NHS FORTH VALLEY

Emotional Regulation, Emotionally Unstable Personality Disorder and Complex Trauma Pathway

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Contents

Introduction

This pathway is designed for individuals with Emotionally Unstable Personality Disorder (EUPD), complex trauma, and emotional dysregulation. Its goal is to foster exemplary clinical practice in the management and treatment of these conditions. It outlines the services patients can anticipate throughout their care journey. NHS Forth Valley has developed this pathway through a collaborative and thorough examination of existing services across the region.
The development of this pathway involved thorough consultations with stakeholders from the community, statutory, and third-sector services. The development team also comprised multidisciplinary members from local mental health services, including community, inpatient, psychological, forensic, substance use, older people's services, primary care, learning disabilities, and child and adolescent mental health services.

Emotionally Unstable Personality Disorder (EUPD) has increasingly become a central focus of secondary care mental health services over the past decade. Annually, more individuals are referred for assistance and treatment. Individuals with EUPD are considered high risk by definition. Crisis presentations are anticipated as part of the disorder. Patients with EUPD have multifaceted needs, and their treatment typically extends over a long duration. The success of the treatment hinges on the individual's active involvement.

The causes of personality disorder are believed to be multifaceted, involving a mix of biological, psychological, and social factors. Genetics may play a role, as certain traits like emotional sensitivity or impulsivity can be inherited. Early development is also crucial; early life experiences, attachment styles, and trauma can influence one's developmental path. Adverse Childhood Experiences, such as abuse or instability and invalidation can have lasting effects. In adulthood, factors like domestic violence or severe poverty can exacerbate these issues. Behaviours that were once adaptive in adverse conditions may become maladaptive coping mechanisms.

The International Classification of Diseases 11th revision, updated in 2022, eliminated specific personality disorder subtypes, opting instead for a single broad category with varying severity levels mild, moderate, and severe based on the impact on relationships, self-identity, and the intensity of emotional, cognitive, and behavioural difficulties. The borderline personality category remains due to its significant evidence base for treatment.

Personality disorders are relatively common, affecting 6-10% of the general population, a figure that rises to 50% among those engaged with specialist mental health services. It is also one of the most under diagnosed psychiatric conditions.

Complex Trauma is characterised by exposure to multiple, often interconnected forms of traumatic experiences, as well as the challenges that emerge from adapting to or enduring these experiences. The harmful experiences encompassed by Complex Trauma usually start in early childhood, persist or recur over time, and are imposed by others. They are most frequently committed within an individual's primary attachment relationships.

Emotional dysregulation, also known as affect dysregulation or simply dysregulation is the inability to manage emotional responses. This condition makes self-soothing difficult when feeling overwhelmed, sad, or angry, and it's challenging to return to a "normal" state after such emotions arise. Emotional dysregulation can trigger the nervous system into a fight, flight, freeze, or fawn response, which are natural reactions to perceived threats. At times, these responses occur even in the absence of actual danger, leading to unexpected anxiety, depression, or difficulty in controlling emotions. Often, these states can present simultaneously.

While certain aspects of the treatment journey for Emotionally Unstable Personality Disorder (EUPD), complex trauma, and emotional dysregulation necessitate specialised skills and specific psychological therapy training, the overall process of assessment, treatment, and support should be a fundamental competency for all mental health service professionals.

Services should embrace diagnostic uncertainty as the process of establishing a firm diagnosis may take several months. Services should be offered to those presenting with emotional dysregulation in the first instance.

Scope

This pathway guidance is applicable to all patients' aged 18+(except CAMHS) seeking services for assessment, diagnosis, treatment, and recovery support. While it is situated within the Mental Health and Learning Disability (MHLD) services, this guideline aims to provide consistent, evidence-based interventions throughout the entire care system, from initial contact to secondary and, where relevant, tertiary care. The purpose of this document is to minimise unwarranted variations across and within services, but also ensuring we have a clear understanding abound the pathways and processes available.

These components of care are delivered within a service which adopts principals of care which are recovery focussed, trauma informed, person centred, developmentally informed, culturally sensitive, hopeful and empowering.

General Principles of Care:

As far as possible the following principles should be adhered to when working with individuals:

1. Consistency of care is extremely important. The same professionals should attempt to see the individual as far as possible.
2. Few rather than many professionals should be involved in the individual's care.
3. Times of contact with professionals should be consistent as much as possible. e.g. The same time should be agreed between appointments, appointments should occur in the same location, cancellations and rescheduling should be kept to a minimum.
4. Periods where professionals will be absent, e.g. due to annual leave or sickness should be planned for as much as possible.
5. The individual should be encouraged to follow a safety plan.
6. All professionals involved in the care of an individual with emotional dysregulation, EUPD and complex trauma should receive some form of regular supervision (all MH and LD professionals).

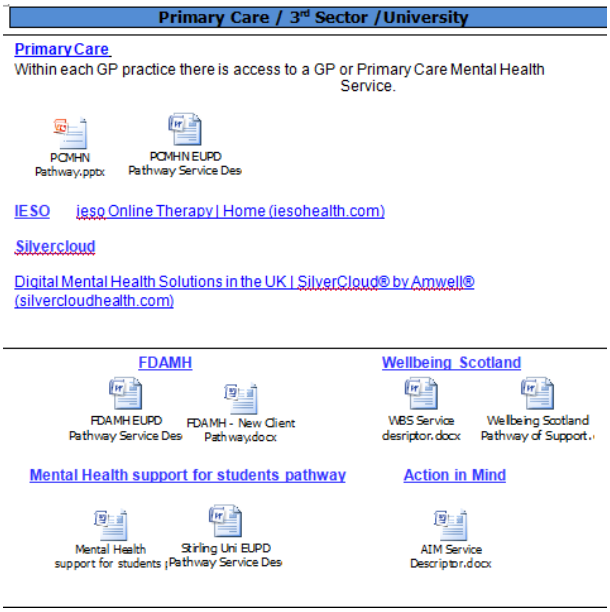
No two individuals experiencing emotional dysregulation, EUPD and complex trauma are the same, however in general the individual should be encouraged to move along the patient journey below.

Overview of the literature

(Healthcare Improvement Scotland 2019)

Initial Contact – Primary Care and Third Sector

Most patients with these conditions will initially be seen in a primary care setting or present themselves to various third sector services. This section of the pathway should delineate the provisions required at this initial stage. For more detailed information / service provision please refer to this part of the pathway:



Referral from initial contact could result in further assessment and treatment from any of the following services:

Timescales for assessment:

- Emergency same day assessments will be provided by MHATTS.
- ICMHS:
  - Urgent - within 5 working days
  - Routine - within 8 weeks
- Psychological therapies and Eating Disorders – within 18 weeks
- Occupational therapy - within 18 weeks
- CAMHS - within 18 weeks
- Forensic CMHT
  - Urgent - within 5 working days
  - Routine - within 12 weeks
- Prison - within 18 weeks
- LD Additional Support Team (AST) within 3 days.
- OPS - within 18 weeks

Screening

All referrals received are screened by a clinician.

Assessment, Diagnosis and Formulation

Initial assessment

Each service uses a standardised assessment process which includes risk assessment.

A person centred and strengths-based approach should be applied and wherever possible a collaborative approach should be taken, considering the person's wants and needs when devising treatment plans. The assessment should address the following domains where appropriate:

- Psychiatric / mental health problems, risk of harm to self or others, alcohol consumption, and prescribed and non-prescribed drug history.
- Medical, including medical history and prescribed drug treatments.
- Physical health and wellbeing
- Psychological and psychosocial, including social networks, relationships and history of trauma / PTSD
- Developmental (social, cognitive and motor development and skills, including coexisting neuro-developmental conditions)
- Social (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer)
- Occupational and educational (attendance at college, educational attainment, employment and activities of daily living)
- Quality of life
- Routinely monitor for other coexisting conditions, including depression, anxiety and substance misuse particularly in the early phases of treatment.
- Past treatment / therapy and benefits from this.
- Goals / expectations.

Establishing a diagnosis

Assessing an individual with suspected EUPD should involve gathering information from multiple sources over a prolonged assessment period. **The diagnosis should not be made after a single contact or consultation**. The process of gathering this information is a generic skill that all mental health professionals should be familiar with and should involve:

- The gathering of a developmental history
- Establishing the timing and quality of fluctuations in mood and self-esteem (particularly to distinguish between EUPD and an affective disorder)
- Gaining a collateral history regarding the individual's developmental history, and the timing of their symptoms
- The use of recognised assessment tools as appropriate, e.g. SCID for borderline personality disorder

Diagnosis should be collaborative to avoid any risk of re-traumatisation, with information provided on treatment options. Specialised therapies are appreciated by those with a diagnosis and are seen to be effective. The establishment of a good therapeutic alliance was also found to be effective in satisfaction with interventions and positive outcomes.
Diagnosis can only be provided by a Consultant Psychiatrist or Practitioner Psychologist.

Please note a diagnosis is not necessary to access certain parts of the pathway and even considered as detrimental in some cases. (Except DBT).

Post Diagnosis
The diagnosis of EUPD should be explained to individual and their carers (where appropriate). The individual should be given written information on the diagnosis which includes self help information. All individuals where appropriate should develop a safety plan. Please refer to this section of the pathway (appendix1):

Identifying complex trauma:

The word trauma means wound. In the past, we only used it to talk about physical injuries and the things that caused them. Today, we also know that some events can cause psychological problems, even if we aren't physically harmed. These traumatic events could be things like:
- A physical or sexual assault
- A road traffic accident
- A natural disaster

Traumatic events are usually unexpected and highly distressing and leave us feeling out-of-control and overwhelmed. Sometimes they can leave us with an 'emotional shock' or psychological trauma. This often includes difficulties like:
- Unwanted memories, flashbacks or nightmares of the event
- Avoiding any reminders of the event
- Feeling unusually tense, irritable or 'on edge' It's important to know that these can all be normal responses to trauma.

The types of trauma mentioned above are usually one-off, unexpected events. These are sometimes called a Type 1 Trauma. Unfortunately, some people also experience multiple traumas, over long periods of time. Often these can start in childhood. They can include:
- Child physical, sexual or emotional abuse
- Child neglect
- Domestic abuse
- Torture

These events can be especially difficult because they're caused by people. Often, these people can be family members, or others that we should be able to trust. Usually, they have some power or control over us too. This can leave us feeling that we're unable to escape the situation, no matter what we do. We call this type of trauma a Complex Trauma or Type 2 Trauma. This type of trauma can lead to extra problems like:
- Difficulties with sense of self
- Difficulties controlling overwhelming feelings
- Difficulties in relationships

Presentation in crisis

Those with a diagnosis of EUPD are more likely than those with other mental health difficulties to have presentations in crisis to A&E, to be taken there by police or ambulance and present with suicidal ideation, mental health comorbidity, self-harm and/or drug intoxication. Existing guidelines offer comprehensive instructions and advice for these scenarios. See section 5, pages

43-47 of the NHS Highland Personality Disorder Integrated Care Pathway and section 7.1 of the NICE guidelines for borderline personality disorder (appendix 6).

Formulation

It is good practice for any individual completing psychological therapy to work collaboratively with their clinician to develop a psychological formulation. This gives the individual and any clinicians involved a deeper understanding of where their issues have arisen from as well as what maintains them.

The 5 P's format can be useful initially. A user friendly template has been developed by NHS Northumberland, Tyne & Wear 5ps and formulation CNTW (see appendix 5). Depending on the complexity of the case it may be that additional and more complex formulation is required. We would recommend psychological therapy / psychology staff undertake this piece of work. If working as part of a multi-disciplinary team, the clinician may facilitate a multi-disciplinary formulation session to enable contribution from across the team.

Family/Carer Engagement

As early as possible in the individuals journey professionals should attempt to engage with the social support network around the individual, where appropriate. Education sessions should be offered about the conditions and carers should be directed to useful self-help materials (see appendix 1). Engagement with family is particularly important at times recognised as being high risk i.e. crisis presentations and discharge from hospital. It is also recognised that involvement with families and carers may not be helpful in some cases.

Stages of Treatment

Phase 1 treatment

Psychosocial and psychological treatment in this stage of the patient journey involves helping an individual become safer and more stabilised. Treatment can involve:

- Extended safety planning
- Addressing any illicit drug or alcohol misuse
- Addressing social factors implicated in the individuals presentation (e.g. housing issues, debts, relationship issues)
- Helping an individual gain more structure and routine in their daily life as a "foundation" e.g. exercising, volunteering, increasing helpful social contacts
- Teaching the individual generic psychological skills that they can use to deal with overwhelming emotions

These may be undertaken by a variety of professionals from different disciplines.

Current packages of psychological intervention approved to use across NHS Forth Valley during phase 1 work are:

- NES safety and stabilisation skills
- The decider skills
- Emotional resources group (ERG)
- MERG

Mental health professionals should negotiate with the patient the goals of phase 1 treatment. For many individuals phase 1 treatment is sufficient in itself. However, for many individuals with EUPD and complex trauma (particularly at the more severe end) the goal of phase 1 treatment should be

to get the individual stabilised to a position where they are able to undertake a higher intensity psychological therapy

Phase 2 treatment
Phase 2 psychological treatment should be offered according to a tiered model. In general, treatment in a group may be offered first. If an individual continues to experience difficulties with EUPD they may be offered the STEPPS group then DBT if appropriate. Many individuals with a diagnosis of EUPD will go straight to DBT when there is risk to life behaviours.

Due to the strong association between psychological trauma/post traumatic stress disorder (PTSD) and EUPD it is likely that trauma re processing (e.g. trauma focussed CBT or EMDR) will be helpful for individuals with EUPD at some point during phase 2 treatments. The decision as to when to start such a treatment, if at all, will need to be assessed based on an individual basis.

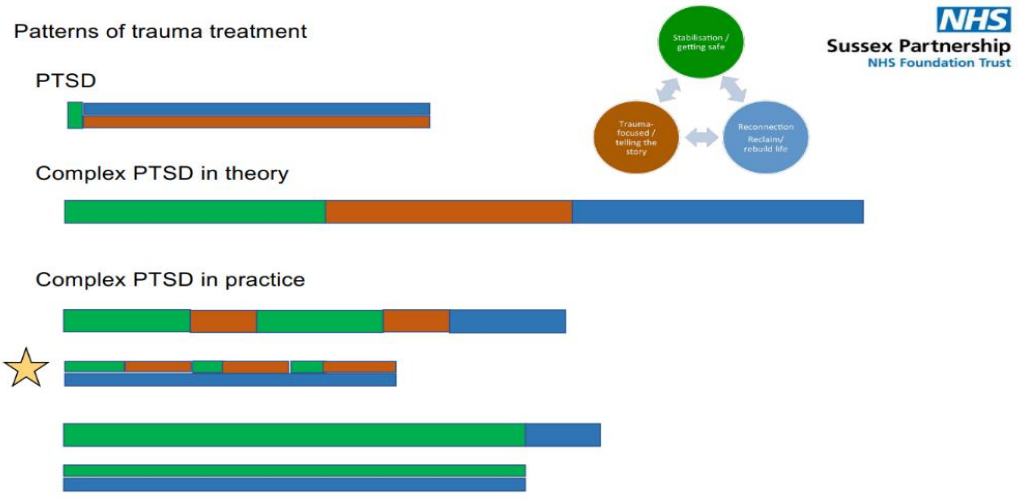
There will always be some individuals who for individual reasons will not be able to tolerate group treatment.

Complex trauma treatment may include phase 1 groups if appropriate.

Phase 3 treatment
This phase of treatment involves supporting an individual to build protective factors in their life as they move on the recovery journey away from mental health services. There is currently no scientific evidence base, or national consensus to guide what good phase 3 treatment would look like. Because of this the EUPD and Complex Trauma pathway group would recommend that professionals offer interventions which would seem to have good face validity. These would include:

- Occupational therapy input
- Encouraging an individual to exercise regularly
- Increasing the amount of positive social contact the individual is exposed too. e.g. Volunteering, study/training, meaningful employment

Not all individuals will require all 3 phases, and the 3 phases are not a linear process. Phase 3 often runs concurrently alongside the completion of Phases 1 and 2. Please note not all services offer all these treatment options.



Discipline Specific Guidance

Integrated Community Mental Health Service (ICMHS)

Key worker allocation

Discussion/referral takes place at the MDT if the person is being referred into the EUPD pathway and the person understands this will involve group therapeutic interventions. All patients referred into the pathway will be allocated a keyworker for individual interventions such as Decider skills, anxiety & depression or Safety & Stabilisation for up to four session prior to commencing group.

Occupational Therapy

Occupational therapy is a profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational Therapists (O.T. s) achieve this outcome by enhancing individuals' ability to participate, by modifying the environment or by adapting the activity to better support participation. (The World Federation of Occupational Therapists http://www.wfot.org/)

OT intervention is not generally diagnosis specific however various interventions can be offered to enable individuals to develop skills that will maximise level of functioning in all areas of occupational performance, for example, self- care, leisure, work and life roles.

Following assessment OT intervention aims to :

- To work with individuals to develop activities, behaviours and occupations to manage the symptoms of mental illness or emotional distress. – Phase 1
- To develop skills that maximise level of functioning in all areas of occupation performance including self care , leisure , work and life roles. – Phase 1
- Use of activity to help the person build skills and challenge negative thoughts and beliefs. – Phase 1
- To work with individuals identify the things that they **want** to do, what they **need** to do, what **barriers** they face in achieving these goals, and the **skills** that they need to be able to achieve these goals. – Phase 3
- To work together to provide opportunity for engagement in activities that build resilience and promote positive use of time. – Phase 1
- To work together to Promote positive daily structure and use of time to support recovery. – Phase 3

Inpatient

Inpatient care should be available for patients who cannot be safely cared for at home. Hospital admissions should be as brief as possible, with clear objectives set early on. The focus of admission typically includes problem-solving, safety planning, and enhancing self-management skills. Follow-up within seven days of hospital discharge is recommended, which can be conducted by a key worker or therapist, not necessarily a consultant psychiatrist.

For individuals with EUPD or complex trauma admitted to the hospital, prompt coordination with the community team is crucial. Any change in diagnosis by the inpatient team should not occur without consulting the outpatient team.

Hope House
Hope House is a six-bedded low secure mental health unit for women, located on the Bellsdyke site. The service provides care for women with severe and complex mental health needs, including some of the most significantly personality-disordered patients within NHS Forth Valley, as well as out-of-area referrals from other Health Boards.

The patient population presents with high levels of complexity and risk that cannot be managed safely in the community. Many patients have histories of complex trauma, often rooted in recurrent and prolonged interpersonal adversity, which significantly impacts emotional regulation, interpersonal functioning, and coping strategies. Patients frequently engage in severe and, at times, life-threatening self-harm and suicidal behaviour, alongside complex comorbidities such as autism spectrum disorder, disordered eating, and somatisation.

Hope House is the only NHS service in Scotland specifically designed to meet the needs of women with severe and complex emotionally unstable personality disorder. Care is delivered by a skilled multidisciplinary team comprising medical staff, nursing staff, and allied health professionals.

The unit offers a safe, secure, and trauma-informed environment, recognising the central role of complex trauma in shaping patients' presentations, behaviours, and relational needs. The service supports rehabilitation and recovery for patients with highly complex needs through consistent, compassionate, and psychologically informed care.

Care is collaborative and person-centred, with a strong emphasis on personal responsibility and empowerment. Patients are actively supported to understand and manage their symptoms, develop coping strategies, and engage in positive risk-taking. This approach supports increased emotional resilience and contributes to a reduction in self-harming behaviours over time.

A focus on structured, meaningful activity and early consideration of community reintegration is embedded within care planning from the outset of admission. This promotes skill development, supports recovery from complex trauma, and facilitates a smoother and more sustainable transition back to the community.

Mental Health Acute Assessment and Treatment Service (MHAATS)

Emergency same day assessments will be provided by MHATTS. IHTT caseload should be considered if there are an increasing level of risk and intensity of care needs which CMHT would be unable to provide or if alternative care to hospital is deemed appropriate in terms of engagement and informal supports available. IHTT caseload can be considered for those patients suitable for early discharge from the ward to continue recovery at home and allow the team to support patients, families and their carers at home. Whilst under the care of MHAATS the following may be provided:

- Relapse prevention, psychoeducation
- Medication monitoring
- Physical health examination- all patients (not inpatients) are offered physical health clinic appointment which includes full physical health examination, bloods, baseline ECG and BMI prior to commencing medications.
- MHAATS team can undertake a team-developed Formulation (5Ps) for complex presentations, if one has not been completed previously using the pro-forma on care partner (see appendix 5). This may involve members of the MDT, including nursing, psychology and psychiatry, and often involves a formulation session facilitated by psychology. (see appendix 5).
- Discharge planning meetings are held weekly with ICMHS.

Psychological intervention

Effectiveness of psychological intervention

Mentalization Based Therapy (MBT), Dialectical Based Therapy (DBT), Systems Training Emotional Predictability and Problem Solving (STEPPS) Schema Therapy and Transference Focused Therapy are the most common specialised interventions for EUPD. The available literature would support effectiveness in improved symptoms, and reductions in behaviours such as suicidal and non-suicidal self-injury. These interventions also tend to have lower levels of drop out than other therapies. Prolonged duration and combination of group/individual sessions have best outcomes.

Effectiveness of Psychological Therapies for complex trauma

- **Psychological interventions outperform pharmacological treatments** for PTSD, anxiety, depression, and sleep problems in individuals exposed to complex trauma
- **Trauma-focused approaches** (e.g. TF-CBT, EMDR, exposure therapies) show the strongest and most consistent benefits for PTSD symptoms
- **Phase-based or multicomponent interventions**, combining trauma-processing methods plus stabilisation or skills training, appear particularly effective for treating affect dysregulation and interpersonal difficulties, key CPTSD domains

The evidence based psychological interventions including low intensity interventions that are provided in NHS Forth Valley include:

- Decider skills
- Safety and Stabilisation
- Emotional resources group (ERG)
- Systems Training Emotional Predictability and Problem Solving (STEPPS)
- DBT
- Psychotherapy
- Cognitive Behavioural Therapy

Intervention Type	PTSD Symptoms	CPTSD Domain: Self-Concept / RTP	Affective Dysregulation / Interpersonal	Attrition / Feasibility
TF-CBT / PE	Moderate–Large reduction	Positive impact	Modest (less effective)	Lower dropout rates
EMDR	Large effect size; remission potential	Some positive effects (limited data)	Limited evidence for interpersonal/affect domains	Possibly higher dropout in some groups
Phase-based / Multicomponent	Moderate/Large PTSD reduction	Stronger outcomes on self-organisation symptoms	Improved regulation and relationships	Generally acceptable; lower dropout in childhood-abuse populations
DBT, IPT, mindfulness-based	Modest benefit for PTSD/depression	Less effective for cognitive/emotional schema targets	Some improvements if adjunctive	Variable acceptability depending on population

Healthcare professionals providing psychological interventions should have an appropriate level of competence in delivering the intervention and have regular supervision in place as specified by the therapy being provided.

Art Therapy

Alex to send paragraph for insertion here

LD

The Learning Disability Service provides care through integrated health and social care teams. There is also a specialist inpatient unit. Referrals are discussed at MDT referral meetings and allocated to the relevant professional based on current presentation. More intensive crisis support is provided by the LD additional support team (AST).

Forensic services

Within NHS Forth Valley forensic services, including FCMHS, inpatient and prisons, when individuals present with difficulties related to an EUPD type presentation, psychological interventions offered would be informed by individual assessment and formulation. All services follow the Matched Stepped Care Model accounting for trauma informed care, and interventions will be matched to level of need. This may include signposting to other services and disciplines, and/or interventions such as Safety and Stabilisation or Decider skills.

Individuals within FCMHS are allocated a key worker and Consultant Psychiatrist on acceptance into the service. Concerns related to EUPD type presentations will be discussed at the MDT to consider further assessment or ongoing intervention. Psychological therapy related to difficulties arising from complex trauma or EUPD type presentations will follow a matched care model and be based on individual formulation, risk assessment and collaboratively agreed goals with the individual. This may include safety and stabilisation delivered by their key worker, or referral to the DBT group supported by an FCMHS FCPN.

Staff Training and Development

Interventions are planned around the individual's presentation and within a stepped care/matched care arrangement. The main interventions that are provided throughout this pathway are detailed below:

- Decider skills – for training contact - fv.decidertraining@nhs.scot
- Safety and Stabilisation- for training contact - susan.ramsay@nhs.scot
- Emotional resources group (ERG)
- Systems Training Emotional Predictability and Problem Solving (STEPPS) via NES - Core psychological interventions for personality disorders and traits | Turas | Learn
- DBT - Dialectical Behaviour Therapy | British Isles DBT Training
- Psychotherapy
- Schema therapy- Schema Therapy Training Scotland | Schematherapy Workshops in Lothians & Stirling

- Compassion Focused Therapy- Compassion Focused Therapy Training | Compassionate Mind
- Cognitive Behavioural Therapy - for training contact - susan.ramsay@nhs.scot or see below:
    - PgDip Cognitive Behavioural Therapy | UWS | University of the West of Scotland
    - Train to be a Cognitive Behavioural Therapist | Courses in Glasgow (glasgowcognitivetherapycentre.com)
    - South of Scotland Cognitive Behavioural Therapy Course – NHS Lothian | Our Services
    - CBT Courses in Glasgow | Act Counselling and CBT Services
    - SCOTACS Diploma in Counselling and Groupwork – a Cognitive Behavioural Approach | Centre of Therapy

    On TURAS Low intensity CBT training:

    - Core psychological interventions for depression | Turas | Learn (nhs.scot)
    - Introduction to CBT for anxiety | Turas | Learn (nhs.scot)
    - Talking therapies for depression : beat it | Turas | Learn (nhs.scot)
    - Part 1 : theory underlying CBT | Turas | Learn (nhs.scot)

Please refer to this section of the pathway for staff training and resources:

Medication/Medical Treatments / Effectiveness of medication

Main prescribing principles – awaiting feedback from Dan Martin

This guidance has been compiled with reference to POMH-UK 2012, relevant NICE guidance on Borderline Personality Disorder, Maudsley Guideline and updated research evidence.

1. Psychotropic drugs have been shown to have only modest and inconsistent positive effects and there is no evidence that they change the course of EUPD. Overall the evidence base for prescribing in EUPD is limited due to small samples with a wide range of drugs, short treatment duration, diverse outcome measures and infrequent replication of findings.

2. In the UK there are no psychotropic drugs licensed for the treatment of EUPD. Psychotropic drugs are most appropriately prescribed for the treatment of co-morbid psychiatric disorders in accordance with specific relevant guidance and should not be used routinely to treat symptoms intrinsic to EUPD. Note however that a diagnosis of BPD predicts a poorer outcome from treatment of depression with antidepressants and ECT. Symptoms of OCD in BPD may be less responsive to clomipramine (Maudsley Guidelines)

3. If psychotropic drugs are prescribed in the absence of a clear co-morbid psychiatric disorder, it should be considered an adjunct to appropriate evidence-based psychological interventions to manage specific symptoms and not instead of. The prescription should be time-limited with a clear plan to review its efficacy and discontinue if there is no response.

4. In prescribing in EUPD Polypharmacy should be avoided.

5. Due consideration should be given to the medication's potential lethality in overdose, risk of dependency and any interactions with alcohol and other psychoactive substances before a decision to prescribe is made.

6. In making decisions about commencing a psychotropic medication where possible collaboration with other professionals involved in the ongoing or longer -term care of the patient should be undertaken and consensus reached about the prescription with the main prescriber identified before prescription commences.

7. Prescribing decisions and plans should be clearly documented in a readily accessible area of the patient's health record and should be consistent with the patient's agreed care plan. Required physical health monitoring should be considered and included in this documentation.

8. Psychotropic drugs may be considered in acute crises situations where psychological interventions are not deemed sufficient. However, these should be withdrawn as soon as the crisis has resolved.

9. A collaborative crisis plan should be agreed with the patient and carer (if appropriate) which indicates clearly if and which medication prescription should be considered during a crisis.

10. If prescribing is considered appropriate in the longer-term for a co-morbid condition, then it is reasonable to ask the GP to continue this, (unless a secondary care only drug is being used).

Complex trauma and medication- awaiting feedback from Dan Martin

The management of crises

Short-term use of drug treatments may be helpful for people with EUPD during a crisis. Use a single drug and avoid polypharmacy whenever possible. Choose a drug (such as a sedative antihistamine, promethazine) that has a low side-effect profile, low addictive properties, minimum potential for misuse and relative safety in overdose. Anticipated side-effect profile and potential toxicity in overdose should guide choice. For example, benzodiazepines (particularly short-acting drugs) can cause disinhibition in this group of patients, potentially compounding problems; sedative antipsychotics can cause EPS and/or considerable weight gain, and tricyclic antidepressants are particularly toxic in overdose.

A thoughtful, joint crisis plan should help people with EUPD, as well as carers and the clinical team, manage during difficult times. This crisis plan should be easily accessible and make specific mention of whether medication is indicated at such times, and if so, what medication should be considered.

Discontinue a drug after a trial period if the target symptoms do not improve. Consider alternative treatments, such as psychological treatments, if target symptoms do not improve or the level of risk does not diminish.

Review after the crisis has subsided. Plan to stop drug treatment begun during a crisis, usually within 1 week. If drug treatment started during a crisis cannot be stopped within 1 week, there should be a regular review of the drug to monitor effectiveness, side effects, misuse and dependency.

When patients with EUPD present in crisis it is not an advisable time to review response to and make changes to regular prescribed medication such as anti-depressants or mood stabilisers. This should be reviewed after the period of crisis has subsided with a view to exploring the efficacy of the treatment over the longer term including periods of greater stability and crisis and then considering making changes or discontinuing medications that aren't effective.

Other medical treatments

If an individual is sexually active they should be counselled regarding the safe use of contraception, to protect again pregnancy and sexually transmitted diseases. They should be encouraged to use appropriate contraception; this discussion can happen with a primary practitioner, pharmacy or central sexual health.

If an individual is self harming through cutting professionals should encourage the individual to ensure that their tetanus immunisation is up to date. Harm reduction should also be encouraged e.g. the use of a sharps bin/dressing wounds appropriately, seeking medical help if necessary.

Support for family and carers

Support for families and carers primarily comes from directing and referring them to third-sector services and carers' groups. If patients are part of STEPPS, this group offers sessions that enable families and carers to enhance their knowledge, confidence, and coping abilities when assisting someone with a personality disorder diagnosis. DBT also provides resources that assist families in managing the challenges of supporting an individual diagnosed with EUPD. Please note not all services have access to these groups.

Falkirk & Clackmannanshire Carers Centre – Inform | Support | Involve (centralcarers.org)

Useful self-help resources

Please refer to this part of the pathway:

Definitions

- DBT- Dialectical behaviour therapy
- EQIA- Equality Impact Assessment
- HSCP- Health and social care partnership
- ICP- Integrated Care Pathway
- ICD-11 International Classification of Diseases 11th revision
- MBT- Mentalization based therapy
- NICE- National Institute of Clinical Excellence
- PDIP -Personality Disorder Improvement Programme
- SIGN- Scottish Intercollegiate Guideline Network
- ST- Schema therapy
- STEPPS- Systems Training Emotional Predictability and Problem Solving
- TFT- Transference focused therapy

Appendices:

- Appendix 1 – Emotional regulation /EUPD/ Complex Trauma pathway with links.

EUPD Pathway watermark.docx

- Appendix 2 – Safety plan with translations.

Safety Planning.pdf

- Appendix 3 - NHS Forth Valley Guidelines for EUPD / Traits (December 2018)

NHS Forth Valley Guidelines for Emotio

- Appendix 4 – HIS Personality Disorder Improvement programme findings - ihub case study template
- Appendix 5 – 5p Formulation

5-Ps-and-formulation-final.pdf

- Appendix 6 –

Complex Trauma V3.0 Final[1].pdf

- Appendix 7 - Complex trauma - UK Trauma Council
- Appendix 8 – Further reading

Further reading

Borderline personality disorder: recognition and management .Clinical guideline [CG78] National Institute for Clinical Excellence (NICE). Published: January 2009
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NHS Highland. Personality Disorder. Integrated Care Pathway
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Personality Disorder in Scotland, raising awareness, raising expectations, raising hope [CR214] The Royal College of Psychiatrists. Published: August 2018
https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr214.aspx

Scottish Government. A stronger and more resilient Scotland: the programme for government 2022 to 2023. The Programme for Government 2022-23 - Programme for Government 2022 to 2023 - gov.scot (www.gov.scot)

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Mental Welfare Commission for Scotland. Capacity, consent and compulsion for young people with borderline personality disorder. YoungPeopleWithBPD_GoodPracticeGuide_20191003_secured.pdf (mwcscot.org.uk)

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Brickman LJ, Ammerman BA, Look AE, Berman ME, McCloskey MS. The relationship between non-suicidal selfinjury and borderline personality disorder symptoms in a college sample. Borderline personality disorder and emotion dysregulation. 2014 Dec;1(1):1-8.

Rethinking personality disorder. Lancet. 2015 Feb 21;385(9969):664. doi: 10.1016/S0140-6736(15)60272-0. Epub2015 Feb 20. PMID: 25706202.

Castle DJ. The complexities of the borderline patient: how much more complex when considering physical health?. Australasian Psychiatry. 2019 Dec;27(6):552-5.

ICD-11 for Mortality and Morbidity Statistics (who.int)

Document Development and Approval Checklist

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Specify the rationale for the development of this policy, procedure, or guideline.

To outline to referrers and staff what the pathway of care is for this population. To help patients understand what care and treatment is available.

Document developed in the NHS Forth Valley document template (Appendix 2) and developed in accordance with the Document Development and Approval Process (Appendix 3). The cover includes the following:

Document title ✓

Lead author ✓

Issue and review date ✓

Version number ✓

EQIA assessment date ✓

Authorising group/committee and approval date ✓

Consultation and change record, including contributing authors ✓

Approval

Specify areas of document applicability.

NHS Board Wide ☐

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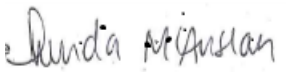
Other, please specify:

Name of Approval Group:

Date: MH and LD clinical governance

Lead Author Signature: 

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