NHS

National Institute for Mental Health in England

Personality disorder: No longer a diagnosis of exclusion

Policy implementation guidance for the development of services for people with personality disorder

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READER INFORMATION

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Foreword

The National Service Framework for adult mental health sets out our responsibilities to provide evidence based, effective services for all those with severe mental illness, including people with personality disorder who experience significant distress or difficulty.

The guidance aims to builds on standards four and five in the national service framework and sets out specific guidance on development of services for people with personality disorder. It brings this often neglected and isolated area of mental health into focus for the first time.

There is some excellent work happening now in general and forensic mental health to provide services and support in this important area of work, examples of which are included in the guidance. I hope that these guidelines will build on the improvements that have already been achieved and set a clear direction for all services for the future.

But writing policy alone isn't enough. We must value time for development at all levels in order to implement lasting, manageable change. With this goal in mind, The Department of Health is working closely with the National Institute for Mental Health in England (NIMHE). NIMHE's role will include working with local teams to help people put this guidance into practice.

Through eight development centres, which are in the process of being established now, and our web site www.nimhe.org.uk, NIMHE will provide a gateway to learning and development, with real opportunities to share experiences, challenges and what works on the ground. Do get in touch if you want to get involved or share your work with others. You can email ask@nimhe.org.uk or write to us at NIMHE, Blenheim House, Duncombe Street, Leeds LS1 4PL.

We look forward to hearing from you.

Antony Sheehan

Chief Executive NIMHE

Introduction

Personality disorders are common and often disabling conditions. Many people with personality disorder are able to negotiate the tasks of daily living without too much distress or difficulty, but there are others who, because of the severity of their condition, suffer a great deal of distress, and can place a heavy burden on family, friends and those who provide care for them.

As with all forms of mental disorder, the majority of people with a personality disorder who require treatment will be cared for within primary care. Only those who suffer the most significant distress or difficulty will be referred to secondary services. This guidance is designed to ensure that once referred, they receive access to appropriate care.

As things stand today, people with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services. A few Trusts have dedicated personality disorder services but these are the exception rather than the rule. In many services people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to inpatient psychiatric wards, on the caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them. Within forensic services a number of regional secure units actively exclude patients with a primary diagnosis of personality disorder, because they do not consider this to be their core business. Many clinicians and mental health practitioners are reluctant to work with people with personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service, and because many believe there is nothing that mental health services can offer.

In addition the changes proposed in the draft Mental Health Bill – the broad definition of mental disorder, the abolition of the so-called "treatability test" in relation to psychopathic disorder and the provisions enabling compulsory treatment in the community – will highlight the need for new community and in-patient services. This also places an emphasis on the need to provide new training in the assessment and diagnosis of personality disorder, in order to ensure clinicians and practitioners are equipped with adequate information about treatment options and service models.

This Guidance has been produced to facilitate the implementation of the National Service Framework for Mental Health as it applies to people with a personality disorder.

The Purpose of the Guidance is:

- *To assist people with personality disorder who experience significant distress or difficulty to access appropriate clinical care and management from specialist mental health services.*

- *To ensure that offenders with a personality disorder receive appropriate care from forensic services and interventions designed both to provide treatment and to address their offending behaviour*

- *To establish the necessary education and training to equip mental health practitioners to provide effective assessment and management.*

Executive Summary

This document provides information for Trusts about the Government's intentions for the delivery of personality disorder services within general mental health and forensic settings. All Trusts delivering mental health services need to consider how to meet the needs of patients with a personality disorder who experience significant distress or difficulty as a result of their disorder. Funding will be available to enable Trusts to develop personality disorder services over the next three-year period from 2003-2006.

Key Points to note are as follows:

General Adult Mental Health Services

1. Good practice indicates that service provision for personality disorder can most appropriately be provided by means of:

   - the development of a specialist multi-disciplinary personality disorder team to target those with significant distress or difficulty who present with complex problems.

   - the development of specialist day patient services in areas with high concentrations of morbidity

Forensic Services

2. In future forensic services will need to consider how to develop expertise in the identification and assessment of personality disordered offenders in order to provide effective liaison to MAPPPs.

3. The DH expects to pump prime the development of a small number of personality disorder centres nationally within regional forensic services to provide dedicated infrastructure for the assessment, treatment and management of personality disordered offenders.

Staff Selection, Supervision, Education and Training

4. The DH will engage in dialogue with the Royal Colleges, regulatory bodies and curriculum setting bodies

   - to address the gap in training provided at pre-registration and pre-qualification for key disciplines
   - to influence the content of undergraduate syllabuses
   - to influence the mechanisms determining selection of CPD educational opportunities

5. The DH expects to pump prime the development of new training opportunities, inviting tenders from recognised sites of good practice and from training providers to offer a range of inputs to Trusts delivering personality disorder services, and to expand the pool and range of personality disorder courses available nationally. Training providers will need to consider how best to involve service users in training professionals.

Background

How common is personality disorder?

1. Health professionals have not always agreed how best to identify personality disorders, but over recent years the World Health Organisation and the American Psychiatric Association have produced useful definitions.

2. The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation 1992), defines a personality disorder as: *'a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'*.

3. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) defines a personality disorder as: *'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment".*

4. There are nine categories of ICD-10 personality disorder and ten categories of DSM-IV personality disorder. The classification scheme is unwieldy as personality-disordered patients rarely belong to just one category of personality disorder. However, the DSM clustering system provides a useful solution to this problem by grouping the subcategories of DSM-IV personality disorder into three broad 'clusters': Cluster A, B and C. These are as follows:

- Cluster A (the 'odd or eccentric' types): paranoid, schizoid and schizotypal personality disorder

Example of a Cluster A patient

AA was referred by his GP to psychiatric outpatients, following the death of his father with whom he had lived. Father had been a 'distant' figure who had suffered a nervous breakdown in early life and, according to A, had 'heard voices'. A had deluged the GP with numerous ways in which the health service had let down his father but had few complaints on his own behalf. However, history-taking revealed a longstanding fascination with the occult and, since his father's death, a preoccupation with euthanasia. This had concerned the GP and occasioned the referral.

A had been a shy child and later a 'poor mixer', with no contacts outside the family. He had no academic qualifications. He had only worked intermittently and for brief periods in solitary situations, for example as a warehouseman. He had been involved in occasional 'scuffles' in the street but had no convictions for violence. He had no sexual experience. He lived with his elderly mother who had chronic arthritis and who, since the death of her husband, depended on him for shopping and the collection of regular drug prescriptions.

At interview, A was hard to engage. He seemed to be lost in his own thoughts and found responding to the interviewing psychiatrist's questions difficult. However, there were no symptoms or signs to suggest a major mood disorder or psychosis. His mother who was also interviewed indicated that her main concern was that A was spending increasing amounts of time at the library or on the internet 'researching' euthanasia and that 'this was not healthy'.

Having gathered sufficient information to make a diagnosis of a Cluster A PD, the psychiatrist recommended attendance at a local Day Hospital to carry out both an assessment of A's social functioning, and the extent to which he might be able to widen his options and activities, and also of his level of risk in relation to his ideas of euthanasia and the safety of his mother. Early observation confirmed his social awkwardness and revealed him to be self-obsessed and easily raised to anger if challenged to engage more socially. His risk assessment continues.

- Cluster B (the 'dramatic, emotional or erratic' types): histrionic, narcissistic, antisocial and borderline personality disorders

Example of a Cluster B patient

BB is a 22 year old unemployed single woman whose two children were adopted shortly after birth.

In the early hours of Saturday morning, B (who was well known to the psychiatric service as someone suffering from a Cluster B PD) had been admitted to the local acute psychiatric ward from the Accident and Emergency Department. She had slashed both her wrists following a row with her ex-boyfriend. This was the latest in a long series of violent relationships with men. None lasted more than a few months. B had become pregnant on five occasions but only two of these had gone to term. On both occasions the infant had been removed into care to be adopted shortly afterwards, as B was not considered to be a fit mother.

B herself had been the product of a short-lived relationship. Her mother had many partners subsequently, some of whom had sexually abused B. It was not clear whether mother had been aware of this as B was growing up. The latter had been noted to be intelligent when assessed at primary school but had played truant from an early age and been expelled for violence to a teacher when at secondary school. By this time she was already abusing both alcohol and 'soft' drugs. This behaviour escalated after leaving school to include heroin addiction. To feed this habit B had prostituted herself on a number of occasions.

At interview on the psychiatric ward, B was noted to have multiple scars on both arms and some on her abdomen. She described herself as feeling 'empty and dead inside'- feelings that were relieved in the short-term by her self-harming. She intermittently heard 'a male voice' inside her head but there was no evidence of a major mood disorder or of psychosis. On the ward she quickly settled into the routine not appearing unduly depressed. She made friends with the younger patients there and was continually asking favours of the younger staff members, sometimes being intrusive and sexually inappropriate. She left the ward on her third day and returned with cannabis, which she encouraged other patients to share. She was discharged on account of this after it was discovered since there were no reasons to consider compulsory detention. She has been referred for an outpatient assessment for psychotherapy.

- Cluster C (the 'anxious and fearful' types): obsessive-compulsive, avoidant and dependent

Example of a Cluster C patient

CC is 42 a mother of four and recently separated from her husband of twenty years.
C was referred by the GP to the liaison psychiatrist visiting his clinic. The GP described C as a kind woman, devoted to her family but who had been a frequent attender over the years for many minor physical ailments. Mostly it was possible to reassure her and yet she would return as before, albeit with a 'new' complaint. Now C had presented tearful and in a dishevelled state accompanied by her eldest daughter who was also upset. It quickly materialised that husband had left the family and it was this that had brought about the current presentation. What also emerged, however, from talking to the daughter, was a long history of agoraphobia, previously unreported due to C's feelings of shame.

C had been an only child of elderly parents. She had always been under-confident and had found it hard going to school and moving to secondary school, where she was also bullied on account of being seen as 'teacher's pet' She was, however, successful academically. After leaving school at 16, she met an older, confident man, a friend of the family, and married him, quickly falling pregnant. He ran his own business from home and C made herself invaluable in taking care of the accounts as well as running the home. She had always been excessively neat and tidy and 'kept the books' and the house in such a state of regimentation that both husband and the children felt uncomfortable. The business proved so successful over the year, however, that it was taken over, enabling husband (and B) in effect to retire early. This change of routine affected C badly. Her husband wished to travel to take advantage of their new freedom only to find that C 'refused' to join him. Eventually he struck up a relationship with a younger woman and suddenly left the marital home. The psychiatrist diagnosed a Cluster C PD in addition to the longstanding phobic disorder. Both aspects are being addressed via a cognitive-behavioural approach from a clinical psychologist. Her depressive symptoms have improved as progress has been made with her ability to leave the housed unaccompanied. She feels freer, although still ashamed of having a psychological problem in the first place. There are no plans for a reconciliation with husband but the relationship with her children is improved, being mutually supportive. Previously, C now realises, she was somewhat infantilising of her teenage brood.

5. Personality disorders are common conditions, although there is considerable variation in severity, and in the degree of distress and dysfunction caused. Epidemiological data needs to be interpreted with some caution, as studies use varying diagnostic standards.

6. Studies indicate prevalence of 10-13% of the adult population in the community, and show that personality disorders are more common in younger age groups (25-44 yrs) and equally distributed between males and females. However, the sex ratio for specific types of personality disorder is variable e.g. antisocial personality disorder is commoner among males, and borderline personality disorder commoner amongst females. Compared with white people, black people attract a diagnosis of personality disorder relatively infrequently. It is still unclear whether this reflects a true difference in prevalence or errors of diagnostic practice.

7. Personality disordered individuals are more likely to suffer from alcohol and drug problems and are also more likely to experience adverse life events, such as relationship difficulties, housing problems and long-term unemployment.

8. Antisocial personality disorder has a prevalence of between 2 - 3%, and is commoner in men, younger people, those of low socio-economic status, single individuals, and in those who have been poorly educated. There is a very high prevalence of personality disorder in the prison population – one recent study indicated this was as high as 78%, with antisocial personality disorder being the most common presentation.

9. Personality disorder in adults has its origins in childhood disturbance. Adults who present with antisocial personality disorder have often been subjected to severe neglect and abuse and are likely to have a parent or caregiver who has a psychiatric disorder and has difficulties in parenting. Key factors in the development of antisocial personality disorder include the early onset of conduct problems, persistent antisocial behaviour, and the presence of attention-deficit/hyperactivity disorder. There is currently no reliable method of identifying adolescents who are a high risk for developing antisocial personality disorder in adult life.

10. Estimates of the prevalence of personality disorders in psychiatric hospital populations vary, but range between 36% - 67%. In psychiatric settings, people with Cluster B personality disorders attract the most attention. They have poor impulse control and often present when in crisis, threatening deliberate self- harm, or aggression to others. Personality disorders are particularly prevalent amongst inpatients with drug, alcohol, and eating disorders. People with personality disorders are more vulnerable to other psychiatric conditions, and in particular, they are more likely to suffer from depression. The existence of a co-morbid personality disorder can complicate recovery in severe mental illness (e.g. schizophrenia.)

11. What is clear is that people with personality disorders make heavy demands on local services, which are often ill equipped to deal with these. One of the characteristics of this group is that they often evoke high levels of anxiety in carers, relatives and professionals. They tend to have relatively frequent, often escalating, contact across a spectrum of services including mental health, social services, A&E, GPs and the criminal justice system. They may present to mental health services with recurrent deliberate self harm, substance abuse, interpersonal problems that may include violence, various symptoms of anxiety and depression, brief psychotic episodes, and eating disturbances.

12. Providing appropriate treatment for people with personality disorder requires clinicians to develop particular skills. Access to good systems for support and supervision is essential: without this staff may experience burn out and exhaustion.

For Further Information: see Key Text on Website link (as listed in Appendix 1)

- **Moran, P. The Epidemiology of Personality Disorders (2002)**

What services currently exist?

General Adult Mental Health Services:

What are Trusts providing ?

13. Many general mental health services struggle to provide an adequate service for people with personality disorder. In many services people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to inpatient wards, on caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them. They have become the new revolving door patients, with multiple admissions, inadequate care planning and infrequent follow-up.

14. Many clinicians are reluctant to work with people with personality disorder because they believe that they have neither the skills, training, or resources to provide an adequate service. Clinicians may find the nature of interactions with personality disordered patients so difficult that they are reluctant to get involved.

15. There is significant disparity in the availability of services for people with personality disorder. A questionnaire issued to all Trusts in England providing general adult mental health services in 2002 found that 17% of trusts provide a dedicated personality disorder service, 40% provide some level of service, and 28% provide no identified service. No Response was obtained from the remainder.

16. These results present a confusing picture that requires some interpretation. We know that all dual diagnosis/drug & alcohol and eating disorder services are treating significant numbers of people with personality disorder. Similarly, clinicians and practitioners in every Trust will assess and provide some kind of intervention for people with personality disorder, if only to exclude them from active treatment. For the 28% of Trusts indicating that they provide no service, this should be taken to mean that the treatment of personality disorder is not seen as the focus of intervention, and that these Trusts do not see the provision of services for personality disorder as being part of their core business.

17. Amongst those Trusts providing services for personality disorder, there was a disparity of therapeutic approach and mode of service delivery. Trusts providing services used the full range of recognised therapeutic models. The most common therapies used being psychodynamic psychotherapy, cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), or cognitive analytic therapy (CAT). Services were being delivered both on an out patient and day patient basis by the full range of disciplines, with the lead being taken variously by psychology departments, psychotherapy departments, community mental health teams, and

specialised PD teams. The only dedicated in patient provision currently provided is in specialist therapeutic communities, although several respondents noted that people with a primary diagnosis of personality disorder are admitted to general in-patient psychiatric wards, often inappropriately, because of a lack of other service options.

18. There was no agreement as to the need to cater for this group. A number of Trusts recognised the inadequate nature of their provision, and several were in the process of reviewing the organisation of their general mental health services with a view to trying to establish an agreed approach to the management of individuals with a personality disorder. However, a minority of respondents did not accept the need to provide a service for people with personality disorder, raising the issue of the "medicalising" of personality disorder as a cause for concern.

19. There are a limited number of gold standard services. Detailed additional information was provided by those Trusts with dedicated personality disorder services, and some examples of these services are cited in this document. No common patterns could be discerned as to costs, numbers of referrals, or numbers in treatment, although it was clear that several services were being delivered at a low cost, involving a handful of clinicians. Many of these services had grown up because of the enthusiasm and commitment of a single individual, who had successfully championed the cause of personality disorder services in the locality, attracting other clinicians over time to join, and persuading local commissioners to fund.

Notable Practice Site :

Winterbourne House – Reading: A therapeutic community as an intensive treatment programme.

The district psychotherapy service is part of the adult mental health services for Berkshire Healthcare Trust, with an intensive treatment programme run as a therapeutic community for the most disturbed patients. The therapeutic community serves a population of about 800,000. The service takes 400-500 referrals per annum, mainly from local GPs, psychiatrists and CMHTs. About 10% of all referrals are routed to the therapeutic community, where the assessment programme is one afternoon per week for between 2 and 12 months, followed by a daily programme of up to 18 months. In the outpatient programmes, individual work takes 12 weeks to 2 years, and group therapy 6 months to 3 years. Inpatients from local psychiatric hospitals can start to attend the assessment programme for the therapeutic community, and some outpatient therapy. A new "inreach" service runs inpatient groups, undertakes joint assessments and offers staff teams 'difficult patient' supervision and general consultancy work with inpatient wards.

What about residential provision ?

20. Patients with severe personality disorder can benefit from intensive residential treatment, and there are currently five specialist residential units which are run as therapeutic communities, and take referrals from across the country. Three of these units, the Henderson Hospital (Sutton, Surrey), Webb House (Crewe) and Main House (Birmingham) currently receive central funding from NSCAG. The Cassell Hospital (Richmond, Surrey) provides separate residential accommodation for adults, adolescents and families, and is part of West London Mental Health Trust. Francis Dixon Lodge (Leicester) is a Monday to Friday residential unit with 15 beds, 10 day places and an outreach programme.

Notable Practice Site :

The Cassel Hospital - Richmond : A therapeutic community

The Cassel Hospital has developed the concept of treating personality disordered patients in a therapeutic community and offers this service to patients who have proved largely resistant to other forms of psychiatric treatment.

The Cassel Hospital is recognised internationally as a leading treatment, research and training centre. It has pioneered a psychosocial model for assessment and treatment, integrating psychoanalytical and social systems theory. Treatment consists of a combination of psychosocial practice and psychoanalytical psychotherapy within a structured therapeutic community.

The hospital, part of West London Mental Health Trust, is widely considered to be a centre of excellence in the treatment of severe emotional and behavioural disturbances in both families and individuals. There are Inpatient Services for Adults, Families and Adolescents, and a Children's Centre, as well as an Outpatient Psychotherapy Service and Outreach Psychosocial Nursing Service.

Forensic Services:

high security

21. Services for the treatment of patients with psychopathic disorder are provided at all 3 high secure hospitals – Ashworth, Rampton and Broadmoor, and these services provide a real repository of expertise in the treatment of personality disorder. Ashworth and Rampton have personality disorder units, whilst at Broadmoor, patients are treated across a number of units, the greatest concentration being on Woodstock ward. A range of therapeutic models are used.

22. Regional commissioners have estimated that around a third of patients with a primary diagnosis of personality disorder in high security could be appropriately cared for in a less secure environment. But because of the lack of service infrastructure for personality disorder many wait long periods of time – years in some cases- for an appropriate placement to be found, either in medium security or in a community setting.

23. It is however acknowledged and recognised that there will be an ongoing need to provide services within high security for patients with a primary diagnosis of personality disorder. Although small specialist units for DSPD are being built (cf para 24), these will cater for the needs of a small group only, and will not replace existing personality disorder provision in high security.

24. 140 new places are being purpose built in new units at Rampton and Broadmoor for those people who are assessed as dangerous as a result of a severe personality disorder (DSPD). It is planned that these units will be operational from 2003/4. These services will be designed to treat only those offenders who demonstrate a clear functional link between their personality disorder and their offending behaviour, and who pose a very high risk indeed to the public. It is estimated that as few as 10% of the current patients in personality disorder beds in the 3 high secure hospitals would meet the criteria to transfer to these units.

25. Parallel developments are taking place within the prison estate. 160 places will be provided at HMP Whitemoor and HMP Frankland by 2003/4.

local and regional forensic services

26. Local and regional forensic services treat many patients with co-morbidity – where aspects of personality disorder present alongside symptoms of major mental illness. However, there is very little in the way of dedicated infrastructure for the assessment or treatment of personality disorder. Arnold Lodge in Leicester is currently the only NHS unit with designated forensic personality disorder beds in the country. There is also some expertise within the independent sector, notably at Kneesworth House.

27. Almost all patients in forensic settings are held under sections of the Mental Health Act, and the current 1983 Act is often interpreted as excluding those with personality disorder from compulsory detention because of the requirement that the mental disorder be "treatable". (i.e. treatment is likely to alleviate or prevent a deterioration in the patient's condition). Many clinicians have not seen personality disorder as a mental disorder that is treatable. This will change with the new mental health legislation (cf paras 60-63) which removes the treatability clause, and provides a generic description of mental disorder.

Notable Practice Site :

Arnold Lodge – Leicester : A forensic residential personality disorder unit within a medium secure unit

The personality disorder Unit at Arnold Lodge aims to reduce the likelihood of further offending by offering treatment to men who have both an offending history and a personality disorder. It is a 12 bedded facility within a medium secure unit dedicated to the treatment of male offenders with a personality disorder. It offers a service to residents of Trent , with the majority of referrals coming from prison, and is funded by health authorities within the region. Individuals first undergo a detailed pre-admission assessment to determine if they are suitable for the unit. If deemed to be suitable, they are then admitted for a maximum period of two years. This is sub-divided into a three-month assessment, a 15-month treatment and a six-month pre discharge phase. The total duration of admission and its various phases are rigidly adhered to, thereby giving the programme a sharply defined focus. Treatment is offered in both group and individual formats. All treatments are integrated so that there is an expectation that gains in any area are generalised to the wider community in which the individuals live.

28. A questionnaire issued to all Trusts providing medium secure forensic services and to independent sector providers of forensic services in 2002 provided evidence of the very limited services for patients with PD within forensic settings.

29. Although medium secure units (MSUs) are experienced in the treatment of patients with co-morbidity, the majority only treat one or two patients as inpatients at any time who have a primary diagnosis of personality disorder. Generally this is because they find it very difficult to manage patients with personality disorder in the same wards as those with major mental illness, and also believe they lack the expertise to provide an effective service for this group. A few units actively exclude patients with a primary diagnosis of personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service.

30. The most common word used by units to describe the therapeutic models and interventions was "eclectic". Units describe a mix of cognitive behaviour approaches, psychodynamic psychotherapy and some therapeutic community elements in the treatment model. CBT was the most commonly mentioned therapeutic provision.

31. There were wide differences in staff training and support, with many units committed to the support and supervision of their staff, but less focussed on their training. The training of staff seemed to be on an "ad hoc " basis, with a great variety in training methods between units. Many reported not having any specific training for work with pd patients. Others reported staff attending courses "when these are arranged " or trained "on the job".

other specialist NHS services:

32. The Portman Clinic in London is the centre for the assessment, treatment, consultation and training for forensic psychotherapy for the UK. It provides an outpatient NHS psychotherapy clinic for people who suffer with problems from criminal or violent behaviour or from disturbing sexual experiences, and accepts referrals from anywhere in the UK. The expansion of specialist training in forensic psychotherapy is a recent development, with training now available in Oxford, Birmingham, Trent, Yorkshire and the North West, as well as in London.

outside the healthcare system: other provision for personality disordered offenders

33. Large numbers of offenders with personality disorders receive the bulk of their care and management from other agencies: social services, voluntary organisations, housing departments and probation. Many are in prison. Whilst none of theses agencies specialise in the management of personality disorder, examples can be found of approaches that have been adopted to meet the needs of this group.

34. The National Probation Services has developed two recent initiatives which will encompass offenders with personality disorder: community based sex offender treatment programmes (SOTP) and the Offender Assessment System (OASys). OASys provides a structured assessment tool to identify the risk of reconviction, and to identify and classify offending related needs, including basic personality characteristics.

35. Initiatives within the prison service include small scale DBT pilots in a limited number of women's prisons, and the gradual introduction of prison inreach teams to all prisons in England. Inreach teams have been set up to provide better general mental health care throughout the prison, both on the wings and in the health centre, using a multi-disciplinary community team approach. Whilst this has been set up primarily to target prisoners with severe mental illness, inreach teams in 6 prisons will focus their attention on prisoners with personality disorder.

36. There are currently 2 prisons which have specialised therapeutic community regimes, geared to cater for offenders with a personality disorder: HMP Grendon Underwood, and HMP Dovegate. The experience in the prison estate is that the therapeutic community setting reduces self harm, assaults on staff, abuse of drugs, and provides a safe environment for treatment to take place.

37. HMP Grendon has 230 beds, and is a specialist prison for males, designed to run on the lines of a therapeutic community for those with a personality disorder. No one is transferred against their will; motivation to change and a willingness to participate in group work are important selection criteria.

38. The treatment model used in HMP Dovegate is similar, although with a slightly different focus. The population is not exclusively personality disordered, and there is a very strong emphasis on the development of skills that will be useful on release. It also differs from HMP Grendon in that psychologists, in contrast to psychotherapists, run the therapy.

Notable Practice Site :

HMP Grendon - A Therapeutic Community

Grendon Prison is a specialist centre for the treatment of personality disorder particularly as it gives rise to serious offending. Five theraputic communities within the prison offer intensive group psychotherapy and social therapy. This core therapy is complemented by activities such as art therapy, psychodrama and cognitive behavioural groups. There is a strong emphasis on multi-disciplinary working and each team consists of forensic psychologist, prison officers, probation officer and psychodynamic psychotherapist . The focus of much of the work is upon disordered relationships, which often arise from intolerable and uncontainable feelings, and the outcome of violence or other offending. Through exploring the past and present, clients can begin to make sense of their cycles of being abused and abusing and through forming reparative relationships with staff over a period of years the energy for violence can be ameliorated.

What do service users want?

The views of service users

39. Views of service users were captured by means of a service user focus group, as well as discussion with a number of organisations that represented service users and carers. The key thoughts and views gathered were as follows:

"A very sticky label"

40. No mental disorder carries a greater stigma than the diagnosis "Personality Disorder", and those diagnosed can feel labelled by professionals as well as by society. There was a strong feeling that many professionals did not understand the diagnosis, and often equated it with untreatability.

41. Those with personality disorder have been described as "*the patients psychiatrists dislike*", and many reported being called time-wasters, difficult, manipulative, bed-wasters or attention-seeking. Some felt that a more appropriate description would be "attachment-seeking". They felt blamed for their condition and often sought basic acceptance and someone to listen to them. They sought to gain legitimacy rather than being told "you're not mentally ill". Some preferred terms such as "emotional distress".

42. 'Antisocial personality disorder' was felt to be even more stigmatising, and there was concern that the "dangerous and severe personality disorder" label would be wrongly applied, and lead to an inappropriate use of compulsory detention.

43. It was acknowledged that accurate diagnosis could be a useful process, but needed to be backed up with the provision of reliable information. Unlike other conditions there is little easily available printed information for patients. More is available on the internet, but its quality is variable, and much is American with little relevance for British service provision.

Experience of Services

44. There was strong agreement that there are not enough services available for people with personality disorder. In the main, experiences of general adult mental health services were negative. Unhelpful attitudes from staff were encountered, who would see "just the label", and were often prejudiced about the condition, and belittling or patronising in manner. Although the benefits of CPA being required were acknowledged, the experience was that procedures were often not followed or not helpful.

45. The different attitudes in adolescent services, compared with adult ones, towards intervention and treatability were striking. Early intervention was highlighted as crucial to the prevention of major deterioration in personality disorder. The need for specific services covering an age range of about 15 -25 was suggested.

"Had I been helped when younger I would not have got this bad."

46. Users felt that there needs to be acknowledgement by professionals that personality disorder is treatable: a negative experience on initial referral to a psychiatrist makes engagement less likely. There was also general agreement that endings of therapeutic relationships were often not addressed adequately. Also, once people show any improvement, services can be removed; this can discourage improvement.

"There is a link between hurting yourself and getting support and treatment. It is hard to resist self- harming behaviour when, you know if you do it, you will get treatment."

Staffing issues

47. Users thought that staff need to be skilled to handle therapeutic relationships, particularly regarding attachment. They need to deal sensitively with issues of gender and sexual orientation in those who have a history of abuse. Staff with their own experiences of mental health difficulties were perceived as having much more insight into the difficulties of patients. It was recognised however that in clinical settings problems arise when boundaries break down, and staff begin to share their own problems with patients. However, it was felt to be therapeutically important for there to be a shared experience between patient and professional, and for professionals to be in touch with the patient's distress but not overwhelmed by it.

48. A number of users thought that they should be engaged and paid to help train professionals in order to promote greater understanding, although it was recognised that this could be a challenging task.

Public awareness and education

49. Users suggested teaching about mental health in schools as part of the life skills and citizenship curriculum. This could have a preventative function, educate adolescents about vulnerability, how to seek appropriate help, and reduce stigma.

50. Users thought that TV soap operas, discussions and documentaries could be effective ways of communicating information, whilst recognising that it is difficult to control how mental health is portrayed. Concerns about "*putting ideas into people's heads*" in relation to self-harm, eating disorders or

personality disorder were acknowledged. They thought that leaflets and posters in GP surgeries and other health settings would be help raise awareness. This could help turn the label of personality disorder into something that could be discussed between users and professionals, and "*stop it being a dirty secret*".

Helpful/Unhelpful characteristics of services

51. One task of the focus groups was to identify characteristics of the service they have found helpful, and unhelpful:

Helpful features for personality disorder services

- Early interventions, before crisis point
- Specialist services, not part of general MH
- Choice from a range of treatment options
- Individually tailored care
- Therapeutic optimism & high expectations
- Develops patients' skills
- Fosters the use of creativity
- Respects strengths and weaknesses
- Good clear communication
- Accepting, reliable, consistent
- Clear and negotiated treatment contracts
  Focus on education and personal development
- Good assessment/treatment link
- Conducive environment
- Listens to feedback and has strong voice from service users
- Supportive peer networks
- Shared understanding of boundaries
- Appropriate follow up and continuing care
- Involves patients as experts
- Attitude of acceptance and sympathy
- Atmosphere of "truth and trust"

...can make people feel respected, valued and hopeful

Unhelpful features for personality disorder services

- Availability determined by postcode
- Office hours only
- Lack of continuity of staff
- Staff without appropriate training
- Treatment decided only by funding/availability/diagnosis
- Inability to fulfil promises made
- Critical of expressed needs (e.g. crisis or respite)
- Staff only respond to behaviour
- Staff not interested in causes of behaviour
- Dismissive or pessimistic attitudes
- Rigid adherence to a therapeutic model in cases where it becomes unhelpful
- Passing on information without knowing a person
- Long-term admissions
- Use of physical restraint and obtrusive levels of observation
- Inappropriate, automatic or forcible use of medication
- Withdrawal of contact used as sanction

...can make people into "career psychiatric patients"

For Further Information see Key Text on Website link: (as listed in Appendix 1)

- **Haigh, R. Services for People with Personality Disorder: The Thoughts of Service Users (2002)**

Which treatments work?

Treatment in primary care and general mental health settings:

52. Many clinicians are sceptical about the effectiveness of treatment interventions for personality disorder, and hence often reluctant to accept people with a primary diagnosis of personality disorder for treatment. However, a range of treatment interventions are available for personality disorder, including psychological treatments and drug therapy, and there is a growing body of literature available on the efficacy of varying treatment approaches. In a study commissioned for this report, Bateman & Tyrer conclude that whilst more research is needed, there are real grounds for optimism that therapeutic interventions can work for personality disordered patients.

53. Bateman & Tyrer review the available evidence on treatment for personality disorder, but do not prescribe any one particular approach. They conclude that in general, a combination of psychological treatments reinforced by drug therapy at critical times is the consensus view of treatment in personality disorder.

54. They also identify the key guiding principles of effective therapy for personality disorder viz. that therapy should:

- be well structured
- devote effort to achieving adherence
- have a clear focus
- be theoretically coherent to both therapist and patient
- be relatively long term
- be well integrated with other services available to the patient
- involve a clear treatment alliance between therapist and patient

55. Part of the benefit which severely personality disordered individuals derive from their treatment comes through their experience of being involved in a well-constructed, well-structured and coherent interpersonal endeavour.

56. The psychological treatments available are as follows:

The drug treatments available are as follows:

Dynamic psychotherapy

- This is based on a developmental model of personality
- Treatment is generally long term
- The aim of therapy is to understand the way in which the past influences the present with the use of interpretation
- Treatment focuses on the therapeutic alliance between patient and therapist, the individual's emotional life, and defences
- Therapy uses the relationship between patient and therapist (transference) as a way to understand how the internal world of the individual affects relationships

Cognitive Analytical Therapy

- Postulates that a set of partially dissociated 'self-states' account for the clinical features of borderline personality disorder
- Rapid switching between these self-states leads to dyscontrol of emotions including intense expression and virtual absence (depersonalisation)
- Therapy aims to formulate these processes collaboratively,examining them as they occur in treatment as well as in life experiences

Cognitive Therapy

- This is a modification of standard cognitive and behaviour therapy that is goal directed and focused more on altering underlying belief structures rather than reduction of symptoms
- It is likely to take up to 30 sessions of treatment of which the initial ones help to define the areas of intervention by identifying what are the fundamental structures of past, present and future experiences
- The therapist and patient maintain a collaborative therapeutic alliance throughout treatment and include homework and testing of core beliefs and structures

Dialectic Behaviour Therapy (DBT)

- This is a special adaptation of cognitive therapy, originally used for the treatment of women with borderline personality disorder who harmed themselves repeatedly
- DBT is a manualised therapy including functional analysis of behaviour, skills training and support (empathy, validation of feelings, management of trauma)
- Directed at reducing self-harm

Therapeutic Community Treatments

- Therapeutic communities provide intensive psychosocial treatment which may include a variety of therapies but where the therapeutic environment itself is seen as the primary agent of change
- They include democratic and concept types, the former including members of the community as decision makers
- External control is kept to a minimum: members of the community take a significant role in decision making and the everyday running of the unit

Antipsychotic drugs

- These have shown variable results in controlled trials
- Reduction in hostility and impulsivity are claimed but not always reliably achieved
- 'Schizotypal' features are helped most
- Atypical neuroleptics may offer advantages but results are preliminary

Antidepressant drugs

- Both tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs) have been recommended in the treatment of borderline personality disorder
- Improvement in borderline patients may be linked to depressive symptoms rather than personality pathology
- Impulsiveness is particularly improved and SSRIs may offer advantages in this respect

Mood stabilisers

- Lithium, carbamazepine and sodium valproate have all been used to treat symptoms of mood disorder in those with personality disorder
- There is weak support for the notion that cluster B (antisocial, borderline, histrionic and impulsive) personality disorders may be helped by mood stabilisers

Treatment in forensic settings for personality disordered offenders

57. The range of treatments described above will form a key part of the therapeutic repertoire available to clinicians treating personality disordered offenders. However, in forensic settings, treatment interventions for personality disorder are aimed not just at relieving the symptoms of mental distress, but also at preventing re-offending.

58. A number of interventions have been developed which are aimed specifically at addressing offending behaviour. In a study commissioned for this report, Craissati et al. describe the key treatments available and review the research evidence. These are as follows:

Thinking Skills

- programmes include Enhanced Thinking Skills (prison service), Think First (probation service) and Reasoning and Rehabilitation (multiple use)
- group programmes comprise between 40 and 80 hours of treatment contact
- treatment goals include being to enhance self-control, inter-personal problem solving skills, social perspective taking, critical reasoning skills, cognitive style, and an understanding of the values which govern behaviour.
- brief focussed training of multi-professional groups is emphasised, in order to ensure treatment integrity and consistent programme delivery.

Dialectical Behaviour Therapy

- a modified version of DBT, for use with men with a diagnosis of antisocial personality disorder, is currently being adapted for use by high secure personality disorder services

Anger/violence management

- recent evaluated programmes for personality disordered offenders in secure health settings include social problem solving, and a Violence Risk Programme
- the RAID ("Reinforce Appropriate, Ignore Difficult and Disruptive") approach for working with extreme behaviour is based on improving and strengthening interpersonal relationships; it is being piloted in high secure personality disorder services

Sex Offender Treatment Programmes

- accredited sex offender treatment programmes (SOTP) take place in prison and the community; additionally, multi-agency programmes have been developed to meet specialist needs, such as for adolescents or personality disordered sex offenders
- programmes are based on a cognitive-behavioural model of treatment, which involves:
  - recognising the patterns of distorted thinking which allow the contemplation of illegal sexual acts,
  - understanding the impact which sexually abusive behaviour has on its victims
  - identifying key triggers to offending as an aid to relapse prevention
- reducing recidivism has been shown to be contingent upon the level of deviancy demonstrated by the offender, and the duration of treatment (between 100-200 hours)

Forensic Psychoanalytic Psychotherapy

- the stated aim of treatment is to help free patients from the more self-destructive ways of feeling, thinking, and behaving and so to enable them to live and function more easily in the community
- staff are multi-disciplinary, but all have undertaken further training as psychoanalytic psychotherapists or psychoanalysts
- the model emphasises consultation and support in forensic services

59. Individuals who score highly on the high scoring psychopaths – as measured by the Psychopathy Checklist (PCL-R, Hare, 1991) - have been thought to perform poorly in therapeutic programmes. However, eclectic long term approaches, such as group and individual therapy, psychoanalytic and the inclusion of family members in treatment programmes, have been found to be highly effective.

For Further Information see Key Text on Website link: (as listed in Appendix 1)

- **Bateman, A. & Tyrer, P. Effective Management of Personality Disorder (2002)**

- **Craissati, J. Horne, L. & Taylor, R. Effective Treatment Models for Personality Disordered Offenders (2002)**

The proposed mental health legislation

60. The proposed mental health legislation introduces a generic and inclusive definition of mental disorder, which will mean that in future people with all forms of personality disorder, including psychopathic disorder, can be subject to compulsion in the same way as those with other forms of mental illness, provided that they meet the conditions for compulsion.

61. The changes proposed in the draft Mental Health Bill – the broad definition of mental disorder, the abolition of the so-called "treatability test" in relation to psychopathic disorder and the provisions enabling compulsory treatment in the community – will highlight the need for new community and in-patient services for people with personality disorder. This will place a new emphasis on the assessment and treatment of personality disorder as part of the legitimate business of mental health services.

62. The introduction of the proposed legislation is likely to have the an impact on clinical practice in the following ways:

- Clinicians will need to develop skills in the identification, assessment and treatment of personality disorder, and appropriate training will need to be provided across all disciplines at pre-qualification, and post qualification stages , as well as becoming part of continuing professional development (CPD)

- Offenders with personality disorders, including psychopathic disorder, will become the legitimate business of mental health services, and there will be an important role for Trusts to provide liaison and consultation to local criminal justice agencies via, the MAPPPs (multi-agency public protection panels).

63. The bulk of work with personality disordered offenders is likely to fall to forensic services both for consultation and advice to criminal justice agencies, and for the assessment, treatment and management of personality disordered offenders. The section on forensic services (paras 88-115) recognises this development, and makes specific recommendations as to how this should be handled.

64. MAPPPs were established by the Criminal Justice and Court Services Act 2000 to make joint arrangements for the assessment and management of the risks posed by sexual and violent offenders. The Act placed a statutory duty on the police and probation to co-operate in this process, and invited the participation of other agencies, notably Social Services, Health and Local Authority Housing Departments.

65. MAPPPs function differently across the country: some discuss risks posed by the "critical few" i.e. those offenders who pose the highest level of risk, whilst others consider cases with a much lower threshold of risk . New Guidelines are being issued to bring a greater degree of uniformity in the way MAPPPs operate. The contribution of health is also variable: responses to a survey issued by DH in 2002 revealed that some Trusts are represented by senior managers at their local MAPPP, others by senior clinicians, and a few by more junior practitioners from the local CMHT (community mental health team).

66. However, MAPPPs are playing an increasingly important role in the multi agency management and supervision of offenders in the community, and are likely to become the key forum for local criminal justice agencies to seek psychiatric advice and consultation from their local Mental Health Trust on the management of mentally disordered offenders. Requests for the preliminary examination of mentally disordered offenders in the community under the proposed Mental Health legislation are likely to be channelled through MAPPPs. It is therefore important that Trusts should be represented by senior clinicians who can provide expert advice, both to divert inappropriate referrals and to ensure that ensure that psychiatric opinion is provided wherever necessary.

Guidance on the development of service models:

General adult mental health services

67. All Trusts delivering general adult mental health services need to consider how to meet the needs of patients with a personality disorder who experience significant distress or difficulty as a result of their disorder.

Specialist Team

68. Trusts are currently developing a range of community teams to meet the requirements of the NHS Plan and NSF to provide appropriate care for those with severe mental illness. In the same way all Trusts may also wish to consider the development of a specialist personality disorder team to meet the needs of those with personality disorder who experience significant distress or difficulty.

69. Such a team would provide the hub within a hub and spoke approach to service delivery, and should target those with significant distress or difficulty who present with complex problems. This development need not be resource intensive, but is likely to require some dedicated funding in order to create several additional specialist posts from any recognised professional background to form a multi-disciplinary team.

70. The following guiding principles should underpin such a development:

- Personality disordered patients will need multi-disciplinary input and a team approach
- Treatment of personality disordered patients should be led by clinicians with appropriate expertise and dedicated resources
- Triggers for referral and acceptance of patients by service hub, and co-working and/or consultation with service spokes will depend on the severity of the patient's personality disorder and the capacity of less specialised services to provide appropriate treatment and containment

71. In a specialist team model, a group of specially trained practitioners work together and, whilst they may divide their roles, all are part of a specialist service. Patients with personality disorder need to feel that those responsible for their care communicate frequently and effectively, get on well together, and are clear about boundaries of treatment. One member may provide individual psychotherapy whilst another is primarily involved in working on behalf of the patient with courts, housing, or social aspects of care, and yet another may provide psychiatric care.

72. All work together as a treatment team and information is shared allowing interventions and management to be informed fully by biological, psychological, and social understanding. Good working relationships within the team and close collaboration are essential if treatment is to be consistent and implemented according to agreed protocols.

73. It is recommended that the specialist team would ideally sit within existing psychotherapy, psychological therapy or psychology departments. Although it may be appropriate for the service to operate from the psychotherapy department, the model of service delivery will be more flexible, multi-disciplinary and assertive than conventional psychotherapy.

74. It is important that there is clarity about the remit of this team and that it does not exclude those patients who most require a service. It is recommended that clear protocols drawn up at the outset, describing referral protocols, and setting out the relationship between this services and other teams, in–patient wards and specialisms within general adult mental health services.

75. The core functions of the specialist team would be as follows:

- To take on patients for assessment and treatment in line with the principles of the Care Programme Approach (CPA)
- To provide consultation and support, supervision and training
- To develop a clear link with local district and regional forensic services
- To develop a self help network
- To set up out of hours/crisis arrangements

Notable Practice Site :

Intensive Psychological Therapies Service (IPTS) – Dorset: An outpatient service

The IPTS is a specialist service for people with a personality disorder. Approximately 50% of patients meet DSM-IV criteria for borderline personality disorder and many engage in self-harming behaviours. The service aims to aim to provide evidence-based, cost-effective outpatient treatments, reduce self-harming behaviour, reduce the frequency and duration of hospital admissions, help patients become more skilled in managing their emotions and relationships, and improve the quality of their lives.

Taking on patients for assessment and treatment.

76. The primary responsibility of the specialist team would be to undertake the comprehensive assessment, treatment and co-ordination of care for patients with a personality disorder, using the mechanism of the CPA. Triggers for referral and acceptance of patients will depend on severity of the patient's personality disorder. This is likely to be determined by:

- The risk of harm to self or to others
- The presence of co-morbid mental illness and/or addiction and the severity of these accompanying problems
- The complexity of personal pathology, including the presence of one or more personality disorders from a single cluster, or diffuse personality disorder (two personality disorders from more than one cluster)
- The degree of burden/distress caused to family and other agencies
- High consultation frequency within general practice

77. The specialist team would take on those patients who experience significant distress or difficulty as a result of their personality disorder, and who present with complex problems. Patients taken on for treatment should meet the criteria for enhanced CPA, and the team should deliver care according to its principles. The team would take responsibility for the management of risk including sharing relevant information where necessary with other staff, consistent with the law, and good practise regarding confidentiality.

78. As discussed above, (para 52) the current state of research evidence on treatment discourages prescriptive statements about the type of treatments which patients should be offered by specialist services, but we can identify the key guiding principles of effective therapy to which all specialist personality disorder teams should adhere. (para 54)

Notable Practice Site :

Paddington Outreach Rehabilitation Team (PORT) – An assertive outreach team

PORT is an assertive outreach team in Paddington that concentrates its work on the care of the most difficult patients in the area, North Westminster, all of whom have personality disorders. It has a maximum case load of 100 all of whom have had recurrent admissions to hospital, are very difficult to engage, cause significant disruption in the community and have an average of three different and largely independent diagnoses. All patients are referred as tertiary referrals from the existing services in Paddington and North Westminster and, after a course of treatment that can extend from 6 months to many years, may be referred back to the maonstream services once they reach a position of stability and are able to cooperate with standard aftercare arrangements.

Providing consultation and support, supervision and training

79. The specialist team would provide consultation and support for staff working in a range of settings in accordance with agreed protocols:

- within the adult mental health service (eg, in patient ward, community teams)
- across the Trust (to CAMHS, A&E, and drug & alcohol teams etc)
- to external agencies (social services, probation, housing, primary care).

80. The provision of consultancy and support should be seen as the core secondary function of the service, and one which should enable staff in a range of settings to manage personality disordered patients who experience significant distress or difficulty. It would take a variety of forms including one –off case discussion, regular case review, initial joint assessments, and shared care.

81. Similarly, the provision of regular case supervision and training would provide the necessary structure to enable staff in a range of settings to take on patients with less severe presentations onto their caseloads.

Developing a clear link with local and regional forensic services

82. The specialist team would develop close links with the local forensic service in order to share and develop expertise, and to pool resources (eg. for staff supervision). Clear protocols would need to be drawn up to set out the mechanics for the transfer of the care of patients between general mental health and forensic services.

Developing a user network

83. Informal mutual support networks operating outside normal working times (overnight and weekends) have been found to be helpful in containing personality disordered patients until services reopen, and in reducing the demands on emergency services. The specialist team would provide the necessary structure and support for service users to develop a self help network that provides mutual support, and links into professionally run out of hours service as needed.

Setting up out of hours/crisis arrangements

84. The Trust will need to ensure that out of hours arrangements are drawn up and linked to existing Trust infrastructure for out of hours services, but with an explicit personality disorder focus. This is to ensure that patients with personality disorder who experience significant distress or difficulty can access care when in crisis, and thence minimise inappropriate use of emergency services, primary care and A&E.

Day Units

85. The need to develop day units will depend on the population and demographics of the Trust catchment area, and it is advised that Trusts with high concentrations of morbidity should develop specialist day patient services, in addition to the specialist team outpatient service. This could involve the re-focusing or re-use of current services and facilities. Such units should be developed in tandem with an outpatient service, and would be expected to prioritise patients with severe personality disorder, including patients who pose a risk to self or others, and who place heavy demands on primary and secondary care.

Notable Practice Site :

Halliwick Unit – London: A day unit and intensive outreach service

The Halliwick Psychotherapy Unit provides a treatment service tailored to the specific needs of patients with severe personality disorder. A package of group and individual treatment is therefore offered either within a day hospital over five days or within an intensive outpatient programme involving three sessions per week. Patients are also offered a self-booking psychiatric clinic to discuss medication and a rapid response in emergencies. Engagement of the patient is important and assertive outreach is included within the programme.

Inpatient and residential units

86. There is no expectation that Trusts should provide dedicated in patient provision for people with personality disorder. Patients with personality disorder do sometimes access in-patient beds, but the role of acute in-patient units in treating patients with personality disorder is largely confined to managing crises, including escalation in risk to self or others.

87. There are currently five specialist residential units run as therapeutic communities (para 20). There are no plans to extend this level of residential provision.

Notable Practice Site :

Francis Dixon Lodge : A Monday to Friday residential theraputic community

Francis Dixon Lodge is a Monday to Friday residential theraputic community, part of the Leicestershire and Rutland Healthcare Trust. It has approximately 50 places per year and accepts referrals from CMHTs, probation, social services and self referrals. Residents play an active part in the day to day running and activities of the unit, whilst using the setting of large and small groups to talk about and try to understand the nature of their difficulties. The day to day experience of living and working together is felt to be as important as formal therapy and the structure is such that the two are closely integrated and inform each other.

Guidance Points:

General Adult Mental Health Services

1. Good practice indicates that service provision for personality disorder can most appropriately be provided by means of:

    - the development of a specialist multi-disciplinary personality disorder team to target those with significant distress or difficulty who present with complex problems.

    - the development of specialist day patient services in areas with high concentrations of morbidity

For Further Information: see Key Text on Website link (as listed in Appendix 1)

- **Fahy,T. General Adult Mental Health – Service Model (2002)**

Forensic Services

88. The basic assumptions on which the delivery of services for personality disordered offenders are based are no different to those underpinning treatment within general mental health services. In other words, (cf paras 70-71) treatment should be led by clinicians with appropriate expertise and access to dedicated resources, and be delivered by a multi-disciplinary team in accordance with the principles of the Care Programme Approach (CPA)

89. However, forensic services are required not only to provide treatment interventions, but also to address offending behaviour, and the reduction of risk. In the case of offenders with personality disorder there is also a need to address issues of social functioning, in order to tackle antisocial behaviour, social exclusion and disorganisation. This underlines the need to develop effective working partnerships with criminal justice agencies, particularly through MAPPPs (multi- agency public protection panels).(cf paras 64-66)

90. Services for personality disordered offenders would therefore combine four key elements: the treatment and/or management of :

- social functioning
- mental health issues
- offending behaviour
- risk

and they should operate in very close partnership with local criminal justice agencies.

91. Over time a range of service provision will need to be developed within forensic services. There needs to be a clear link between this provision and personality disorder services in high secure hospitals, so that there is a clear pathway and continuum of care for all personality disordered offenders across all levels of security. This is vital in order to ensure that patients do not get stuck at one level of security and are unable to move when they are ready to do so.

92. New services are required for offenders with personality disorder in order to:

- fill the gap in current provision,

- meet the new demands that are likely to arise as a result of the proposed mental health legislation, particularly in relation to the need to provide liaison, consultation and advice on the assessment and management of personality disordered offenders for criminal justice agencies via. the MAPPP

- link in with prison mental health care services in order to provide treatment for some very disturbed and difficult individuals in prison for whom services do not currently exist

Development of Expertise

93. All Trusts delivering forensic services will need to consider how to develop expertise in the identification and assessment of offenders with personality disorder. This may involve the provision of specialist training for a number of existing staff, and/or the creation of a small specialist multi-disciplinary team.

94. This team would work in close partnership with criminal justice agencies, and would provide:

- consultation, liaison and case management advice

- advice to courts, including court reports

- preliminary examination under the proposed mental health legislation

- links with prison mental health care services

95. Where appropriate the team would also take on the treatment and management of personality disordered offenders, and would provide an assertive outreach service to those individuals who are unwilling to engage with services, and who, because of their offending history, and the nature of the risks they pose, will need assertive management in the community.

96. Close links will be need to be made between this team, and the specialist personality disorder teams being developed within general mental health services in order to share and develop expertise, and to pool resources (eg. for staff supervision). Clear protocols will be required for the transfer of the care of personality disordered patients between general mental health and forensic services.

Personality Disorder Centres

97. The DH expects to pump prime the development of a small number of personality disorder centres nationally within regional forensic services to provide dedicated infrastructure for the assessment, treatment and management of personality disordered offenders. We anticipate that these centres will provide for the treatment of male offenders most of whom will have a primary diagnosis of antisocial personality disorder.

98. Work is currently in hand to develop three early pilots: two in London and one in the North East, which between them will pilot the main components of a personality disorder centre. The pilots will initially provide services for their local catchment area.

99. In time these personality disorder centres will provide:

- new service infrastructure for the treatment of personality disordered offenders
- in-patient assessment and treatment services for a broad geographical catchment area
- a focus for research into effective interventions
- training and consultation for forensic services in local Trusts to assist them to develop their own expertise with personality disordered offenders

100. These centres should provide a range of services including in patient facilities , a multi-disciplinary specialist team, and specialist psychiatric support for community hostels and other forms of supervised accommodation. They will need to work closely with local police, probation and prisons, and to link in with local prison mental health inreach services.

101. The core clinical function of these centres will be to provide:

- **Assessment under the proposed mental health legislation**
- **Short term treatment**
- **Longer term rehabilitation**

102. They will take referrals from the courts, from prisons, from local criminal justice agencies, from high secure hospitals, from local general mental health services and from the forensic services in other Trusts.

103. Triggers for referral and acceptance of offenders to these centres should include the following:

- Presence of one or more personality disorders
- History of persistent or very severe antisocial behaviour
- Considered by experienced workers to be at risk of harm to others

104. The philosophy of care provided by these centres will be in accordance with the principles of the Care Programme Approach (CPA), and a key function will be to ensure that risk assessment is carried out on all offenders referred to the service. There are a range of risk assessment tools available, and it is anticipated that clinicians will use a combination of actuarial tools and clinical judgement to assess risk.

Assessment under the proposed mental health legislation

105. Under the proposed mental health legislation, Trusts will be required to respond to any "reasonable request" for preliminary examination. In the case of personality disordered offenders, such requests are likely to be made by local criminal justice agencies, often via the MAPPP, and every Trust should consider how to develop the necessary expertise to respond to such requests. (cf para 62)

106. As part of the process of preliminary examination a decision will be made as to whether someone meets the criteria for detention under the Mental Health Act of up to a 28 day period of assessment. Such assessment should wherever possible take place within one of the designated personality disorder centres, rather than in a standard medium secure unit (MSU) or in a general acute mental health ward. These centres will therefore take patients for assessment from a wide geographic catchment area.

107. Specialist DSPD assessment units will be provided at Rampton and Broadmoor for those offenders who are thought to pose a very high risk and to exhibit severe personality disorder.

Short term treatment

108. This would include:

- treatment under the Mental Health Act following assessment, where a tribunal decides that detention for a period of treatment is warranted
- treatment of patients taken in from prison for specific interventions aimed to address their offending behaviour and their personality disorder

- treatment of patients under the Mental Health Act, who have been assessed for the DSPD units at Broadmoor or Rampton, do not meet the threshold of dangerousness for continued treatment in a maximum secure DSPD unit, but where a tribunal decides they require further compulsion and intervention

- crisis management of patients requiring short term interventions from community placements and community hostels

109. The current state of research evidence on treatment discourages prescriptive statements about which type of interventions should be offered, but interventions should be targeted both at relieving the symptoms of mental distress, and at preventing re-offending.

Longer term rehabilitation.

110. Longer term beds are needed for some patients leaving high secure hospitals. There are clearly patients with psychopathic disorder within the current system who could move directly from high secure hospitals to supervised accommodation in the community, with the right level of support. Research indicates that direct transition to a supported community setting may be associated with a better eventual outcome for those whose risk has been assessed to be low, than a move to an interim setting of a medium secure unit.

111. However, there will also be a need for a limited number of longer term rehabilitative beds for those requiring the level of containment that a medium secure unit offers.

112. In time these facilities will also provide rehabilitation for those offenders who are assessed as ready to leave DSPD high secure units, but who require step-down care in a medium secure setting, prior to discharge into the community.

113. Community hostel and supported accommodation will be needed to provide step-down care from medium secure provision, as well as having the facility to take directly from high secure hospitals, from the community and from prison. Community hostels can work effectively with different agencies taking responsibility for different aspects of care; the housing stock provided and administered by a housing association, day to day care delivered by a specialist care provider, and psychiatric care provided by clinicians from the personality disorder centre.

114. All Trusts hosting a personality disorder centre will be required to develop community hostel places in conjunction with local suppliers, and to provide the specialist psychiatric input to the residents living there.

115. There will need to be an overarching service model that sets out the relationship between multidisciplinary specialist team, the inpatient facility and the community hostel, to ensure continuity of care, and clarity of responsibility.

Guidance Points:

Forensic Services

2. In future forensic services will need to consider how to develop expertise in the identification and assessment of personality disordered offenders in order to provide effective liaison to MAPPPs.

3. The DH expects to pump prime the development of a small number of personality disorder centres nationally within regional forensic services to provide dedicated infrastructure for the assessment, treatment and management of personality disordered offenders.

For Further Information: see Key Text on Website link (as listed in Appendix 1)

- **Thomas-Peter, B. Forensic Service Models (2002)**

Staff Selection, Supervision, Education and Training

Key Issues:

116. The need to provide appropriate training opportunities for staff at all levels of experience- from the newly qualified practitioner to the experienced clinical leader - is a central requirement of this Guidance. Practitioners will need to develop skills in the identification, assessment and treatment of personality disorder both within existing services, and in particular in existing forensic services, and in new personality disorder teams and services as these become established.

117. It is important that training is team focused, supported and valued by the organisation, and tailored to meet the specific requirements of the service. It should also be recognised that the provision of training is not solely the province of professionals. Service users who contributed to the development of this strategy were keen to stress the value of user involvement in training, and some current training providers, including the Henderson Hospital actively involve users in their training programme. The active involvement of service users in training is an area that requires further thought and development.

118. But training alone is not sufficient. Pre-registration and pre-qualification education across all disciplines needs to offer sufficient grounding to provide practitioners with an understanding of the basic issues involved in the treatment of personality disorder. Continuing professional development (CPD) needs to be appropriately targeted to ensure that clinicians who may be experienced mental health professionals, but who have had little exposure to working with people with a primary diagnosis of personality disorder, can develop new skills.

119. It is also important that the right staff are selected to work in this field, and that they are supported by their organisation through the provision of access to adequate support and supervision. A scoping study commissioned for this report by Maria Duggan identified existing training capacity in personality disorder and also explored the competencies and attributes ideally required by staff to work effectively with people with personality disorder.

The Selection of Staff:

120. Working in the field of personality disorder is not easy. Staff need a high degree of personal resilience and particular personal qualities that allow them to maintain good boundaries, survive hostility and manage conflict. They need to appreciate the value of team working, be effective team players and feel comfortable working as part of a multi-disciplinary team.

121. The scoping study suggests that in some important respects, the competencies required to work effectively with people with personality disorder are similar to those required for work with other groups of people with mental disorders, although there are also some key differences. These include emotional resilience, particular clarity about personal and interpersonal boundaries, and the ability to tolerate and withstand the particular emotional impact that working with personality disordered patients can have on relationships within a team and service.

122. Further work needs to be done to build on existing competency/capability frameworks in order to identify more clearly the particular attributes needed for effective work with personality disordered patients. The DH will collaborate with the lead Workforce Development Confederation to provide an indicative list of competencies at various levels, taking account of the differing skills needed by newly qualified practitioners, experienced clinicians and clinical leaders across all disciplines.

123. The development of these competencies will assist Trusts in deploying and recruiting staff for personality disorder services, and will provide the framework to ensure that selection procedures are appropriately targeted to facilitate the appointment of staff with the appropriate personal characteristics and skills.

Supervision:

124. As well as having the appropriate personal characteristics to work effectively in this field, practitioners also need access to regular supervision. Without this there is likely to be a high degree of staff burn out, absenteeism, sickness and disillusion , and services may fail.

125. All personality disorder teams and services should set out robust structures for supervision that support reflective practise, and assist staff to manage anxiety and deal with conflict. There will be a need both for individual supervision, and for team based supervision and case discussion. This is particularly important in forensic services where staff are likely to be working with offenders who have no wish to engage in treatment, and who may be very resistant and hostile.

Education:

126. The scoping study found that pre-registration/pre-qualification education across all mental health disciplines generally provides little specific content that would enable trainees to understand and feel confident to assess or manage personality disorder, although those with an interest could seek out training attachments that would address this gap.

127. The importance of continuing professional development (CPD) is recognised across all disciplines, but the choice of course or educational event attended may well be determined again by the individual practitioner's interests, rather than changing service need.

128. In order to promote greater generic understanding of personality disorder DH will engage in dialogue with the Royal Colleges, regulatory bodies and curriculum setting bodies

- to address the gap in training provided at pre-registration and pre-qualification for key disciplines
- to influence the content of undergraduate syllabuses
- to influence the mechanisms determining selection of CPD educational opportunities

Training:

Characteristics of Training

129. Training should be team focused, supported and valued by the organisation, appropriately targeted and context specific.

130. **Team focused.** The management and treatment of patients with personality disorder requires the expertise of a multi-disciplinary team (paras 68-71). Patients with personality disorder need to feel that those responsible for their care communicate frequently and effectively, get on well together, and are clear about boundaries of treatment. Training in team building and team working should be provided as an essential part of the training requirements of a personality disorder service. Team focused training will need to assist practitioners to work effectively in teams by addressing issues around hierarchy, rivalry, conflict resolution and collaboration.

131. **Supported and valued by the organisation.** It is essential that the Trust recognises and supports the need for training in personality disorder both for existing staff and where new services or teams are being established, by identifying the necessary resource and by providing cover where necessary to free up staff to attend training.

132. **Appropriately targeted.** The training needs of newly qualified staff will be different to those of experienced practitioners and to those of clinical leaders, and training should be targeted to meet recognise different needs. The role of clinical leader is crucial, and particular attention should be given to ensure that leaders are adequately trained, with the requisite skills as individual therapist, as team leaders, and as political players within their organisation.

133. **Responsive to local need.** Training must be tailored to meet the specific requirements of the service. Staff working in forensic services, for example, are likely to need specific training in the identification and assessment of personality disorder, so that they can provide appropriate liaison and consultation to MAPPPs. If a service is dealing with a number of very aggressive individuals with behavioural dyscontrol, it makes sense to have several staff trained in skills based approaches. Conversely, if other problems pre-dominate (e.g. self-harming behaviour because of childhood sexual abuse) it may be appropriate to call on DBT or psychodynamic psychotherapy.

Training:

Availability

134. It is not always easy for Trusts to access the right training for their staff. The scoping study commissioned for this report found that there is a paucity of training available at all levels of demand.

135. The study found that access to training in specialist therapeutic techniques is limited, with a small number of courses being delivered by an equally small number of training providers. Such training as is available is often driven by local needs and interests and by the energy and commitment of local "product champions". The current level of training provision is not adequate to support any major service expansion at any level.

136. In addition, less formal opportunities for learning from acknowledged experts in the field are reducing. The Personality Disorder Beacon scheme, set up as part of the NHS Beacon initiative, funded 5 beacon sites to provide advice and consultation to Trusts wishing to develop personality disorder services, through educational visit and day events. The NHS Beacon initiative came to an end in

2002. The Personality Disorder Beacon scheme provided a very useful opportunity, particularly in personality disorder, for Trusts to learn from the experience of established services, and the withdrawal of funding leaves a significant gap.

137. In order to stimulate training initiatives, DH will pump prime the development of new training opportunities. DH will invite tenders from recognised sites of good practice and from training providers to enable them to develop or to expand their training arm to:

- provide a range of inputs to Trusts delivering personality disorder services.
- expand the pool and range of personality disorder courses available nationally

138. Tenders will be invited for the provision of a range of training opportunities which could include:

- educational visits
- on-going advice and consultancy
- basic introductory training in working with personality disordered patients
- team management and team building
- training in specialist techniques

139. DH will work with the lead Workforce Development Confederation, and with the National Institute of Mental Health (NIMHE) to work up a tendering exercise, and to examine a range of options to develop appropriate training opportunities. It will be important to ensure that new training opportunities set up as a result of the tendering exercise do not themselves become fragmented and ad hoc in their delivery.

Guidance Points:

Staff Selection, Supervision, Education and Training

4. The DH will engage in dialogue with the Royal Colleges, regulatory bodies and curriculum setting bodies

   - to address the gap in training provided at pre-registration and pre-qualification for key disciplines
   - to influence the content of undergraduate syllabuses
   - to influence the mechanisms determining the selection of CPD educational opportunities

5. The DH expects to pump prime the development of new training opportunities, inviting tenders from recognised sites of good practice and from training providers to offer a range of inputs to trusts delivering personality disorder services, and to expand the pool and range of personality disorder courses available nationally. Training providers will need to consider how best to involve service users in training professionals.

For Further Information: see Key Text on Website link (as listed in Appendix 1)

- **Duggan, M. Developing Services for people with Personality Disorder: The Training Needs of Staff and Services (2002)**

Appendix 1

Key Texts

All were written in 2002, and will be posted on the following websites:
www.nimhe.org.uk and at www.doh.gov.uk

Effective Management of Personality Disorder	Dr Anthony Bateman & Professor Peter Tyrer
Effective Treatment Models for Personality Disordered Offenders	Jackie Craissati, Louise Horne, & Ricky Taylor
Pathways in and out of secure care for personality disordered offenders	Professor Conor Duggan
Developing Services forPeople With Personality Disorder: The Training Needs of Staff and Services	Maria Duggan
General Adult Mental Health - Service Model	Professor Thomas Fahy
Services for People with Personality Disorder: The Thoughts of Service Users	Dr Rex Haigh
The Epidemiology of Personality Disorders	Dr Paul Moran
Personality Disorder in African and African-Caribbean People in the U.K.	Dr David Ndegwa
Forensic Service Models	Professor Brian Thomas-Peter
Personality Disorder and Substance Abuse	Dr Sarah Welch

Appendix 2

Strategy Development Process

Membership of expert groups

Dr Anthony Bateman	Consultant Psychotherapist, Halliwick Day Unit, London
Dr Jed Boardman	Consultant Psychiatrist, General Mental Health Services, South London & Maudsley
Ms Jackie Craissati	Head of Forensic Clinical Psychology Services, The Bracton Centre
Professor Conor Duggan	Consultant Forensic Psychiatrist, Arnold Lodge, Leicester
Ms Maria Duggan	Independent Policy Analyst, London
Professor Tom Fahy Chair of GMH Sub Group	Consultant Forensic Psychiatrist, Institute of Psychiatry
Dr Brian Ferguson	Consultant Psychiatrist, General Mental Health Services, Stonebridge Centre, Nottingham
Mr Paul Gantley	Social Work Manager, Three Bridges MSU, Enfield and Broadmoor Hospital
Acting Superintendent Ray Groves	West Mercia Police
Professor John Gunn	Consultant Forensic Psychiatrist, Institute of Psychiatry
Dr Rex Haigh	Consultant Psychiatrist in Psychotherapy, Winterbourne House, Reading
Ms Louise Horne	Chartered Clinical Psychologist, Ashworth
Dr Jeremy Holmes	Senior Lecturer In Psychotherapy, Barnstaple, North Devon

Dr Gill McGauley	Senior Lecturer, Consultant Forensic Psychotherapist, Broadmoor
Ms Fiona McGruer	Nurse Consultant, Webb House Theraputic Community
Dr Sarah Marriott	Consultant Psychiatrist, General Mental Health Services
Ms Elizabeth Moody	Joint Programme Head, DSPD Programme and Mental Health Unit, Home Office
Dr Paul Moran	Honorary Specialist Registrar, Institute of Psychiatry
Mr Andrew Morley	DSPD Programme, Home Office
Dr Kingsley Norton Chair of Training Sub group	Director of Henderson Hospital, Sutton
Mr Adam Penwarden	Business and Policy Development Manager, Stonham Housing Association
Mr Simon Rippon	Nurse Consultant, Miranda House, Hull
Dr Tony Roth	Joint Course Director, and Chartered Clinical Psychologist, UCL
Ms Ethel Samkange	Director of Link Worker Schemes, The Revolving Door Agency, London
Mr Chris Scanlon	Psychotherapist, Henderson Outreach Service
Ms Sara Scott	Deputy Director, The Revolving Door Agency, London
Ms Fiona Spencer	Joint Programme Head, DSPD Programme and Mental Health Unit, Home Office
Dr Pete Snowden	Chair of Steering Group Consultant Forensic Psychiatrist, Ashworth
Mr Les Storey	University of Central Lancashire
Mr Ricky Taylor	R&D Project Manager, DSPD Programme, Home Office
Professor Brian Thomas-Peter Chair of Forensic Sub Group	Director of Psychological Services, The Reaside Clinic, Birmingham

Ms Louise Tuhill	Acting Assistant Chief Probation Officer, Mitre House, London
Professor Peter Tyrer	Consultant Psychiatrist, Imperial College
Ms Georgina Wilcocks	PD Services Directorate Manager, Rampton
Dr Heather Wood	Clinical Psychologist, Halliwick Day Unit, London
Dr Tony Zigmond	Consultant Psychiatrist, General Mental Health Services, Leeds

Membership of Service User Focus groups

Lesley Allen	Northants
Mary-Ann Ambrose	Colchester
Yolandé Hadden	Berkshire
Cameron Jordan	Colchester
Liz Main	London
Sheena Money	Berkshire
A. Mills	London
Peter Oates	London
Paul Priami	Coventry
Ms S. Mulholland	London
Hannah Stein	London
Jayne Treby	Jersey
Kati Turner	London

Focus Group Facilitators

Dr Rex Haigh	Consultant Psychiatrist in Psychotherapy, Winterbourne House
Dr Kevin Healy	Clinical Director, The Cassell Hospital, Richmond, Surrey
Ms Fiona McGruer	Nurse Consultant, Theraputic Community Service
Dr Gary Winship	Adult Psychotherapist, Winterbourne House

Advice from User Groups

Jean Haldane	Breakthrough
Dale Ashman	Borderline UK
Vicky Cox	Borderline UK
Debbie Tallis	Borderline UK
Heather Castillo	Colchester Mind
Maggi Harrison	District Alliance
Julie Bayley	First Steps to Freedom, and BPD Carers
Michael Connar	First Steps to Freedom
Sue Johnson	James Naylor Foundation

Input from North East

Anthony Nemo	Service User
Dr Peter Whewell	Consultant Psychotherapist, Newcastle
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Further Input from

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