patients across 438 teams. For this re-audit 51 Trusts participated submitting data for 4,014 patients across 522 clinical teams.
National and Trust performance against the clinical practice standards

The following two figures illustrate performance against the practice standards nationally and for your Trust at baseline and re-audit.

Figure 1. National and Trust results for standard 1: proportion of patients prescribed one or more antipsychotic medications, for whom the clinical reasons for prescribing the most recently initiated antipsychotic were documented in your Trust (n=46) and the TNS (n=2,758)

Figure 2. National and Trust results for standards 2 and 3: proportion of all patients with a crisis plan and involvement in its development in your Trust (n=53) and the TNS (n=4014)
National and Trust performance against the treatment targets

The following four figures illustrate performance against the treatment targets nationally and for your Trust at baseline and re-audit.

**Figure 3. National and Trust level results for treatment target 1:** proportion of patients with a PD diagnosis only (i.e. no co-morbid psychiatric diagnosis) prescribed antipsychotics in your Trust (n=17) and the TNS (n=1,689)

**Figure 4. National and Trust level results for treatment target 2:** proportion of patients with a PD diagnosis only (i.e. no co-morbid psychiatric diagnosis) prescribed z-hypnotics in your Trust (n=17) and the TNS (n=1,689)
Figure 5. National and Trust level results for treatment target 3: proportion of patients with a PD diagnosis only (i.e. no co-morbid psychiatric diagnosis) prescribed benzodiazepines in your Trust (n=17) and the TNS (n=1,689)

Figure 6. National and Trust level results for treatment target 4: review of medication prescribed for more than four weeks in your Trust (n=53) and the TNS (n=4,014) at baseline (B) and re-audit (R)
Key national findings

1. **The total national sample (TNS) at re-audit was considerably larger than the TNS at baseline.** This was primarily due to an increased number of cases from general adult outpatient settings. At re-audit, 60% of the total national sample were under the care of general adult community psychiatric teams and 20% were under the care of forensic mental health services.

2. **Almost three-quarters of the TNS at re-audit had a diagnosis of emotionally unstable personality disorder.** This diagnosis likely reflects the severity and complexity of the clinical presentation.

3. **Almost three-fifths of the TNS had at least one diagnosed co-morbid mental illness and associations between personality disorder subtype and mental illness diagnosis were clinically plausible.** For example, a schizophrenia spectrum disorder was documented more often for those with paranoid and schizoid personality disorder, a mood disorder more often for those with emotionally unstable personality disorder, and an anxiety spectrum disorder in those with anxious-avoidant personality disorder.

4. **Almost half of all patients in the total national sample had an admission to a psychiatric ward in the last year.** This suggesting that people with personality disorder who are in contact with mental health services are high users of NHS resources.

5. **Almost a third of outpatients had contact with personality disorder services in the last year.** This proportion is relatively high and potential explanations include that Trusts have invested in such services in order to implement the recommendations in the two NICE guidelines that focus on the management of PD and/or that the Trusts and services that participated in the audit had relatively well-developed clinical pathways for people with PD.

6. **Overall 80% of patients in the TNS had a written crisis plan in their clinical records, 70% of whom were involved in developing this plan.** This represents a modest increase from baseline (see Figure 2). Only half of crisis plans mentioned medication: this relatively low emphasis on medication in crisis plans should be contrasted with the high use of medication in people with PD (see point 7).
7. **Of those patients with a personality disorder but no diagnosed co-morbid psychiatric illness (n=1,689), more than two-thirds were prescribed an antidepressant, almost two-thirds an antipsychotic, almost half a sedative and almost a fifth a mood stabiliser.** This high use of psychotropic medication is not consistent with the recommendations for the management of personality disorder made by NICE. The most common reasons for prescribing psychotropic medication were clinically plausible. For example depressive symptoms and emotional instability were frequent treatment targets in patients with emotionally unstable personality disorder, and aggression/hostility in those with dissocial personality disorder.

8. **Once prescribed, most psychotropic medicines are continued for at least 4 weeks, and probably much longer.** Considering findings 7 and 8 together, this suggest that clinicians extrapolate from the evidence underpinning the use of psychotropic medication in mental illness, and may not accept the recommendations for the treatment of personality disorder made by NICE as being clinically valid.

9. **In around a quarter of patients, the clinical reason for prescribing an antipsychotic was not documented.** Antipsychotic medicines are not licensed for the treatment of personality disorder, placing an additional responsibility on the prescriber to carefully document target symptoms and treatment emergent side effects, in order to ensure the benefits of treatment outweigh the risks. In the absence of clearly documented target symptoms/behaviours, it is difficult to ascertain the benefits of treatment (if any) and medication that has been of limited utility may be continued long-term by default.

10. **Approximately 1 in 10 (11%) of women of childbearing potential (<50 years) in the total national sample were prescribed valproate.** The respective figure for the remainder of the total sample (men and older women) was 12%. Valproate is a known human teratogen and also adversely affects cognitive and emotional development in a child: NICE recommends that valproate is avoided in women of childbearing age. These figures suggest that gender and age may have little influence on the decision to prescribe valproate in people with personality disorder.

11. **Where medication was continued for more than four weeks, there was a documented medication review in over four-fifths of cases.** This represents a modest improvement from baseline. Therapeutic response and a patient’s view of treatment were considered at review more often than side effect and adherence to treatment.
What happens next?

- We hope that the data presented in this report, and any evident change in prescribing practice in your Trust over the successive audits, will generate local review and discussion of prescribing practice for patients with a personality disorder. In order to facilitate this, Trusts should consider local practice and systems with respect to aspects of care which their POMH-UK data indicate fall short of the standards, or where the Trust, or teams within the Trust, appear to be outliers in terms of their practice.

- Customised PowerPoint slide sets will be generated for each participating Trust, summarising the benchmarked findings of this audit. This is to help ensure that all participating clinical teams have access to the audit findings relating to their own practice.

- Clinicians who reflect on their performance data and generate and implement action plans as appropriate should be encouraged to submit evidence of this process as part of their CPD, to inform their appraisal and to support revalidation.

- On the basis of the re-audit findings, POMH-UK will consider appropriate change interventions for provision to participating Trusts to support their local action plans.

- In addition, Trusts might find the leaflet ‘Meeting the challenge, making a difference’ (July, 2014), produced by the Department of Health useful for staff, patients and carers who would like accessible information about personality disorders. This resource can be found online (http://www.emergenceplus.org.uk/)
Table of Contents

Executive summary ................................................................. 2
  Background ........................................................................... 2
  Sample .................................................................................. 2
  Practice standards for audit .................................................. 2
  National and Trust performance against the clinical practice standards .... 3
  National and Trust performance against the treatment targets ............ 4

Key national findings .................................................................. 6
What happens next? .............................................................. 8
List of figures ............................................................................ 11
List of tables ............................................................................. 13

Introduction .............................................................................. 14
  POMH-UK ............................................................................. 14
  How to use this report .......................................................... 14
  Further analysis of your Trust’s data ....................................... 14

Audit standards .......................................................................... 15
  Audit standards .................................................................... 15

Method ...................................................................................... 16
  Data cleaning ......................................................................... 16

1. National level results .......................................................... 18
  Audit standards .................................................................... 18
  1.1 Patient demographics and clinical characteristics ...................... 19
  1.2 Medication review ............................................................ 31

2. Trust level section .............................................................. 33
3. Team level results .............................................................. 44

Appendix A: Trust demographics ............................................. 48
Appendix B: References ......................................................... 51
Appendix C: Participating Trusts .............................................. 52
Appendix D: Audit data collection guide and form ...................... 53
Appendix E: Data control .......................................................... 62
Appendix F: POMH-UK QIP 12 Advisory Group ....................... 63
List of figures

Figure 1. National and Trust results for standard 1: ................................................................. 3
Figure 2. National and Trust results for standards 2 and 3: ..................................................... 3
Figure 3. National and Trust level results for treatment target 1: ........................................ 4
Figure 4. National and Trust level results for treatment target 2: .......................................... 4
Figure 5. National and Trust level results for treatment target 3: .......................................... 5
Figure 6. National and Trust level results for treatment target 4: .......................................... 5
Figure 7. Documentation of clinical reasons for prescribing the most recently initiated
antipsychotic at baseline (n=1,673) and re-audit (n=2,758) .................................................. 24
Figure 8. Proportion of patients for whom there is a crisis plan in the clinical records at re-
audit (n=4,014) ........................................................................................................ 25
Figure 9. Reference to medication in the crisis plan at re-audit (n=4,014) ............................ 26
Figure 10. Documentation in the clinical records of reasons for prescribing the most recent
antipsychotic medication: in each Trust and the Total National Sample (TNS=2,758) ........ 35
Figure 11. Crisis plan and patient involvement: in each Trust and the Total National Sample
(TNS=4,014) .............................................................................................................. 36
Figure 12. Reference to medication in the crisis plan: in each Trust and the Total National
Sample (TNS=4,014) ................................................................................................. 37
Figure 13. Antipsychotic prescription and duration of treatment in patients with personality
disorder only in each Trust and the Total National Sample (n=1,689) ................................. 38
Figure 14. Z-hypnotic prescription and duration of treatment in patients with personality
disorder only (n=1,689) ............................................................................................ 39
Figure 15. Benzodiazepine prescription and duration of treatment in patients with personality
disorder only (n=1,689) ............................................................................................ 40
Figure 16. Proportion of patients in the TNS prescribed any antipsychotic, antidepressant,
mood stabilisers or sedative for more than four weeks (TNS=4,014) .................................. 41
Figure 17. Patients prescribed any antipsychotic, antidepressant, mood stabiliser or sedative
for more than four weeks (n=3,172) and documented evidence of medication review in the
clinical records ............................................................................................................. 42
Figure 18. Proportions of general adult inpatients and outpatients with or without a hospital
admission in the last year at re-audit (n=2,653) ................................................................ 43
Figure 19. Standard 1: documentation in the clinical records of reasons for prescribing the
most recent antipsychotic medication in your Trust (n=46) and the TNS* (n=2,758) .......... 44
Figure 20. Standards 2 and 3: crisis plan and patient involvement in your Trust (n=53) and
the TNS (n=4,014) ................................................................................................. 44
Figure 21. Reference to medication in the crisis plan in your Trust (n=53) and the TNS
(n=4,014) .............................................................................................................. 45
Figure 22. Treatment target 1: antipsychotic prescription and duration of treatment in
patients with personality disorder only in your Trust (n=17) and the TNS* (n=1,689) ........ 45
Figure 23. Treatment target 2: z-hypnotic prescription and duration of treatment in patients
with personality disorder only in your Trust (n=17) and the TNS* (n=1,689) .................... 46
Figure 24. Treatment target 3: benzodiazepine prescription and duration of treatment in
patients with personality disorder only in your Trust (n=17) and the TNS* (n=1,689) ......... 46
Figure 25. Treatment target 4: proportion of patients prescribed any antipsychotic,
antidepressant, mood stabiliser or sedative for more than four weeks and documented
evidence of medication review in the clinical records in your Trust (n=53) and the TNS (n=4,014)........................................................................................................................................................................... 47

Figure 26. Ethnicity profile in each Trust and the total national sample at re-audit (TNS=4,014)........................................................................................................................................................................... 48

Figure 27. Age groups in each Trust and the total national sample at re-audit (TNS=4,014) 49

Figure 28. Gender distribution in each Trust and the total national sample at re-audit (TNS=4,014)........................................................................................................................................................................... 50
List of tables

Table 1. Demographic characteristics of the total national sample: baseline (n=2,600) and re-audit (n=4,014) ...................................................................................................................... 19
Table 2. Clinical characteristics of the total national sample: baseline (n=2,600) and re-audit (n=4,014) .................................................................................................................. 20
Table 3. Mental health inpatient admission within the past year in the total national sample at baseline and re-audit ........................................................................................................ 21
Table 4. Specialist personality disorder service referrals* within the past year in the total national sample at baseline and re-audit ........................................................................ 21
Table 5. Association between diagnosed personality disorder subtypes and co-morbid ICD-10 diagnoses at re-audit .............................................................................................................. 22
Table 6. The two most common personality disorders in the sample and class of medication prescribed at re-audit ................................................................................................. 23
Table 7. The most common clinical reasons for prescribing psychotropic medication* in the total national sample and PD diagnosis subsamples ......................................................................... 27
Table 8. Clinical reasons for prescribing psychotropic medication for patients with personality disorder ................................................................................................................................. 28
Table 9. Antipsychotic medication currently prescribed in patients with personality disorder only (no co-morbid ICD-10 psychiatric diagnosis) at re-audit .............................................................................................................. 29
Table 10. Z-hypnotics and benzodiazepines currently prescribed in patients with personality disorder only (no co-morbid ICD-psychiatric 10 diagnosis) at re-audit .............................................................................................................. 30
Table 11. Medication review for those patients who were prescribed a drug from any of the four groups of psychotropic medication (antipsychotics, antidepressants, mood stabilisers and sedatives) for more than four consecutive weeks at baseline (n=2,138) and re-audit (n=3,172) ...................................................................................................................... 31
Table 12. Outcome of medication review for those patients who were prescribed a drug from any of the four groups of medications (antipsychotics, antidepressants, mood stabilisers and sedatives) for more than four consecutive weeks at baseline (n=1,744) and re-audit (n=2,758) ...................................................................................................................... 32
Table 13. Number of clinical teams and patient records submitted by participating Trusts at baseline (n=2,600) and re-audit (n=4,014) .................................................................................................................... 34
Introduction

POMH-UK
The Prescribing Observatory for Mental Health (POMH-UK) runs national audit-based quality improvement programmes open to all specialist mental health services in the UK. The aim is to help mental health services improve prescribing practice.

This report presents the re-audit results for a quality improvement programme (QIP 12) addressing prescribing for people with a personality disorder.

How to use this report

Data from each clinical team or Trust are presented by code only.

The POMH-UK central project team does not know the identity of individual teams.

Only the local project team lead for your Trust has the key to team codes for your Trust. You should contact this person if you need to identify data for your own particular team.

Further analysis of your Trust’s data

An Excel file containing the data submitted by your Trust has been made available to the local project team lead for your Trust. Please contact this person if you wish to conduct further analyses on your data.

The clinical background for this QIP can be found in the Topic 12a report baseline report: Prescribing for people with a personality disorder. 2012, CCQI139.
Audit standards

These audit standards and treatment targets were developed and agreed by clinician advisors on an expert steering group and partially extrapolated from relevant recommendations in the NICE guideline CG078 on borderline personality disorder (2009).

Audit standards

1. A clinician’s reasons for prescribing antipsychotic medication (i.e. target symptoms or behaviour) are documented in the clinical records.
2. There is a written crisis plan which is accessible in the clinical records.
3. There is evidence that the patient’s views have been sought in the development of the crisis plan.

Treatment targets

1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.
   Derived from NICE CG078 recommendation 6.12.1.2: Antipsychotic drugs should not be used for the medium and long term treatment of borderline personality disorder; and 3.12.1.3: Drug treatment may be considered in the overall treatment of co-morbid conditions.
2. Z-hypnotics should not be prescribed for more than four consecutive weeks.
3. Benzodiazepines should not be prescribed for more than four consecutive weeks.
4. Medication prescribed for more than four consecutive weeks should be reviewed, and such a review should take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records.
Method

The Prescribing Observatory for Mental Health (POMH-UK) invited all National Health Service (NHS) Trusts in the United Kingdom providing specialist mental health services to participate in this re-audit as part of a QIP focusing on the use of medication in people with a personality disorder.

All Trusts and clinical teams were self-selected in that they chose to participate. All participating Trusts/healthcare organisations (hereafter referred to as ‘Trusts’) are listed in alphabetical order in Appendix C.

An audit of clinical records on the use of antipsychotic medication was conducted. A questionnaire/audit tool was sent to Trusts with instructions that copies should be made available to allow clinical teams to audit all current inpatients with an ICD-10 diagnosis of personality disorder, and for outpatient services everyone on the current caseload if possible, or (if the caseload were too large to audit) every patient who had an outpatient appointment in the two months prior to the audit (minimum expected sample: 10 patients).

The data collected on each patient included:

- Demographic variables
- Psychiatric diagnoses
- Type of service providing care
- Information about antipsychotic(s), mood stabiliser(s), sedative(s) antidepressant(s) currently prescribed and the clinical indications
- Other medicines prescribed
- Duration of current antipsychotic prescription
- Information about medication review

A copy of the data collection tool can be found in Appendix D.

Data cleaning

Data were collected using SNAP (electronic survey software), and stored and analysed using SPSS. Data were cleaned to correct instances of obvious data entry error. Details of all corrections are held on file by POMH-UK; please contact pomh-uk@rcpsych.ac.uk if you wish to examine these.

Data analysis

As in the baseline report the data were analysed at three levels:

1. **National data.** This section describes the demographic and clinical characteristics of the patients, as well as the quality of prescribing in the total national sample. The data were analysed in a variety of ways to facilitate understanding of the national picture and stimulate discussion in Trust clinical teams.

2. **Trust level data.** The analyses conducted on the national data were repeated for each Trust. This allows Trusts to compare the demographic and clinical characteristics of their patients, and their practice in relation to the quality of prescribing, with the anonymised data from each of the other participating Trusts and the national data set as a whole.

3. **Service level data.** This allows Trusts and individual clinical teams to compare their practice with each other and against the national data.
All figures are rounded to zero decimal places for clarity of presentation. Therefore the total percentages for some charts or graphs add up to 99% or 101%. The abbreviation ‘TNS’ on some charts refers to the ‘total national sample’.

The POMH team lead for each participating Trust will be sent an Excel dataset containing their Trust’s data. This allows Trusts to conduct further analyses on their own data should they wish.

**Change interventions**

After the baseline audit, POMH made the following available to participating Trusts

1. Benchmarked audit reports customised for each Trust
2. Slide set customised for each Trust
3. Leaflet titled ‘Prescribing for people with borderline personality disorder (PD)’ (POMH-UK, 2012). This contained a list of practical practice points, compiled by our expert advisors.

Following analysis of these after data this re-audit, the POMH-UK team made the following available to participating Trusts:

**A customised re-audit report**: a benchmarked audit report individualised for each Trust that allowed clinical teams to compare their prescribing practice against the recognised clinical standard and targets, and against other teams in their own Trust and other Trusts.

**Slide set**: a PowerPoint presentation with notes for speakers, individualised for each Trust, to help local clinicians present the evidence base underpinning the standards, and disseminate the audit findings.
National level results

The analyses presented in this section of the report were conducted on the total national sample (n=4,014)

Audit standards

1. A clinician’s reasons for prescribing antipsychotic medication (i.e. target symptoms or behaviour) are documented in the clinical records.
2. There is a written crisis plan which is accessible in the clinical records.
3. There is evidence that the patient’s views have been sought in the development of the crisis plan.

Treatment targets

1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.
   Derived from NICE CG078 recommendation 6.12.1.2: Antipsychotic drugs should not be used for the medium and long term treatment of borderline personality disorder; and 3.12.1.3: Drug treatment may be considered in the overall treatment of co-morbid conditions.
2. Z-hypnotics should not be prescribed for more than four consecutive weeks.
3. Benzodiazepines should not be prescribed for more than four consecutive weeks.
4. Medication prescribed for more than four consecutive weeks should be reviewed, and such a review should take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records.
1.1 Patient demographics and clinical characteristics

The clinical and demographic characteristics of the baseline and re-audit sample were very similar (see Tables 1 and 2).

Table 1. Demographic characteristics of the total national sample: baseline (n=2,600) and re-audit (n=4,014)

<table>
<thead>
<tr>
<th>Key demographic characteristics</th>
<th>Baseline (April, 2012)</th>
<th>Re-audit (July, 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,533 (59)</td>
<td>2,536 (63)</td>
</tr>
<tr>
<td>Male</td>
<td>1,067 (41)</td>
<td>1,478 (37)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/White British</td>
<td>2,281 (88)</td>
<td>3,406 (85)</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>81 (3)</td>
<td>100 (3)</td>
</tr>
<tr>
<td>Asian</td>
<td>57 (2)</td>
<td>95 (2)</td>
</tr>
<tr>
<td>Mixed or other</td>
<td>46 (2)</td>
<td>165 (4)</td>
</tr>
<tr>
<td>Not specified or not collected</td>
<td>135 (5)</td>
<td>248 (6)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age in years (SD)</td>
<td>39 (11.8)</td>
<td>38 (11.9)</td>
</tr>
<tr>
<td>Min-max</td>
<td>18-78</td>
<td>14-93</td>
</tr>
<tr>
<td>14-25 years</td>
<td>402 (16)</td>
<td>664 (17)</td>
</tr>
<tr>
<td>26-35 years</td>
<td>651 (25)</td>
<td>1,158 (29)</td>
</tr>
<tr>
<td>36-45 years</td>
<td>749 (29)</td>
<td>1,024 (26)</td>
</tr>
<tr>
<td>46-55 years</td>
<td>564 (22)</td>
<td>848 (21)</td>
</tr>
<tr>
<td>56-65 years</td>
<td>180 (7)</td>
<td>253 (6)</td>
</tr>
<tr>
<td>66 years and over</td>
<td>54 (2)</td>
<td>61 (2)</td>
</tr>
<tr>
<td>Missing</td>
<td>-</td>
<td>6 (1)</td>
</tr>
</tbody>
</table>

As can be seen in Table 1, relative to the demographic characteristics of the UK population as a whole, a higher proportion of people with a personality disorder were White, and fewer were 55 years of age or older. The former finding may reflect the known reluctance to diagnose PD in people from ethnic minority groups due to a lack of cultural confidence, and the latter that disinhibition decreases with age, which may result in under-recognition of PD in older adults.

Table 2 reveals that nearly 60% of the sample was under the care of general adult community mental health teams, and 20% were under forensic mental health services (including prison inreach team and specialist PD services).

Emotionally unstable (borderline) personality disorder was by far the most common subtype of personality disorder (PD) in the total national sample at baseline and re-audit; this diagnosis likely reflects the severity and complexity of the clinical presentation.

ICD10 recommends that a patient should be assigned the PD diagnosis that best reflects their problems, rather than be given multiple diagnoses. Eleven percent of the total national re-audit sample had more than one PD diagnosis, perhaps reflecting the severity and complexity of some clinical presentations. The most common co-morbid mental illness was an affective disorder, followed by mental and behavioural disorders due to psychoactive substance use, with more than half the sample (n=2,296, 58%) having at least one co-morbid mental illness.
Table 2. Clinical characteristics of the total national sample: baseline (n=2,600) and re-audit (n=4,014)

<table>
<thead>
<tr>
<th>Key clinical characteristics</th>
<th>Baseline n (%)</th>
<th>Re-audit n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical setting</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General adult – inpatient</td>
<td>199 (8)</td>
<td>280 (7)</td>
</tr>
<tr>
<td>General adult – outpatient</td>
<td>1,426 (55)</td>
<td>2,396 (60)</td>
</tr>
<tr>
<td>Specialist personality disorder service - inpatient</td>
<td>52 (2)</td>
<td>160 (4)</td>
</tr>
<tr>
<td>Specialist personality disorder service - outpatient</td>
<td>260 (10)</td>
<td>300 (8)</td>
</tr>
<tr>
<td>Forensic – inpatient</td>
<td>382 (15)</td>
<td>449 (11)</td>
</tr>
<tr>
<td>Forensic – outpatient</td>
<td>53 (2)</td>
<td>89 (2)</td>
</tr>
<tr>
<td>Prison- inreach team</td>
<td>-</td>
<td>34 (1)</td>
</tr>
<tr>
<td>Forensic specialist personality disorder service - inpatient</td>
<td>261 (10)</td>
<td>241 (6)</td>
</tr>
<tr>
<td>Forensic specialist personality disorder service - outpatient</td>
<td>14 (&lt;1)</td>
<td>24 (1)</td>
</tr>
<tr>
<td>Other setting</td>
<td>21 (1)</td>
<td>188 (5)</td>
</tr>
<tr>
<td><strong>Subtype of personality disorder diagnosis: ICD-10 category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F60.0: Paranoid personality disorder</td>
<td>152 (6)</td>
<td>170 (4)</td>
</tr>
<tr>
<td>F60.1: Schizoid personality disorder</td>
<td>44 (2)</td>
<td>56 (1)</td>
</tr>
<tr>
<td>F60.2: Dissocial personality disorder</td>
<td>484 (19)</td>
<td>548 (14)</td>
</tr>
<tr>
<td>F60.3: Emotionally unstable (borderline) personality disorder</td>
<td>1,776 (68)</td>
<td>2,972 (74)</td>
</tr>
<tr>
<td>F60.4: Histrionic personality disorder</td>
<td>44 (2)</td>
<td>39 (1)</td>
</tr>
<tr>
<td>F60.5: Anankastic personality disorder</td>
<td>29 (1)</td>
<td>21 (&lt;1)</td>
</tr>
<tr>
<td>F60.6: Anxious avoidant personality disorder</td>
<td>102 (4)</td>
<td>129 (3)</td>
</tr>
<tr>
<td>F60.7: Dependent personality disorder</td>
<td>73 (3)</td>
<td>102 (3)</td>
</tr>
<tr>
<td>F60.8: Other specific</td>
<td>33 (1)</td>
<td>51 (1)</td>
</tr>
<tr>
<td>F60.9: Personality disorder, unspecified/ Sub-type not yet determined</td>
<td>219 (8)</td>
<td>289 (7)</td>
</tr>
<tr>
<td>F61: Mixed and other personality disorders</td>
<td>140 (5)</td>
<td>233 (6)</td>
</tr>
<tr>
<td>More than one personality disorder diagnosis</td>
<td>356 (14)</td>
<td>426 (11)</td>
</tr>
<tr>
<td>F00-F09: Organic, including symptomatic, mental disorders</td>
<td>18 (&lt;1)</td>
<td>28 (&lt;1)</td>
</tr>
<tr>
<td>F10-F19: Mental and behavioural disorders due to psychoactive substance use</td>
<td>324 (13)</td>
<td>590 (15)</td>
</tr>
<tr>
<td>F20-F29 (excluding F21): Schizophrenia, schizotypal and delusional disorders</td>
<td>352 (14)</td>
<td>419 (10)</td>
</tr>
<tr>
<td>F21: schizotypal disorder subgroup</td>
<td>54 (2)</td>
<td>74 (2)</td>
</tr>
<tr>
<td>F30-F39 (excluding F31): Mood (affective) disorders</td>
<td>471 (18)</td>
<td>680 (17)</td>
</tr>
<tr>
<td>F31: bipolar disorder subgroup</td>
<td>135 (5)</td>
<td>184 (5)</td>
</tr>
<tr>
<td>F40-F48: Neurotic, stress-related and somatoform disorders</td>
<td>266 (10)</td>
<td>503 (13)</td>
</tr>
<tr>
<td>F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors</td>
<td>87 (3)</td>
<td>169 (4)</td>
</tr>
<tr>
<td>F70-F79: Mental retardation</td>
<td>107 (4)</td>
<td>157 (4)</td>
</tr>
<tr>
<td>F80-F89: Disorders of psychological development</td>
<td>29 (1)</td>
<td>73 (2)</td>
</tr>
<tr>
<td>F90-F98: Behavioural and emotional disorders with onset occurring in childhood and adolescence</td>
<td>64 (3)</td>
<td>72 (2)</td>
</tr>
<tr>
<td>F99: Unspecified mental disorder</td>
<td>4 (&lt;1)</td>
<td>5 (&lt;1)</td>
</tr>
<tr>
<td>None documented</td>
<td>1,054 (41)</td>
<td>1,689 (42)</td>
</tr>
<tr>
<td>Other</td>
<td>49 (2)</td>
<td>52 (1)</td>
</tr>
<tr>
<td><strong>Crisis plan in the clinical records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1,759 (67)</td>
<td>3,229 (80)</td>
</tr>
<tr>
<td>No</td>
<td>841 (32)</td>
<td>785 (20)</td>
</tr>
</tbody>
</table>

*Please note that for 'clinical setting', 'personality disorder diagnosis' and 'other ICD-10 diagnoses' more than one option could have been selected.
Almost half (49%) of all patients in the total national re-audit sample had a hospital admission in the previous year (this was 54% at baseline), suggesting that this group of patients are high users of NHS resources.

Table 3. Mental health inpatient admission within the past year in the total national sample at baseline and re-audit

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n=2,594)**</th>
<th>Re-audit (n=3,906)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently an inpatient</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Outpatient with admission(s)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatients with no admission in the past year</td>
<td>45%</td>
<td>51%</td>
</tr>
</tbody>
</table>

The overall proportion of patients in the TNS who had contact with a specialist personality disorder service in the previous year was 36% (this figure was 38% at baseline). This proportion is relatively high and potential explanations include that Trusts have invested in such services in order to implement the recommendations in the two NICE guidelines that focus on the management of personality disorder and/or that the Trusts and services that participated in the audit had relatively well-developed clinical pathways for people with PD.

Table 4. Specialist personality disorder service referrals* within the past year in the total national sample at baseline and re-audit

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n=2,594)**</th>
<th>Re-audit (n=3,906)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently an inpatient</td>
<td>438 (49%)</td>
<td>614 (55%)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>547 (32%)</td>
<td>809 (29%)</td>
</tr>
</tbody>
</table>

* includes referral to, seen by or assessed by specialist PD services. ‘Specialist PD services’ includes dedicated specialist PD services.
** Due to missing data
Table 5. Association between diagnosed personality disorder subtypes and co-morbid ICD-10 diagnoses at re-audit

The light orange-shaded boxes indicate the more common personality disorder subtypes associated with ICD-10 diagnoses in the F10-19 (Mental and behavioural disorders due to psychoactive substance use), F20-F29 (schizophrenia, schizotypal and delusional disorders), F30-F39 (mood disorders) and F40-F48 (neurotic, stress-related and somatoform disorders) categories. For example, of the patients with paranoid personality disorder (F60.0) 29% had a co-morbid psychiatric diagnosis in the ICD-10 F20-29 category. The general pattern of association is similar to baseline.

<table>
<thead>
<tr>
<th>PD Subtype</th>
<th>F00-F09</th>
<th>F10-F19</th>
<th>F20-F29</th>
<th>F30-F39</th>
<th>F40-F48</th>
<th>F50-F59</th>
<th>F70-F79</th>
<th>F80-F89</th>
<th>F90-F98</th>
<th>F99</th>
<th>No other co-morbid diagnosis</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>F60.0: Paranoid personality disorder (n=170)</td>
<td>1%</td>
<td>15%</td>
<td><strong>29%</strong></td>
<td>15%</td>
<td>11%</td>
<td>1%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
<td>-</td>
<td>37%</td>
<td>2%</td>
</tr>
<tr>
<td>F60.1: Schizoid personality disorder (n=56)</td>
<td>-</td>
<td>7%</td>
<td><strong>36%</strong></td>
<td>13%</td>
<td>13%</td>
<td>-</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
<td>-</td>
<td>32%</td>
<td>2%</td>
</tr>
<tr>
<td>F60.2: Dissocial personality disorder (n=548)</td>
<td>2%</td>
<td><strong>21%</strong></td>
<td><strong>30%</strong></td>
<td>11%</td>
<td>7%</td>
<td>&lt;1%</td>
<td>8%</td>
<td>5%</td>
<td>4%</td>
<td>-</td>
<td>32%</td>
<td>2%</td>
</tr>
<tr>
<td>F60.3: Emotionally unstable borderline personality disorder (n=2,972)</td>
<td>&lt;1%</td>
<td>14%</td>
<td>8%</td>
<td><strong>22%</strong></td>
<td>12%</td>
<td>5%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
<td>&lt;1%</td>
<td>46%</td>
<td>1%</td>
</tr>
<tr>
<td>F60.4: Histrionic personality disorder (n=39)</td>
<td>-</td>
<td>13%</td>
<td>8%</td>
<td><strong>23%</strong></td>
<td><strong>23%</strong></td>
<td>-</td>
<td>8%</td>
<td>-</td>
<td>3%</td>
<td>-</td>
<td>36%</td>
<td>5%</td>
</tr>
<tr>
<td>F60.5: Anankastic personality disorder (n=21)</td>
<td>-</td>
<td>5%</td>
<td>14%</td>
<td><strong>29%</strong></td>
<td><strong>33%</strong></td>
<td>5%</td>
<td>5%</td>
<td>-</td>
<td>5%</td>
<td>-</td>
<td>33%</td>
<td>-</td>
</tr>
<tr>
<td>F60.6: Anxious avoidant personality disorder (n=129)</td>
<td>&lt;1%</td>
<td>15%</td>
<td>11%</td>
<td><strong>26%</strong></td>
<td><strong>22%</strong></td>
<td>2%</td>
<td>8%</td>
<td>7%</td>
<td>1%</td>
<td>-</td>
<td>32%</td>
<td>3%</td>
</tr>
<tr>
<td>F60.7: Dependent personality disorder (n=102)</td>
<td>1%</td>
<td>12%</td>
<td>10%</td>
<td><strong>29%</strong></td>
<td><strong>27%</strong></td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
<td>-</td>
<td>-</td>
<td>31%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Most of the associations between PD subtypes and the co-morbid psychiatric diagnoses shown above are clinically plausible. For example, paranoid and schizoid PD are more often associated with a psychotic illness, emotionally unstable PD with an affective illness, and anxious-avoidant PD with an anxiety spectrum illness.
The role of drug treatment in managing borderline personality disorder (NICE CG78, 2009)

1.3.5.1 Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk taking behaviour and transient psychotic symptoms).

1.3.5.2 Antipsychotic drugs should not be used for the medium- and long-term treatment of borderline personality disorder.

1.3.5.3 Drug treatment may be considered in the overall treatment of co-morbid conditions.

Table 6. The two most common personality disorders in the sample and class of medication prescribed at re-audit

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Medications prescribed: n (%)</th>
<th>Antipsychotic</th>
<th>Antidepressant</th>
<th>Mood stabiliser</th>
<th>Sedative</th>
<th>Not prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally unstable personality disorder (F60.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no co-morbid ICD-10 diagnosis (F60.3) n= 1,366</td>
<td></td>
<td>906 (66)</td>
<td>977 (72)</td>
<td>276 (20)</td>
<td>705 (52)</td>
<td>128 (9)</td>
</tr>
<tr>
<td>with psychotic illness (F20-29) n=243</td>
<td></td>
<td>233 (96)</td>
<td>142 (58)</td>
<td>97 (40)</td>
<td>159 (65)</td>
<td>6 (3)</td>
</tr>
<tr>
<td>with bipolar disorder (F31) n=135</td>
<td></td>
<td>115 (85)</td>
<td>83 (62)</td>
<td>75 (56)</td>
<td>79 (59)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>with mood disorder other than bipolar disorder n=516</td>
<td></td>
<td>337 (65)</td>
<td>466 (90)</td>
<td>112 (22)</td>
<td>288 (56)</td>
<td>20 (4)</td>
</tr>
<tr>
<td>Dissocial personality disorder (F60.2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no co-morbid ICD-10 diagnosis (F60.2) n=175</td>
<td></td>
<td>101 (58)</td>
<td>63 (36)</td>
<td>34 (19)</td>
<td>79 (45)</td>
<td>39 (22)</td>
</tr>
<tr>
<td>with psychotic illness (F20-29) n=165</td>
<td></td>
<td>159 (96)</td>
<td>57 (35)</td>
<td>49 (30)</td>
<td>93 (56)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>with bipolar disorder (F31) n=22</td>
<td></td>
<td>21 (96)</td>
<td>6 (27)</td>
<td>18 (82)</td>
<td>13 (59)</td>
<td>-</td>
</tr>
<tr>
<td>With mood disorder other than bipolar disorder n=41</td>
<td></td>
<td>24 (59)</td>
<td>31 (76)</td>
<td>11 (27)</td>
<td>21 (51)</td>
<td>4 (10)</td>
</tr>
</tbody>
</table>

In the subsample of patients with any personality disorder diagnosis but no co-morbid psychiatric diagnosis (n=1,689: data not shown in table), more than two thirds were prescribed an antidepressant, almost two thirds an antipsychotic, almost half a sedative and almost a fifth a mood stabiliser. This high use of psychotropic medication in patients who do not have a co-morbid mental illness is not consistent with the recommendations for the management of personality disorder made by NICE. Valproate is a known human teratogen and NICE recommend that use should be avoided in women of childbearing age. Of women under 50 years of age with a PD, 11% were prescribed valproate. For all other patients (women over 50 and male patients), this figure was 12%. These figures suggest that gender and age have little influence on the decision to prescribe valproate.
Audit standard

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

Figure 7. Documentation of clinical reasons for prescribing the most recently initiated antipsychotic at baseline (n=1,673) and re-audit (n=2,758)
**Audit standards**

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

**Figure 8.** Proportion of patients for whom there is a crisis plan in the clinical records at re-audit (n=4,014)

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

Overall, 80% (n=3,229) of patients in the total national sample had a written crisis plan in their clinical records. Of those patients who had a crisis plan available in their clinical records, 70% (n=2,255) had been involved in developing this plan. This represents a modest increase from baseline.
Overall, 50% of crisis plans mentioned medication, which is an increase from 42% at baseline. The relatively low emphasis placed on medication in crisis plans should be contrasted with the high use of medication in people with personality disorder as shown in Table 6 (page 24).
Table 7. The most common clinical reasons for prescribing psychotropic medication* in the total national sample and PD diagnosis subsamples

<table>
<thead>
<tr>
<th>Reasons for prescribing</th>
<th>TNS n=4,014</th>
<th>Personality disorder only n= 1,689</th>
<th>Emotionally unstable PD n= 2,972</th>
<th>Dissocial PD n= 548</th>
<th>Unspecified PD /subtype not determined n= 289</th>
<th>Paranoid PD n= 170</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>2,033 (51)</td>
<td>794 (47)</td>
<td>1,617 (54)</td>
<td>147 (27)</td>
<td>143 (50)</td>
<td>70 (41)</td>
</tr>
<tr>
<td>Affective/emotionally</td>
<td>1,639 (41)</td>
<td>708 (42)</td>
<td>1,345 (45)</td>
<td>216 (39)</td>
<td>69 (24)</td>
<td>53 (31)</td>
</tr>
<tr>
<td>instability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disturbed sleep</td>
<td>1,476 (37)</td>
<td>577 (34)</td>
<td>1,191 (40)</td>
<td>132 (24)</td>
<td>94 (33)</td>
<td>39 (23)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1,474 (37)</td>
<td>557 (33)</td>
<td>1,139 (38)</td>
<td>143 (26)</td>
<td>94 (33)</td>
<td>49 (29)</td>
</tr>
<tr>
<td>Aggression/hostility</td>
<td>916 (23)</td>
<td>335 (20)</td>
<td>655 (22)</td>
<td>255 (47)</td>
<td>36 (13)</td>
<td>71 (42)</td>
</tr>
</tbody>
</table>

*Psychotropic medication refers to antipsychotics, antidepressants, mood stabilisers and sedatives.
Table 8. Clinical reasons for prescribing psychotropic medication for patients with personality disorder

<table>
<thead>
<tr>
<th></th>
<th>Antidepressant n=2745</th>
<th>Antipsychotic n=2758</th>
<th>Mood stabiliser n=918</th>
<th>Sedative n=2143</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personality disorder only n=1,144</td>
<td>Personality disorder with any co-morbid mental illness n=1,601</td>
<td>Personality disorder only n=1,060</td>
<td>Personality disorder only n=317</td>
</tr>
<tr>
<td><strong>Depressive symptoms</strong></td>
<td>66% 73% 8% 11% 10% 15% 2%</td>
<td>Affective/emotional instability 17% 14% 46% 34% 63% 59% 9% 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disturbed sleep</strong></td>
<td>10% 14% 12% 11% 2% 3%</td>
<td>Anxiety (including phobic anxiety and panic) 19% 25% 19% 19% 6% 7% 37% 39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Distress</strong></td>
<td>7% 7% 16% 13% 5% 5%</td>
<td>Aggression/hostility 2% 2% 23% 24% 9% 12% 17% 22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transient psychotic-like experiences or symptoms</strong></td>
<td>1% 1% 27% 22% 1% 2% 1% &lt;1%</td>
<td>Known or suspected psychotic illness &lt;1% 2% 5% 29% 1% 22% &lt;1% 3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Impulsivity</strong></td>
<td>4% 3% 18% 14% 8% 9% 5% 5%</td>
<td>Epilepsy - - - - 10% 8% - -</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self harm; deliberate/repeated</strong></td>
<td>8% 8% 17% 10% 9% 7% 5% 4%</td>
<td>Other* 11% 17% 14% 14% 9% 7% 7% 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Not known</strong></td>
<td>11% 7% 10% 7% 12% 5% 12% 8%</td>
<td><strong>Other</strong> 11% 17% 14% 14% 9% 7% 7% 10%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The following clinical reasons for prescribing were amalgamated into “other”: anorexic/bulimic symptoms, depersonalisation/derealisation, obsessional thoughts or acts, PTSD or other stress related adjustment problems and failure of other treatments. More than one reason for prescribing could be selected.

All four groups of drugs are prescribed for a relatively broad range of clinical indications, the vast majority of which are unlicensed. The orange shaded boxes show those clinical reasons applying to prescriptions for 10 % or more of people with PD only.
### Treatment targets

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

### Table 9. Antipsychotic medication currently prescribed in patients with personality disorder only (no co-morbid ICD-10 psychiatric diagnosis) at re-audit

<table>
<thead>
<tr>
<th>Personality disorder only (no co-morbid psychiatric diagnosis)</th>
<th>Treatment target 1 Antipsychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prescribed for more than four weeks</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
</tr>
<tr>
<td>Any personality disorder only (n=1689)</td>
<td>802 (47)</td>
</tr>
<tr>
<td>Emotionally unstable personality disorder (F60.3): n=1366</td>
<td>700 (51)</td>
</tr>
<tr>
<td>Dissocial personality disorder (F60.2): n=175</td>
<td>81 (46)</td>
</tr>
<tr>
<td>Paranoid personality disorder (F60): n=63</td>
<td>32 (51)</td>
</tr>
</tbody>
</table>
Table 10. Z-hypnotics and benzodiazepines currently prescribed in patients with personality disorder only (no co-morbid ICD-psychiatric 10 diagnosis) at re-audit

<table>
<thead>
<tr>
<th>Personality disorder only (no co-morbid psychiatric diagnosis)</th>
<th>Treatment target 2 Z-hypnotics</th>
<th>Treatment target 3 Benzodiazepines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prescribed for more than four weeks</td>
<td>Duration of prescription unclear</td>
</tr>
<tr>
<td>Any personality disorder (n=1,689)</td>
<td>214 (13)</td>
<td>79 (5)</td>
</tr>
<tr>
<td>Emotionally unstable personality disorder (F60.3): n=1,366</td>
<td>203 (15)</td>
<td>67 (5)</td>
</tr>
<tr>
<td>Dissocial personality disorder (F60.2): n=175</td>
<td>15 (9)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Paranoid personality disorder (F60): n=63</td>
<td>2 (3)</td>
<td>4 (6)</td>
</tr>
</tbody>
</table>

Of those patients with PD only, 63% were prescribed at least one antipsychotic (at baseline this figure was 55%). As can be seen in Tables 9 and 10, if prescribed, psychotropic drugs are usually continued for more than four consecutive weeks whether or not patients have a co-morbid psychiatric diagnosis.
1.2 Medication review

<table>
<thead>
<tr>
<th>Treatment target</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Medication prescribed for more than four consecutive weeks should be reviewed, and such a review should take into account a) therapeutic response and b) possible adverse effects and also c) be documented in the clinical records.</td>
</tr>
</tbody>
</table>

Table 11. Medication review for those patients who were prescribed a drug from any of the four groups of psychotropic medication (antipsychotics, antidepressants, mood stabilisers and sedatives) for more than four consecutive weeks at baseline (n=2,138) and re-audit (n=3,172)

<table>
<thead>
<tr>
<th>Patients prescribed medication for more than four weeks</th>
<th>Documented medication review</th>
<th>Clinical factors considered at medication review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proportion with no documented evidence of a medication review</td>
<td>Proportion with documented evidence of a medication review</td>
</tr>
<tr>
<td>Baseline</td>
<td>349 (18%)</td>
<td>1,744 (82%)</td>
</tr>
<tr>
<td>Re-audit</td>
<td>414 (13%)</td>
<td>2,758 (87%)</td>
</tr>
</tbody>
</table>

There was documented evidence of medication review in over four-fifths of cases. Therapeutic response and the patient’s views were considered more often than side-effect and adherence to treatment.
### Table 12. Outcome of medication review for those patients who were prescribed a drug from any of the four groups of medications (antipsychotics, antidepressants, mood stabilisers and sedatives) for more than four consecutive weeks at baseline (n=1,744) and re-audit (n=2,758)

| Patients prescribed medication for more than four weeks with documented evidence of a medication review | Documentation of the outcome of medication review |
|---|---|---|
| | Yes, clearly documented | Yes, partially documented | Not documented |
| **Baseline** | 1,211 (69%) | 441 (25%) | 92 (5%) |
| **Re-audit** | 2,065 (75%) | 578 (21%) | 113 (4%) |

In the re-audit sample, three-quarters of medication reviews were clearly documented.
Trust level section

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

Data from each Trust are presented by code.

Your Trust code is 79

Audit standards

1. A clinician’s reasons for prescribing antipsychotic medication (i.e. target symptoms or behaviour) are documented in the clinical records.
2. There is a written crisis plan in the clinical records.
3. There is evidence that the patient’s views have been sought in the development of the crisis plan.

Treatment targets

1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.
   
   Derived from NICE CG078 recommendation 6.12.1.2: Antipsychotic drugs should not be used for the medium and long term treatment of borderline personality disorder; and 3.12.1.3: Drug treatment may be considered in the overall treatment of co-morbid conditions.

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

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

4. Medication prescribed for more than four consecutive weeks should be reviewed, and such a review should take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records.
Table 13. Number of clinical teams and patient records submitted by participating Trusts at baseline (n=2,600) and re-audit (n=4014)

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Audit standard

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

Figure 10. Documentation in the clinical records of reasons for prescribing the most recent antipsychotic medication: in each Trust and the Total National Sample (TNS=2,758)

The clinical reasons for prescribing antipsychotic medication (a proportion of which is off-label use) was fully documented in around half of cases (45%) in the total national sample (this was 48% at baseline). Please note that this Figure includes all patients prescribed one or more antipsychotic, whether or not they have a co-morbid mental illness. This should be considered alongside Figures 13-15 which show prescribing practice for those with a diagnosis of PD only.
Figure 11. Crisis plan and patient involvement: in each Trust and the Total National Sample (TNS=4014)

Audit standards

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

Proportion of patients

Trust code

Note that Figures 11 and 12 include all patients whether or not they have a co-morbid psychiatric diagnosis.
Reference to medication in the crisis plan may include new medication to be prescribed or change in dosage of current medication. When reflecting on the data contained in this Figure, Trusts may also like to look at Figure 16 which illustrates the proportion of patients currently prescribed psychotropic medication for more than four weeks.
Treatment target
1. Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness.

Figure 13. Antipsychotic prescription and duration of treatment in patients with personality disorder only in each Trust and the Total National Sample (n=1,689)

Trusts are ordered on the proportion of patients in their samples prescribed an antipsychotic. The red segment relates to the proportion of patients prescribed at least one antipsychotic for more than four consecutive weeks, the orange section to duration of prescribing being unknown and the green section relates to those prescribed antipsychotics for four weeks or less. The white segment relates to the proportion of patients who were not prescribed an antipsychotic. This figure shows that almost half of those with a diagnosis of PD but no co-morbid psychiatric illness are prescribed an antipsychotic for more than 4 weeks and this proportion has not changed since the baseline audit. This prescribing is not consistent with relevant NICE recommendations and one explanation may be that not all clinicians agree with these recommendations.
Treatment target

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

Figure 14. Z-hypnotic prescription and duration of treatment in patients with personality disorder only (n=1,689)
Treatment target

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

Figure 15. Benzodiazepine prescription and duration of treatment in patients with personality disorder only (n=1,689)
Figure 16. Proportion of patients in the TNS prescribed any antipsychotic, antidepressant, mood stabilisers or sedative for more than four weeks (TNS=4,014)

The purple segment relates to the proportion of patients in each Trust and the total national sample prescribed at least one medication from the four groups of drugs (antipsychotics, antidepressants, mood stabilisers and sedatives) where at least one of these medications was prescribed for more than four weeks.
Figure 17. Patients prescribed any antipsychotic, antidepressant, mood stabiliser or sedative for more than four weeks (n=3,172) and documented evidence of medication review in the clinical records

The green segment relates to the proportion of patients who had documented evidence in their clinical records of a medication review in the last 13 months and the red segment shows the proportion that had no documentation of a medication review in their clinical records.

Treatment target

4. Medication prescribed for more than four consecutive weeks should be reviewed
When interpreting the above figure, Trust might want to reflect on how they recruited their sample. Trusts might also consider comparing their performance against the audit practice standards with Trusts with a similar sample profile.
3. Team level results

**Figure 19. Standard 1:** documentation in the clinical records of reasons for prescribing the most recent antipsychotic medication in your Trust (n=46) and the TNS* (n=2,758)

*The subsample of the TNS prescribed an antipsychotic.

**Figure 20. Standards 2 and 3:** crisis plan and patient involvement in your Trust (n=53) and the TNS (n=4,014)

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Figure 21. Reference to medication in the crisis plan in your Trust (n=53) and the TNS (n=4,014)

- Patient does not have a crisis plan
- Patient has a crisis plan but it does not refer to medication
- Patient has a crisis plan which refers to medication

Figure 22. Treatment target 1: antipsychotic prescription and duration of treatment in patients with personality disorder only in your Trust (n=17) and the TNS* (n=1,689)

*Subsample of TNS with personality disorder only

Please note that if a team is missing from Figures 21 to 23, this means that all the patients in the sample had a co-morbid psychiatric diagnosis.
Figure 23. **Treatment target 2**: z-hypnotic prescription and duration of treatment in patients with personality disorder only in your Trust (n=17) and the TNS* (n=1,689)

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*Subsample of TNS with personality disorder only

Figure 24. **Treatment target 3**: benzodiazepine prescription and duration of treatment in patients with personality disorder only in your Trust (n=17) and the TNS* (n=1,689)

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<th>Team code</th>
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*Subsample of TNS with personality disorder only
Figure 25. **Treatment target 4**: proportion of patients prescribed any antipsychotic, antidepressant, mood stabiliser or sedative for more than four weeks and documented evidence of medication review in the clinical records in your Trust (n=53) and the TNS (n=4,014)
Appendix A: Trust demographics

Figure 26. Ethnicity profile in each Trust and the total national sample at re-audit (TNS=4,014)
Figure 27. Age groups in each Trust and the total national sample at re-audit (TNS=4,014)
Figure 28. Gender distribution in each Trust and the total national sample at re-audit (TNS=4,014)
Appendix B: References


Prescribing Observatory for Mental Health (2012). Topic 12a baseline report: Prescribing for people with a personality disorder. CCQI139
Appendix C: Participating Trusts

The Trusts that participated in this audit are listed below in alphabetical order.

5 Boroughs Partnership NHS Foundation Trust
Alpha Hospitals
Avon & Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield & Haringey Mental Health NHS Trust
Belfast Health and Social Care Trust
Berkshire Healthcare NHS Foundation Trust
Betsi Cadwaladr University Health Board
Birmingham and Solihull Mental Health NHS Foundation Trust
Black Country Partnership NHS Foundation Trust
Bradford District Care Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Central and North West London NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Coventry and Warwickshire Partnership Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership Trust
Dorset Healthcare University NHS Foundation Trust
Dudley and Walsall Mental Health Partnership Trust
East London NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Humberside NHS Foundation Trust
Kent and Medway NHS and Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
NAVigiGO Health and Social Care CIC
North East London NHS Foundation Trust
North Essex Partnership NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northumberland Tyne and Wear NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust
Oxford Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Partnerships in Care
Pennine Care NHS Foundation Trust
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
Sheffield Health & Social Care NHS Foundation Trust
Solent NHS Trust
Somerset Partnership NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South West London and St George’s Mental Health Trust
South West Yorkshire Partnership NHS Foundation Trust
St Andrew’s Healthcare
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
West London Mental Health NHS Trust
Worcesestershire Health & Care Trust
Appendix D: Audit data collection guide and form

### Topic 12b: Prescribing for people with a personality disorder

- Complete a separate form for each patient - ONLY include patients with a diagnosis of personality disorder (ICD-10 diagnosis in the F50-F51 category) who are under the care of adult or forensic services. There is no upper age limit.
- To help you complete this re-audit, please use all the patient's clinical records - these include all electronic and paper notes, letters, and other patient information available to the clinical team. To complete the questions relating to reasons for prescribing (clinical indications), please obtain the information from the prescribing clinician and/or clinical team directly.
- All questions are mandatory unless marked with an asterisk (*).
- If you need help completing this audit form, contact the local POMH lead for your Trust. You can also contact POMH-UK on 020 3701 2687.
- Guidance notes can be found at the end of this form.

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#### Audit standards

1. A clinician’s reasons for prescribing psychotropic medication (i.e. target symptoms or behaviour) are documented in the clinical records.
2. There is a written crisis plan which is accessible in the clinical records.
3. There is evidence that the patient’s views have been sought in the development of the crisis plan.

All data should be collected by: 30 June 2014

Data should be entered online at [www.ccqi.org.uk/pomh/data](http://www.ccqi.org.uk/pomh/data). You will need to log in using your Trust’s POMH-UK log in details to access the data entry webpage.

*If you do not know the log-in details for your trust, please contact your Trust’s local POMH-UK lead in the first instance.*

*Please make sure you start from the data entry page for each patient.*

This form is intended for use as part of the POMH-UK Topic 12b quality improvement programme only and may not be suitable for other purposes.

#### Trust, team and patient information

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<th>Question</th>
<th>Answer</th>
</tr>
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<td>Q1 Trust code</td>
<td>The Trust code is a 2 digit code (e.g. 04).</td>
</tr>
<tr>
<td>Q2 Team code</td>
<td>The team code is your 3 digit Trust code followed by 3 digit team code (e.g 044-003). Please ensure that the first 3 digits match the Trust code entered in Q1. Your team codes are known only to your Trust, the POMH-UK team cannot tell you what your team code is.</td>
</tr>
<tr>
<td>Q3 Optional additional identifier</td>
<td>This field gives your Trust the option of identifying data by site, lead consultant, or any other variable you wish. Year Trust codes are being issued to aid the use of this field. Enter the numerical code that is used by your Trust and keep a record for yourself. If you do not want to use an additional identifier, simply leave this field blank.</td>
</tr>
<tr>
<td>Q4 Initials of data collector</td>
<td>Enter your own initials in this field (e.g. SB). This will enable your Trust to identify you should we need to query something about this data collection.</td>
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#### Patient details

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<td>Q6 Patient year of birth</td>
<td>YYYY e.g. 1998</td>
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<tr>
<td>Q7 Patient gender</td>
<td>Male</td>
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<td>Q8 Patient self-assigned ethnicity as recorded in case notes</td>
<td>Other:</td>
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<td>Q9.1 Current patient setting: (see guidance notes)</td>
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</tr>
</tbody>
</table>

*Please specify if "other" or if you are unsure which category to tick.

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Q9.2 If not currently an inpatient, has the patient been an inpatient (admitted to a psychiatric ward or other ward) in the last year with mental health service involvement? (see guidance notes)

- Yes
- No
- Unclear/don’t know

Q9.3 Has the patient been referred to, seen by and/or assessed by specialist personality disorder services in the last year?

- Yes
- No
- Unclear/don’t know

Q10 Sub-type of personality disorder diagnosis (ICD-10 category): Tick all that apply

- F60.6: Narcissistic personality disorder
- F60.8: Antisocial (involuntary) personality disorder
- F60.9: Dependent personality disorder
- F60.4: Avoidant personality disorder
- F60.3: Borderline personality disorder
- F60.7: Personality disorder, not otherwise specified
- F60.5: Personality disorder, unspecified
- F60.1: Histrionic personality disorder
- F60.2: Narcissistic personality disorder
- F60.1: Borderline personality disorder
- F60.7: Personality disorder, not otherwise specified
- F60.5: Personality disorder, unspecified
- F60.3: Borderline personality disorder
- F60.9: Dependent personality disorder
- F60.8: Antisocial (involuntary) personality disorder
- F60.6: Narcissistic personality disorder
- Sub-type not yet determined

Q11 Other current psychiatric diagnoses within the following ICD-10 categories: (see guidance notes) Tick all that apply

- F09–F90
- F08–F91
- F20–F29
- F60.7: Personality disorder, not otherwise specified
- F60.5: Personality disorder, unspecified
- F60.3: Borderline personality disorder
- F60.2: Narcissistic personality disorder
- F60.1: Histrionic personality disorder
- F60.9: Dependent personality disorder
- F60.8: Antisocial (involuntary) personality disorder
- F60.6: Narcissistic personality disorder
- Sub-type not yet determined

Q12.1 If you have ticked F20–F39 in Q11 above, please indicate whether the diagnosis is schizophrenia.

- Yes
- No

Q12.2 If you have ticked F30–F39 in Q11 above, please indicate whether the diagnosis is bipolar disorder.

- Yes
- No

Crisis Plan

Q13 Does the patient have a written crisis plan in their clinical records? (see guidance notes)

- Yes
- No

Q14 If the answer to Q13 is yes, does the crisis plan refer to medication?

- Yes
- No

Q15 Is there documented evidence in the clinical records that the patient’s involvement was sought during the development of the crisis plan? (see guidance notes)

- Yes
- No
### Q16.1
If the patient has been prescribed an oral, depot or short-acting IM antipsychotic (routinely and/or PRN, even if not taken), please indicate, from the list below, which of these were prescribed in the last 13 months. Please tick a maximum of three antipsychotics.

<table>
<thead>
<tr>
<th>Antipsychotic 1</th>
<th>Antipsychotic 2</th>
<th>Antipsychotic 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
</tr>
<tr>
<td>NAME (IM)</td>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
</tr>
<tr>
<td>NAME (depot)</td>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
</tr>
<tr>
<td>NAME (IM)</td>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
</tr>
<tr>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
<td>NAME (oral)</td>
</tr>
</tbody>
</table>

### Q16.2
If this patient has been prescribed four or more antipsychotics in the past 13 months, please tick here:

- [ ] Yes
- [ ] No
- [ ] Don't know

### Q17
Antipsychotic 1: please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply)

<table>
<thead>
<tr>
<th>Month(s)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic 1</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Q18
Antipsychotic 2: please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply)

<table>
<thead>
<tr>
<th>Month(s)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Q19
Antipsychotic 3: please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply)

<table>
<thead>
<tr>
<th>Month(s)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Q20
Were any antipsychotics prescribed for more than four consecutive weeks on any occasion (even if PRN/not taken)?

- [ ] Yes
- [ ] No
- [ ] Don’t know

### Q21
Antipsychotic 1: clinical indications

- Affective/mood disturbance (e.g. as a mood stabiliser)
- Aggression/ hostility
- Anxiety/insomnia
- Anxiety/somatic symptoms
- Depression/depersonalisation
- Depression
- Delusion
- Disordered thought or acts
- Self-harm; delirious/poor insight
- Risk of harm to self or others
- Recent psychotic-like experiences or symptoms
- Recent risk
- Reaction to other treatments (no guidance noted)
- Other
- Not known

If other, please state: [ ]

Q22 Antipsychotic 2: clinical indications
- Attentional, emotional instability (i.e. as a mood stabiliser)
- Aggression/irritability
- Anxiety (including phobic anxiety and panic)
- Insomnia/difficulty in sleeping
- Depressive symptoms
- Delusional thinking
- Impulsivity

*If other, please state:

Q23 Antipsychotic 3: clinical indications
- Attentional, emotional instability (i.e. as a mood stabiliser)
- Aggression/irritability
- Anxiety (including phobic anxiety and panic)
- Insomnia/difficulty in sleeping
- Depressive symptoms
- Delusional thinking
- Impulsivity

*If other, please state:

Q24 In relation to the most recently initiated antipsychotic in the last 13 months, are the clinical indications for this documented in the clinical records?
- Fully documented
- Partially documented
- Not documented

---

Mood Stabilisers

Q25 If the patient has received a mood stabiliser, please indicate from the list below which of these were prescribed in the last 13 months. Please tick a maximum of three mood stabilisers.

- Carbamazepine
- Lamotrigine
- Lithium
- Topiramate
- Valproate
- Other mood stabiliser

*If any other mood stabiliser has been prescribed, but is not listed above or at QIS 1, please specify the drug name.

Q25a Mood stabiliser 1: please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply)

Q26 Mood stabiliser 2: please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply)

Q27 Mood stabiliser 3: please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply)

Q28 Were any mood stabilisers prescribed for more than four consecutive weeks on any occasion (even if PRN not taken)?
- Yes
- No
- Don't know
### Sedatives

<table>
<thead>
<tr>
<th>Sedative</th>
<th>Sedative 1</th>
<th>Sedative 2</th>
<th>Sedative 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clonazepam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temazepam</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Zopiclone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other sedative, not listed above*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*All other sedative medications are prescribed, but not listed above, please specify the drug name.

**Q41** If the patient has received a sedative medication, please tick from the list below those which were prescribed in the last 13 months. Please tick a maximum of three sedatives.

**Q42** Sedative 1; please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply). See guidance notes.

**Q43** Sedative 2; please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply). See guidance notes.

**Q44** Sedative 3; please indicate in which month(s) over the last year this was prescribed (Tick all those months which apply). See guidance notes.

**Q45.1** Were any benzodiazepines prescribed for more than four consecutive weeks on any occasion (even if PRN not taken)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
</table>

**Q45.2** Were any a-hypnotics prescribed for more than four consecutive weeks on any occasion (even if PRN/not taken)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
</table>

### Reasons for prescribing (clinical indications) for each of the sedatives prescribed, please tick all that apply. Please ask the treating clinical team for this information.

**Q46** Sedative 1; clinical indications

- **Affective/emovalional instability**
- **Aggression/hyperactivity**
- **Anxiety (including phobic anxiety and panic)**
- **Anorexic/hyponic symptoms**
- **Dopaminergic/s急tosis**
- **Depressive symptoms**
- **Drowsiness**
- **Dysphoric state**
- **Insomnia**
- **Known or suspected psychotic illness such as schizophrenia, bipolar disorder, psychotic depression**

*If other, please state*

**Q47** Sedative 2; clinical indications

- **Affective/emovalional instability**
- **Aggression/hyperactivity**
- **Anxiety (including phobic anxiety and panic)**
- **Anorexic/hyponic symptoms**
- **Dopaminergic/s急tosis**
- **Depressive symptoms**
- **Drowsiness**
- **Dysphoric state**
- **Insomnia**
- **Known or suspected psychotic illness such as schizophrenia, bipolar disorder, psychotic depression**

*If other, please state*

**Q48** Sedative 3; clinical indications

- **Affective/emovalional instability**
- **Aggression/hyperactivity**
- **Anxiety (including phobic anxiety and panic)**
- **Anorexic/hyponic symptoms**
- **Dopaminergic/s急tosis**
- **Depressive symptoms**
- **Drowsiness**
- **Dysphoric state**
- **Insomnia**
- **Known or suspected psychotic illness such as schizophrenia, bipolar disorder, psychotic depression**

*If other, please state*

Other medications

Q49.1 Please identify any other **psychotropic** medications that the patient is currently prescribed (i.e. other than those already identified above). No dosage, administration or other information is required.

- Amantadine
- Bupropion
- Methadone
- Metacycloxate
- Methylphenidate
- Propylhale
- Other* *

*Other psychotropic medications are prescribed but not listed above, please specify the drug name.

Q49.2 Please identify any **non-psychotropic** medications the patient is currently prescribed. No dosage, administration or other information is required.

- Analgesics - non-opioid (e.g. aspirin, paracetamol)
- Analgesics - opioid (e.g. co-codamine)
- Antacids and anti-ulcer medications
- Anticoagulants
- Anti-cholesterol agents
- Anti-obesity medication (including appetite suppressants)
- Antidepressants
- Beta-blockers (e.g. propranolol)
- Beta-blockers (non-cardiac)
- Blood pressure reducing agents
- Breathing agents
- Bronchodilators
- Calcific anti-inflammatory (oral or injectable)
- Cocaine
- Decongestants
- Diuretics
- Electrolyte preparations
- Herbal
- H2 blockers
- Hormonal contraception (oral or injectable)
- Levosalbutamol
- Opioids
- Other *

* Other non-psychotropic medications are prescribed but not listed above, please specify.

If you answered no or don’t know to Q50, Q51, Q52, Q53, Q45.1 or Q45.2 then you have reached the end of this questionnaire, please stop here.

Thank you.

If you answered “yes” to any of the following questions: Q20, Q29, Q37, Q45.1, Q45.2, then please continue and go to Q50.

Medication Review

Q50 Is there documented evidence of a medication review having taken place in the past year?
- Yes, there is documented evidence
- No, there is no medication review documented in the

Q51 If yes, please tick in which month(s) a medication review took place (Tick all those which apply)

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Medication review

Q52 Is there documented evidence of the following being considered as part of the most recent medication review? (see guidance notes) Please tick all that apply

- Therapeutic reasons
- Side-effects/seriousity
- Adherence

Q53 Is the outcome of the most recent medication review clearly documented in the clinical records (e.g. medication warrants continuation unchanged, change in dosage required, change of antipsychotic drug required)?
- Yes, clearly documented
- Yes, but only partially documented
- No, not documented

The data should be submitted online to POMH-UK by: 28 July 2014

Data should be entered online at www.rcpsych.ac.uk/surveys/data.

You will need to log in to access the data entry webpage. If you do not know the log in details for you/your Trust, please contact your Trust’s local POMH-UK lead in the first instance.

Please press submit when this form is completed to send the data to POMH-UK.

Data cannot be altered via this site once submitted. If you have made a mistake, please email the correction to POMH-UK@rcpsych.ac.uk and include the following details to help us identify the correct case: Trust code, form code, initials of data collector, patient code and patient year of birth.

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**Guidance notes**

**Q9.1:** Specialist personality disorder (PD) services may be known by different names such as complex needs services, service for complex emotional cases, etc.

**Q9.2:** Other ward in this context includes medical admissions, perhaps via A&E related to self-harming or impulsive behaviour.

**Q11:** The ICD-10 diagnostic codes are:

- F00-F09: Organic, including symptomatic, mental disorders
- F10-F19: Mental and behavioural disorders due to psychoactive substance use
- F20-F29: Schizophrenia, schizotypal and delusional disorders
- F30-F39: Mood (affective) disorders
- F40-F48: Neurotic, stress-related and somatoform disorders
- F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors
- F60-F69: Disorders of adult personality and behaviour
- F70-F79: Mental retardation
- F80-F89: Disorders of psychological development
- F90-F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- F99: Unspecified mental disorder

**Q13:** The crisis plan may be found in a letter to the GP, progress notes, or the care plan if the patient is subject to a CPA. It may also be part of the risk management plan.

**Q15:** If the crisis plan is written in the first person and/or records the patient’s view/comments, this can be taken to indicate patient involvement was sought in the development of the crisis plan.

**Q21-23:** Q30-Q32; Q38-Q40; Q46-Q48: Select “failure of other treatments” if other strategies, which may include psychological interventions, were previously tried but were not effective enough.

**Q52:** A statement in the clinical records relating to a medication review saying a review took place is insufficient; there should be evidence that the risks and benefits of the medication were considered.
Appendix E: Data control

Data control statement for POMH-UK quality improvement programme 12b: prescribing for people with a personality disorder

In line with the original memorandum of understanding between POMH-UK and member healthcare organisations (predominantly mental health NHS Trusts), the following statement outlines the agreement regarding control of the audit data in this quality improvement programme.

Control of the local data submitted to POMH-UK is retained by the healthcare organisation that submitted them. These data have been made available to POMH-UK in a way that is anonymous, with the exception of the identity of the source organisation. The aggregate data from all participating organisations have been analysed by POMH-UK, to produce this customised report. This report summarises the national results, and local results at organisation and clinical team level, benchmarked anonymously against the other organisations taking part.

There is a publication strategy allowing POMH-UK to publish the anonymous aggregated data on its web site and/or in appropriate scientific journals. Any requests from other organisations for the audit data will be referred to the POMH-UK reports appearing in the public domain or provided with a list of member healthcare organisations and asked to approach them individually. It is each organisation’s decision whether, and with whom, to share their data.

Reflection by clinical teams on their benchmarked performance is perhaps the most potent element of POMH-UK programmes. In addition to performance against the clinical standards, the audit data include demographic, diagnostic and other relevant clinical information that not only provide a context for interpretation and understanding of practice, but can also inform local strategies and systems to achieve improvement. The data collected are designed to be suitable for quality improvement purposes, and not for objective ranking of healthcare organisations, for which they are untested and would not necessarily be appropriate.
Appendix F: POMH-UK QIP 12
Advisory Group

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