Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg Shared health / Soins communs Manitoba **Clinical Practice Guideline**	**Practice Guideline:** Clinical Guideline for Evidence-Based Treatment Approaches for Individuals with Borderline Personality Disorder (BPD)	
	Approval Date: January 2025	**Page:** 1 of 11 **Supersedes:** N/A

1. **Purpose**

   1.1. To provide Individuals living with Borderline Personality Disorder (BPD) consistent and evidence-based treatment within mental health services.

   1.2. To provide clinical guidance to Mental Health Professionals who are providing care to Individuals living with BPD.

2. **Definitions**

   2.1 Behavioral Activation: is a therapeutic approach that focuses on modifying behaviors to alleviate mental health conditions, particularly depression, by encouraging engagement in positive and rewarding activities.

   2.2 Behavioral Chain Analysis: is a therapeutic approach used to break down a problematic behavior into its triggering events, thoughts, emotions, and actions to identify patterns and opportunities for healthier coping strategies.

   2.3 Borderline Personality Disorder (BPD): DSM-5 classifies as a personality disorder; BPD is a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

   2.4 Brief Treatment: a therapeutic approach characterized by a limited number of sessions, typically focused on specific issues or goals, designed to provide quick resolution or management of a particular problem or symptom.

   2.5 Case Management: an effective intervention for Individuals with complex care needs that is centered around a strong therapeutic relationship, continuity of care, and an understanding of the complexities of the disorder; a crucial component in providing care to an individual living with BPD, helping to reduce hospitalizations, improve treatment adherence, and enhance overall well-being.

   2.6 Clinical Psychologist: a health care professional that applies principles of human behavior and mental processes to understand, assess, and treat a variety of psychological issues; psychologists typically do not prescribe medication but instead use various therapeutic approaches, including counseling and psychotherapy, to help Individuals manage and overcome psychological challenges.

   2.7 Collateral Information: refers to supplementary details and insights gathered from sources other than the Individual receiving care. This information may come from Natural Supports or other relevant sources and is valuable for a more comprehensive understanding of the Individual's mental health.

   2.8 Comprehensive Dialectical Behavioral Therapy (DBT): a psychotherapy developed by Marsha Linehan, DBT combines cognitive-behavioral techniques with mindfulness

concepts delivered both individually and in group settings for ~ 12 month period. It focuses on teaching skills in: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. DBT is particularly effective in reducing Self-Harm behaviors and Suicidal Ideation.

2.9 Crisis Response Center (CRC) Collaborative Health Record (CHR): is a separate and distinct electronic medical record used at CRC (previous known as Momentum).

2.10 DBT Informed Skills Training: a component of Standardized DBT, commonly delivered in a group format, DBT skills training aims to teach skills to reduce dysfunctional behavior and facilitate the adoption of new behavioral, emotional, and thinking patterns.

2.11 Emergency Coordinated Care Plan (ECCP): an individualized care plan identifying relevant medical, psychosocial, behavioral, cognitive, functional, and psychiatric issues or interventions to assist the inter-professional team in an ED in providing a consistent approach to the management of an Individual's needs.

2.12 Emergency Department (ED): Emergency Departments and Urgent Care Centers.

2.13 Individual: A patient, client, participant or resident receiving services from the Mental Health and Addictions Program.

2.14 Inpatient Admission: Individual is admitted to a Mental Health Unit within a hospital or acute care setting.

2.15 Mental Health Professionals: staff and physicians of the Mental Health and Addictions Program who are directly involved in an Individual's care.

2.15.1 Staff include but are not limited to: Psychiatrists, Psychologists, Clinical Assistants, Physician Assistants, Registered Psychiatric Nurses, Registered Nurses, Social Workers, Occupational/Nurse Therapists, Recreational Therapists, Pharmacists, Community Mental Health Workers, Service Coordinators, Transition Workers, Shared Care or Brief Treatment Counsellors, Case Managers, Clinical Specialists, or any other health care professional or paraprofessional working in the mental health program.

2.16 Mentalization-Based Treatment (MBT): A psychotherapy developed by Peter Fonagy and Anthony Bateman, MBT focuses on improving an Individual's ability to recognize and understand their own and others' mental states, with an emphasis on emotions and how emotions drive behavior.

2.17 Natural Support(s): refers to a person who plays a significant role in offering support to an Individual. A natural support is not necessarily a part of the formal support system and is not remunerated for offering support. This may include persons from a broad network of social support, (e.g. family member, friend, significant other, clergy etc.) and is defined by the individual. Natural supports may or may not be the same as the individual's identified next of kin.

2.18 Non-Suicidal Self-Injurious Behaviors (NSSB): acute behaviors that are not suicidal in intent; frequently present as superficial cutting to arms and wrists.

2.19 Primary Care Provider (PCP): is a healthcare professional (i.e., general practitioner, family physician, nurse practitioner) who serves as the first point of contact for Individuals seeking medical care. PCPs manage and coordinate an Individual's overall health and well-being.

2.20 Psychiatric Liaison Nurse (PLN): a mental health professional who provides mental health assessment and care to Individuals presenting to an ED or UC.

2.21 Psychiatrist: a medical doctor specializing in the diagnosis, treatment, and prevention of mental illnesses and emotional disorders. They employ a combination of medication, psychotherapy, and other therapeutic interventions to address various mental health conditions.

2.22 Psychoeducation: is a simple, cost-effective therapeutic intervention delivered by Mental Health Professionals that combines education and psychological support.

2.23 Psychotherapy: There are various psychotherapies, each a distinct therapeutic interaction or treatment between a trained mental health professional and an Individual, aimed at addressing mental health issues and improving emotional well-being.

2.24 Safety Plan: a plan developed collaboratively between the Individual and the Mental Health Professional, when reviewing risk for suicide and/or Non-Suicidal Self-Injurious Behaviors, to address the immediate suicide risks.

2.25 Schema Therapy: a psychotherapy developed by Jeffrey Young, this therapy integrates elements of CBT with concepts from other psychotherapies. It focuses on identifying and changing deeply rooted patterns or schemas, which are often established in childhood and can be maladaptive in adulthood. Schema therapy is particularly useful for patients with chronic BPD symptoms.

2.26 Suicidal Ideation: having thoughts of wanting to end one’s own life.

2.27 Suicidality: refers to the presence of suicidal thoughts, behaviors, or tendencies and encompasses a range of thoughts and actions related to self-harm, suicide ideation, suicide attempts, and completed suicides.

3. Background

BPD is a complex and serious mental disorder characterized by instability in relationships and self-image, impulsive actions, self-harm, persistent thoughts of suicide, and difficulty functioning effectively (Bohus et al., 2021). Individuals living with BPD commonly have comorbid and co-occurring mental health disorders which can complicate diagnosis, prognosis and treatment (Bohus et al., 2021). While the manifestation of BPD can differ widely among individuals, those living with BPD commonly undergo substantial psychological distress impacting different areas of their lives. Natural Supports attempting to support Individuals with BPD may undergo significant distress and exhaustion due to the intense and unpredictable moods of the Individual, while impulsive behaviors contribute to substantial conflicts (Bateman 2019). Evidence suggests psychotherapies are effective first-line treatments for BPD (Choi-Kain et al., 2016).

Psychotherapies are considered specialized and resource intensive treatments. The most researched psychotherapy for BPD treatment is Comprehensive Dialectical Behavioral Therapy (DBT). Comprehensive DBT has demonstrated effectiveness in reducing hospital admissions, frequency of self-harm and reducing emergency room visits for suicidality (Crisanti et al., 2017; Paris, 2019). Recent research utilizing DBT Skills Training, a component of Comprehensive DBT, has shown effectiveness as a stand-alone treatment. However, additional research is needed to establish its effectiveness conclusively. Nevertheless, the potential of DBT Skills Training as a treatment will facilitate greater accessibility, requiring fewer specialized resources. There is no pharmacologic treatment standard for BPD. However, treatment plans often include medications that address comorbid and co-occurring conditions (Choi-Kain et al., 2016). Inpatient hospital admissions for treatment are not advised due to the absence of established inpatient protocols, and psychotherapy is typically not available in inpatient settings (Webb et al., 2023). With that said, short-stay inpatient admissions may be necessary if suicide risk is high. Psychotherapy for BPD is facilitated through outpatient services, enabling Individuals to engage in therapeutic interventions while actively participating in their daily lives. Therefore, ensuring Individuals are connected to outpatient services is essential.

4. **Practice Outcome**

   4.1. Provide clinical guidance for ED crisis presentations.

   4.2. Provide clinical guidance for Inpatient Admission.

   4.3. Provide guidance for Community /Outpatient services.

   4.4. Provide clinical guidance for pharmacological treatment.

5. **Guiding Principles**

   5.1. Health care professionals such as Psychiatrists, Clinical Psychologists and Primary Care Providers who have experience with BPD can provide a BPD diagnosis after conducting a thorough evaluation.

   5.2. Many BPD symptoms overlap with other mental health diagnoses; therefore, a BPD diagnosis often requires ongoing interactions and assessments over time.

   5.3. Early diagnosis and intervention for BPD have higher rates of remission. Alternatively, in the absence of treatment and intervention, symptoms like NSSB and suicidality often move into remission after many years of living with BPD.

   5.4. Individuals with BPD often have comorbid mental health disorders; the non-BPD disorder should be managed concurrently with BPD-specific treatment.

   5.5. The hallmark characteristics of BPD include intense and rapidly changing emotions, including impulsivity; unstable and inconsistent identity; and problems in interpersonal relations.

   5.6. BPD is often characterized by aggressive outbursts, sensitivity to rejection, self-harm behaviors, persistent suicidal thoughts, which can last for months or years and often fluctuate with stress.

5.7. Suicidal thoughts are common, however not always indicative of imminent suicide risk. Nevertheless, individuals with BPD who exhibit suicidal behaviors have a higher risk of suicide.

5.8. Clinical trials have not shown that pharmacologic treatments can lead to remission in BPD or prevent suicide.

5.9. Hospitalization offers only short-term relief for chronic suicidality; suicidal thoughts often persist after discharge.

5.10. Various psychotherapies are effective in treating Individuals with BPD.

5.11. A definitive road map that matches evidence-based treatments, therapist traits, patient characteristics, and the clinical environment does not exist therefore establishing an effective treatment plan can take time.

6.0 Guidance for ED Crisis Presentations (for Psychiatric Liaison Nurse [PLN]):

6.1 Assess Individuals who present to ED with a mental health crisis.

6.2 Crisis behaviors include:

- Non-Suicidal Self-Injurious Behaviors;
- Suicidal Ideations;
- Violence towards other people, and/ or
- other high-risk behaviors.

6.3 Assess with seriousness despite crisis behaviors being common with BPD.

6.4 Follow Regional Mental Health Program Suicide Assessment, Intervention & Monitoring Practice Guidelines to complete a Suicide Risk Assessment (SRA).

6.5 Collect Collateral Information from Natural Supports by utilizing:

6.5.1 Adult Mental Health Family Perspective on Current Situation Form

6.5.2 Adult Mental Health Family Perspective on Current Situation Completion Guide

6.6 Adhere to Regional Mental Health Involving Families Practice Guideline

6.6.1 Ensure clinical practice adheres to The Mental Health Act, Bill 5 amendment "Under the Personal Health Information Act, a trustee may disclose personal health information to any person to prevent or lessen a risk of serious harm to a person or the public when the sharing of an Individuals personal health information without consent is warranted".

6.7 Verify if Individual has a Winnipeg Emergency Medicine Guideline: Emergency Coordinated Care Plan (ECCP)

6.7.1 If ECCP is available, adhere to the ECCP while exercising clinical judgment and practice.

6.7.2 If no ECCP, access CRC CHR for Collateral Information on the individual.

6.7.3 Refer to SOP CRC CHR Access Standard Work Flow, note:

- if any ALERTS exist

- if there is a CRC Service Plan (to guide ED/UC treatment)
- most recent mental health assessment and psychiatric assessment
- frequency of presentation (note if the mental health assessment comments on frequency of presentations at other sites in the last 6 months)
- if CRC is accessed for walk-in service or mobile crisis line support
- if CRC referrals sent to Psychiatric Urgent Referral Clinic, Post Crisis Services

6.8 Complete a mental health assessment.

6.9 Consult with Psychiatry if indicated, related to immediate care and treatment plan.

6.10 Determine if an ECCP is needed to ensure a consistent treatment approach. For ECCP template and guidelines: WRHA Insite Emergency Medicine Order Sets / Protocols/ Practice Guidelines

6.10.1 When determining an ECCP assess the following:

- degree of the Individual's distress related to BPD and the co-occurring conditions,
- the risk of suicidality, and
- the frequency of ED presentations (including CRC presentations) in the last 6 months

6.11 The development of an ECCP must start in the ED if there is no Inpatient Admission.

6.12 If Inpatient Admission planned, the development of an ECCP can occur on the mental health unit.

6.13 In preparation for discharge, review the Regional Mental Health Program Practice Guideline, Ensuring Informational Continuity

6.14 For discharge planning refer to Appendix A: Clinical Staging, System Navigation and Services for BPD

6.15 Although Inpatient Admission is generally not advised, it may be required if suicide risk is high.

7.0 Guidance for Inpatient Admissions:

7.1 The purpose of an Inpatient Admission should center on a specific goal, such as symptom stabilization, connecting to outpatient resources, or engaging in behavioral activation, in preparation for discharge.

7.2 Goal length of stay for Inpatient admissions is 48 - 72hr; mental health unit staff must be mindful of not fostering feelings of rejection and abandonment.

7.3 Utilize the Regional Mental Health Program Suicide Assessment, Intervention & Monitoring Practice Guidelines to complete SRA.

7.4 Collect Collateral Information utilizing:

- Adult Mental Health Family Perspective on Current Situation Form
- Adult Mental Health Family Perspective on Current Situation Completion Guide

7.5 Adhere to Regional Mental Health Program Involving Families Practice Guideline

7.5.1 Consider the Mental Health Act, Bill 5 amendment, "*Under the Personal Health Information Act, a trustee may disclose personal health information to any person to prevent or lessen a risk of serious harm to a person or the public when the sharing of an Individuals personal health information without consent is warranted.*"

7.6 Provide psychoeducation and education about evidence-based treatment options offered as community or outpatient services as soon as possible with Individual and Natural Supports.

7.7 Provide direction and support related to appropriate interpersonal behavior to Natural Supports.

7.8 Monitor and document well-being with appropriate level of observation (based on assessment of safety risk); pay attention to affect.

7.9 Reassess suicide risk as per the Regional Mental Health Program Suicide Assessment, Intervention & Monitoring Practice Guideline and at intervals appropriate to the current level of risk and circumstances.

7.10 Work with the Individual to develop a personal My Safety Plan.

7.11 Document Inpatient interventions based on a behavioral chain analysis that provides an understanding of the problem behavior by:

- detailing its nature,
- identifying triggering parameters (factors that lead to the behavior),
- specifying maintenance parameters (factors that sustain the behavior), and
- noting vulnerability factors such as sleep problems, alcohol or drug misuse, or serious social problems that can contribute to or exacerbate the Individual's mental health challenges.

7.12 Engage to develop skills to reduce high levels of distress and cultivate self-efficacy.

7.13 Establish a validating atmosphere that balances acceptance of the Individual's perceived experience and opportunities to change dysfunctional behavior with a clear orientation towards problem solving.

7.14 Focus on maximizing the Individual's motivation and engagement for treatment; this includes reviewing previous admission care plans and engage in discussion with the individual.

7.15 Prior to discharge, Mental Health Professionals in consultation with the Individual/Natural Supports will establish a treatment plan utilizing services; refer to Appendix A: Clinical Staging, System Navigation and Services for BPD.

7.16 Prior to discharge, Mental Health Professionals will consider and establish an ECCP if clinically appropriate; consider the following:

- degree of the Individual's distress related to BPD and the co-occurring conditions,
- the risk of suicidality and

- the frequency of ED presentations (including CRC presentations) in the last 6 months

7.17 In preparation for discharge, review the Regional Mental Health Program Practice Guideline, Ensuring Informational Continuity ; note the guideline highlights discharge from hospital is a time of increased risk, therefore ensure:

7.17.1 A reassessment of suicide risk is completed.
7.17.2 Individual has a My Safe Plan.
7.17.3 Natural Supports are included in discharge planning (where possible).
7.17.4 Medication Reconciliation is completed.
7.17.5 Dissemination of ECCP (if deemed appropriate, Appendix B within the Emergency Medicine Coordinated Care Plan)
7.17.6 Participation in services and treatment programs is encouraged
7.17.7 Regular medical check-ups with PCP are encouraged
7.17.8 Individual has been referred to Family Doctor Finder (204-786-7111) if a PCP is required

8 Guidance for Community/Outpatient Services:

8.1 Evidence-based psychotherapies are recommended first-line treatments; psychotherapy is shown to be effective in targeting the Individual's emotion regulation.

8.1.1 Evidence-based psychotherapies such as Dialectical Behavior Therapy (DBT), Mentalization-Based Treatment (MBT), Schema Therapy are available via Private Therapists.

8.2 Encourage Individual to start treatment as early as possible to mitigate chronic progression of the disorder.

8.3 Inform Individuals /Natural Supports about different evidence-based psychotherapies.

8.4 Advise that psychotherapies such as DBT-Informed Skills Training are offered within public health care services.

8.5 Recommend to Individuals who are waitlisted for services to participate in less intensive service options while waiting (See Appendix A).

8.6 Assess progress regularly to ensure that each session aligns with the overall treatment goal. If there's no observable progress within a span of 6 months, consider changing the treatment approach or seeking a different therapist.

8.7 Refer to **Appendix A: Clinical Staging, System Navigation and Services for BPD**

9 Clinical Guidance for Pharmacological Treatment:

9.1 There is no pharmacological treatment standard for BPD.

9.2 Medication is only indicated if a comorbid condition that requires medication is present (e.g., severe depression, or severe sleep disturbances), or if crisis psychosocial interventions are not available or sufficiently effective.

9.3 The prescription of medications for specific prevalent symptom domains in individual cases such as impulsivity, emotional instability, or cognitive-perceptual symptoms,

should be approached with caution, i.e., antidepressants or antipsychotics (quetiapine)

9.4 A medication review including prescription and non-prescription medications is indicated when the Individual has comorbid conditions or during a crisis if psychosocial interventions are insufficient.
- Include Individual in discussion about medication use.
- Use of medication must be in conjunction with psychosocial interventions and not as the sole therapy.
- If comorbid conditions require medication management, define target symptoms and a time period for reassessment of treatment effects and for monitoring side-effects.

9.5 Review prescription and over-the-counter medications on a regular basis.

9.6 Reduce polypharmacy and higher risk medications, as appropriate.
- Discontinue medications that are not effective or indicated.
- Use extreme caution with prescribed medications with risk of harm from overdose (e.g., tricyclic antidepressants, benzodiazepines, and lithium) and prescribe only if clinically indicated. Medications may be dispensed daily with observation to ensure risk of overdose is mitigated.
- Avoid prescribed medication with high potential for addiction or misuse (e.g., benzodiazepines). If deemed necessary use extreme caution.

10 References:

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Appendix A: Clinical Staging, System Navigation and Services for individuals with BPD

Severity	Indicator/Risk	Interventions	Provider	Crisis Presentation	Self-Referral Pathways
Mild Severity: Subthreshold	**Indicator/Risk:** • Family history • Mild self-regulation problems • BPD: 3-4 criteria out of 10 • BPD traits vs diagnosis • Presenting with NSSB and no suicidality	**Interventions**: • Psychoeducation • Counselling • DBT Skill Training • Brief treatment	**Provider:** • Primary Care Provider (PCP)	**Crisis Presentation (CRC, Urgent Care, ED) Referral Pathway:** • UFITT • Crisis Stabilization Unit (CSU) • Provincial Virtual Crisis Service (PVCS)	**Self-Referral Pathways:** • Fee for Service Therapist • DBT Winnipeg • www.mps.ca • CMHA • Sara Riel • Mood Disorders (MDAM) • Family Peer Support
Moderate Severity: 1st episode of threshold BPD	**Indicator/Risk**: • Exhibits minimum number of criteria 5 out of 10 needed for the diagnosis of BPD • Presenting with NSSB and no suicidality	**Interventions**: • Psychoeducation • Counselling • DBT Skill Training • Brief treatment	**Provider Referral Pathway:** • PCP w/ consult to R.A.C.E • Psychiatry Central Intake	**Crisis Presentation (CRC, Urgent Care, ED) Referral Pathway:** • UFITT • CSU • PVCS	**Self-Referral Pathways:** • Fee for Service Therapist • DBT Winnipeg • www.mps.ca • CMHA • Sara Riel • Mood Disorders • Family Peer Support
Moderate/ Severe Severity: Sustained threshold-level symptoms	**Indicator/Risk:** • Unresponsive to basic treatment • Presenting with severe self-harm • Presenting with suicidality	**Interventions**: • Psychoeducation • DBT Skill Training • Case management • Other psychotherapies	**Provider Referral Pathway:** • STAT Program • CODI	**Crisis Presentation (CRC, Urgent Care, ED) Referral Pathway:** • UFITT / CSU / PVCS • Inpatient Admission • Outpatient Services	**Self-Referral Pathways:** • Fee for Service Therapist • DBT Winnipeg • www.mps.ca • CMHA • Sara Riel • Mood Disorders • Family Peer Support
Severe Severity: Remitting and relapsing	**Indicator/Risk**: • Multiple ED presentations or hospital admissions • Presenting with severe self-harm • Presenting with potentially fatal suicide attempt(s)	**Interventions**: • Psychoeducation • DBT Skill Training • Case management • Other psychotherapies	**Provider Referral Pathway:** • STAT (Repeat) • CODI	**Crisis Presentation (CRC, Urgent Care, ED) Referral Pathway:** • UFITT / CSU • Inpatient Admission • Outpatient Services	**Self-Referral Pathways:** • Fee for Service Therapist • DBT Winnipeg • www.mps.ca • CMHA • Sara Riel • Mood Disorder • Family Peer Support

Service Descriptions: UFITT, STAT, CODI

UFITT (Urgent Follow-Up InTervention Team) is a specialized mental health service comprising clinicians, psychologists, and psychiatrists. It provides care to individuals who have accessed crisis services. Referrals to UFITT come from CRC or UC/ED clinicians following a mental health assessment. The service offers prompt entry and a range of interventions such as DBT Skill Training, Managing Difficult Emotions classes, case management, brief treatment, individual psychotherapy, and psychiatric assessments. UFITT can refer to the STAT program for more intense treatment if required with the prerequisite psychiatric consult.

The STAT Program, **or Short Term Assessment & Treatment Program**, focuses on offering thorough assessment and intensive psychoeducation and psychotherapy in a Day Hospital setting. Services include: (1) Psychiatric Intake Assessment to evaluate program suitability (2) Daily psychoeducation groups (Mon -Fri) over a five week period, (3) Continuous individual therapy and psychiatric assessments, including medication therapies (4) Possible short-term follow-up for 2 to 3 months post-program, and (5) Potential assessment for DBT skills training group after completing the STAT Day Hospital, with no direct referrals to DBT accepted. Referral Criteria: Acceptance of referrals from psychiatrists with a recent (within one year) psychiatric assessment, or from family physicians as advised in a current psychiatric assessment. All patients must have a family physician ready to offer general medical care during and after the STAT Program.

The **CODI program** offers comprehensive support to adults facing co-occurring mental health and substance use disorders. The CODI team works intensively with participants, focusing on skill-building and resource development to reduce the negative impacts of substance use and enhance success in crucial life areas, including living, learning, working, and social engagement. Services provided by CODI encompass consultation and assessment, DBT skills training in both group and individual formats, case management, individualized service planning, linking to services/resources, and assertive outreach. To be eligible for CODI Outreach, individuals must be diagnosed with both a mental health disorder and a co-occurring substance use disorder, demonstrating a willingness to engage in intensive, integrated rehabilitation services. The referral process involves submission of the referral form through Psychiatrists, Physicians, or Nurse Practitioners, with the active involvement of psychiatrists in the referral process when applicable.